SETTLEMENT AGREEMENT

dated as of

May 23, 2005

by and among

DEFENDANTS,

THE REPRESENTATIVE PLAINTIFFS,

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AND CLASS COUNSEL

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 Medical Society of the State of New York (hereinafter "MSSNY") and 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 Medical Society of the State of New York v. Excellus, Inc., et al. and Dolan, et al. v. Excellus, Inc., et al. Civ. Nos. 9769-01, 9768-01 the "Actions") (hereinafter collectively, "Plaintiffs") and Excellus, Inc. Excellus Health Plan, Inc., and Excellus Benefits Services, Inc., (hereinafter collectively "Defendant"). MSSNY, the Representative Plaintiffs, the Class Members who have not validly and timely requested to Opt-Out of this Agreement, and the Defendant 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, on August 15, 2001 an action was filed in the Supreme Court, State of New York, County of Monroe (the "Court"), entitled Dolan, et al.v. Excellus, Inc., et al. and whereas an action was filed on August 15, 2001 in the Supreme Court, State of New York, County of Monroe, entitled Medical Society of the State of New York v. Excellus, Inc., et al.

WHEREAS, on May 22, 2003, an action was filed in the United States District Court for the Southern District of Florida entitled Thomas, et al., v. Blue Cross and Blue Shield Association, et al., Case No. 03-21296-CIV (the "Thomas Action").

WHEREAS, Defendant denies the material factual allegations and legal claims asserted in the Actions, 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 Actions including without limitation the allegations that the Representative Plaintiffs and/or other Class Members have suffered damages; that Defendant improperly manipulated claim procedures or fraudulently misrepresented the criteria for insurance coverage determination, treatment decisions, and payments; that Defendant 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 Actions;

WHEREAS, Defendant has asserted a number of defenses to the claims set forth in the Actions that Defendant believes are meritorious; nonetheless, Defendant has a desire to make more transparent, simplify and otherwise improve

the system through which it conducts business with Representative Plaintiffs and other class members, has concluded that further conduct of the Actions would be protracted and expensive and that it is desirable that the Actions be fully and finally settled in the manner and upon the terms and conditions set forth in this Agreement;

WHEREAS, the Representative Plaintiffs believe that the claims asserted in the Actions have merit; provided that Class Counsel recognize and acknowledge the expense and length of continued proceedings that would be necessary to prosecute the Actions against Defendant 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 Actions, as well as the difficulties and delays inherent in such Actions, and Counsel for the Representative Plaintiffs believe that the settlement set forth in this Agreement confers substantial benefits upon the Representative Plaintiffs and the other Class Members;

WHEREAS, based on their evaluation of all of these factors, and recognizing that Defendant'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, Plaintiffs have determined that it is in their best interests to obtain the benefits afforded 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 § 7;

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 MSSNY and 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 Defendant, that, subject to the approval of the Court, the Actions and the Released Claims shall be finally and fully resolved, compromised, discharged and settled under the following terms and conditions:

1. Definitions.

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

1.1. "**Actions**" means Dolan, et al. v. Excellus, Inc., et al. and Medical Society of the State of New York v. Excellus, Inc., et al., Nos. 9768-01 and 9769-01, Supreme Court, State of New York, County of Monroe.

1.2. "**Active Physician**" means a Class Member who is a Physician and who is not a Retired Physician.

1.3. "**Active Physician Benefit**" shall have the meaning assigned to that term in § 8 of this Agreement.

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

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

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

1.7. "**Billing Dispute**" shall have the meaning assigned to that term in § 7.10 of this Agreement.

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

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

1.10. "**Class**" means any and all Participating and Non-Participating Physicians, Physicians Groups and Physician Organizations who provided Covered Services in the State of New York to any Plan Member or any individual enrolled in or covered by an insured plan in the State of New York offered or administered by any Person named as a defendant in the Actions or by any of their respective current or former subsidiaries or affiliates, in each case from August 15, 1996 through the Preliminary Approval Date.

1.11. "**Class Counsel**" means those Persons set forth on Exhibit A attached hereto.

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

1.13. **"Complete Claim"** means a claim for Covered Services that (a) is timely received by Company (b) has a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (c) (i) when submitted via paper has all the elements of the UB-92 or Form 1500 (or successor standard) forms as specified in the New York State Insurance Regulation defining "clean claims" (II NYCRR Section 217) 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, and (d) is a claim for which Company is a responsible payor.

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

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

1.16. **"Company"** means Excellus Health Plan, Inc.

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

1.18. **"Compliance Dispute"** means (i) any claim with respect to which 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 § 1.71 and § 13.2 of this Agreement that is not also any of the following: (A) a Released Claim, (B) a Billing Dispute; or (C) a claim for which the Medical Necessity External Review Process is available.

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

1.20. **"Compliance Dispute Facilitator"** means the person who, pursuant to §11.1 a of this Agreement, shall first hear Compliance Disputes in conjunction with Company's Internal Compliance Officer.

1.21. **"Compliance Dispute Review Officer"** means the person chosen pursuant to § 11.1 b of this Agreement and charged with the administration of Compliance Reports and Compliance Disputes under this Agreement.

1.22. **"Court"** shall mean New York State Supreme Court, Monroe County.

1.23. **"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 Benefits Plan and which are provided by a Participating or

Non-Participating Physician or a licensed professional, working under the direction of a Physician, who is recognized by the Company to provide Covered Services.

1.24. **"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.

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

1.26. **"Day"** means a calendar day, unless otherwise noted herein.

1.27. **"Deductible"** means the amount a Plan Member must pay for Covered Services during a specified coverage period in accordance with the Plan Member's plan before benefits are payable by such Plan.

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

1.29. **Provision Deleted**

1.30. **"Effective Period"** of this Agreement shall be four years from the Implementation Date.

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

1.32. **"Electronic Remit Advice and Electronic Fund Transfer (ERA/EFT Software)"** shall have the meaning assigned to that term in § 7.12 of this Agreement.

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

1.34. "**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, and Class Counsel have been delivered to Company.

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

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

1.37. "**Implementation Date**" means the 41st day after the entry of the Final Order and Judgment approving this Agreement, unless a notice of appeal is filed therefrom. In such event, at the option of the Defendant, the Implementation Date shall be eleven calendar days after the Final Order and Judgment is affirmed, all appeals are dismissed, and no further appeal or review in any court remains.

1.38. "**Independent Practice Association**" means those IPAs and IPA-like entities with which Excellus has contracts as set forth in Exhibit D attached hereto.

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

1.40. "**Mailed Notice**" means the form of notice attached hereto as Exhibit E.

1.41. "**Material Adverse Change**" means any change in the Company's 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 for Covered Services (ii) a significant number of Participating Physicians' administration of their practices, or (iii) Physicians in any specialty or subspecialty.

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

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

1.44. "**Medical Necessity Independent Review Organization**" means an organization that provides independent medical reviews of Company's denials of coverage which are based on the lack of medical necessity or the experimental/investigational nature of the proposed or rendered service or supply for self-funded groups.

1.45. "**Multiple Procedure Logic**" means the adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered

Services (excluding evaluation and management CPT® Codes), when multiple such procedures or services are performed at the same session.

1.46. "**Non-Participating Physician**" means any Physician Class Member other than a Participating Physician.

1.47. "**Notice Date**" shall have the meaning assigned to that term in § 5.1 of this Agreement.

1.48. "**Objection Date**" shall have the meaning assigned to that term in § 5 of this Agreement.

1.49. "**Opt-Out**" shall have the meaning assigned to that term in § 5.1 of this Agreement.

1.50. "**Opt-Out Deadline**" shall have the meaning assigned to that term in § 5.1 of this Agreement.

1.51. "**Overpayment**" means, with respect to a claim submitted by or on behalf of a Physician (or Physician Group or Physician Organization), any erroneous or excess payment that Company makes because of payment of an incorrect rate, (e.g., inconsistent with the fee schedule), 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.

1.52. "**Participating Physician**" means any Physician who has entered into a valid written contract with the Company (directly or indirectly through a Physician Organization or Physician Group) to provide Covered Services during the period the contract is in force.

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

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

1.55. "**Petitioner**" shall have the meaning assigned to that term in § 11.2 of this Agreement.

1.56. "**Physician**" means an individual duly licensed by the New York State licensing board as a Medical Doctor or as a Doctor of Osteopathy and shall include both Participating Physicians and Non-Participating Physicians.

1.57. "**Physician Group**" means two or more Physicians who practice medicine under a single taxpayer identification number.

1.58. "**Physician Advisory Committee**" shall have the meaning assigned to that term in § 7.9 of this Agreement.

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

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

1.61. "**Physician Specialty Society**" means a United States medical specialty society recognized by the American Medical Association as a national medical specialty society or that represents physicians certified by a board recognized by the American Board of Medical Specialties.

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

1.63. "**Plan Member**" means an individual enrolled in or covered by a Plan offered or administered by Company. Plan Member does not include participants of the FEP program for Federal employees.

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

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

1.66. "**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.excellusbcbs.com/providers/index.shtml

1.67. **"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.excellusbcbs.com.

1.68. **"Published Notice"** means the form of notice attached hereto as Exhibit G.

1.69. **Provision Deleted**

1.70. **"Released Parties"** means the Defendant as defined and each of their respective officers, directors, employees, and attorneys, and their heirs, executors, administrators, legal representatives, assigns and agents.

1.71. **"Released Rights"** or **"Released Claims"** means any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities, and demands of whatever kind or character that relate, arise from, or pertain to billing or payment for Covered Services and includes any and all claims that have been or could have been asserted by or on behalf of MSSNY and any or all Class Members against the Released Persons, or any of them, and which arise prior to Final Approval by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in any of the Actions, 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 claims based upon a capitation agreement with Company, and any allegation that Company has conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions or with regard to Company's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, and/or other third parties. Notwithstanding this definition Released Claims do not include any claims that are alleged in the action Rochester Community Individual Practice Association, Inc. v. Finger Lake Health Insurance Company (State of New York, County of Monroe) Index No. 2975/98.

1.72. **"Releasing Parties"** (each a "Releasing Party") means MSSNY and Class Members who have not submitted a valid and timely Opt-Out of this Agreement and their respective heirs, executors, agents, legal representatives, professional corporations, partnerships, assigns and successors, and, to the extent they have claims against Company derived by contract or operation of law separate from the claims of such Class Members, any and all Subsidiaries, affiliates, shareholders, parents, directors, officers, employees, professional corporations, agents,

administrators, executors, legal representatives, partners and partnerships, heirs, predecessors, successors and assigns of such Class Members.

1.73. "**Representative Plaintiffs**" means William A. Dolan, M.D., and Sylvia W. Norton, M.D.

1.74. "**Retired Physician**" means a Class Member who, subsequent to August 15, 1996, has retired from the practice of, or has otherwise ceased to practice medicine, or has died.

1.75. "**Retired Physician Amount**" shall have the meaning assigned to that term in § 8 of this Agreement.

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

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

1.78. "**Senior Management**" shall have the meaning assigned to that term in § 11.7 of this Agreement.

1.79. "**Settlement Administrator**" shall be Rust Consulting, Inc.

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

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

1.82. "**Settlement Hearing Date**" shall have the meaning assigned to that term in § 6 of this Agreement.

1.83. "**Termination Date**" shall have the meaning assigned to that term in §24.2 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 Actions between Company and MSSNY and all Class Members who have not validly and timely requested to Opt-Out of this Agreement.

a. Commitment to Support and Communicate with Class Members

The Settling Parties agree that it is in their best interests to consummate this Agreement and to implement 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 endorse and 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 § 11.

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.

3. Preliminary Approval of Settlement.

Pursuant to New York Civil Practice Law and Rules Article 9, 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 F ("Preliminary Approval Order").

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

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

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

Company shall pay the reasonable cost of notice to Class Members, including without limitation first class mail costs for the mailing of the Mailed Notice, substantially in the same form as Exhibit E. Payment by Company of the cost of the Mailed Notice shall be non-refundable and shall be in addition to the other agreements made herein. Company shall pay for the cost to publish the Published Notice no more than three times in the legal notices section in the daily newspapers published in the regions the Company serves. 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 MSSNY's publication. 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 § 4:

Representative Plaintiffs and MSSNY: Notice to be given to Representative Class Counsel as described in § 20 on behalf of Representative Plaintiffs and MSSNY.

Class Counsel: Edith Kallas, Esq.
Milberg Weiss Bershad and Schulman
One Pennsylvania Plaza
49th Floor
New York, New York 10119

Company: Kimberly C. Lawrence, Esq.
Hinman Straub, P.C.
121 State Street
Albany, New York 12207

In the event that any Party receives a notice from any another Party (in accordance with the provisions of § 4 of this Agreement and as required by any other provision of this Agreement) and such receiving Party does not respond to

such notice within 20 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.

5. Procedure for Final Approval; Limited Waiver.

Following the dissemination of Notice as described in § 4, 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**").

5.1. Notice and Opt-Out Timing and Rights.

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

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

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

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

Within ten (10) days after the Opt-Out Deadline, the Settlement Administrator shall furnish Company with a complete list in machine-readable

form of all Opt-Out requests filed by the Opt-Out Deadline and not timely revoked. Company shall pay costs of obtaining a copy of the Opt-Out requests.

Notwithstanding any other provisions in this Agreement, after reviewing said list and/or copies of Opt-Out requests and revocations, Company reserves the right, in its sole and absolute discretion, to terminate this Agreement by delivering a notice of termination to Class Counsel, with a copy to the court, prior to the commencement of the Settlement Hearing if Company determines that Opt-Out requests have been filed (i) relating to or representing more than 5% of participating and/or non-participating Physicians who are Class Members; (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 the calendar year 2004; or (iii) one or more Independent Practice Associations.

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

Representative Plaintiffs, MSSNY, 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, MSSNY, 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 and shall meet and confer prior to the Settlement Hearing to coordinate their presentation to the Court in support of Court approval thereof.

6.1. Limited Waiver.

Solely for purposes of securing settlement of the Actions, upon the entry of the Final Judgment and Order, MSSNY, Representative Plaintiffs, the Class Members and Company shall be deemed to have waived any and all rights (known or unknown) to arbitrate any Released Claim.

7. Settlement Consideration: Business Practice Initiatives.

The settlement consideration to the Class Members who have not validly and timely requested to Opt-Out of this Agreement includes, among other things, initiatives and other commitments with respect to Company's business practices. The Parties agree that the business practice initiatives and other commitments set forth below, which absent this Agreement, Company would be under no obligation to undertake, constitute substantial value, and will enhance and facilitate the delivery of Physician Services by Class Members who have not validly and timely requested to Opt-Out of the Agreement. Company investigated

and began to implement certain of the business practice initiatives described in this § 7 while the Parties were engaged in discussions to resolve the Action. Such initial and partial implementation, which shows the Company's good faith desire to resolve the Actions, were undertaken to form part of the consideration of the settlement. Company shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives set forth below to such Class Members, if any, who Opt Out. Without in any way qualifying or limiting the foregoing, Company 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.

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 and other improvements deemed necessary by the Company not inconsistent with this Agreement.

Company shall be obligated to commence implementing each commitment set forth in this § 7 from and after the Implementation Date, except as otherwise expressly noted, and shall continue implementing such commitment until the Termination Date.

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 Company's Members through, among other things, efficiency in the processing of claims, has made substantial investments and will continue to make investments in target claims platforms to which the Company will be migrating substantially all the claims handling now being performed on its existing claims platforms; and by the use of its common claims platforms, and through streamlining processing on these platforms, will 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.

Company shall make investments designed to facilitate the automated adjudication of claims submitted by Physicians, which is intended to reduce the average time taken by Company to pay Complete Claims for Covered Services. Company shall develop and implement plans as soon as reasonably practical and intended to increase the rate of auto-adjudication of completed clean claims submitted by Physicians by not less than 5 percentage points by December 31, 2008.

7.2. Increased Internet and Clearinghouse Functionality.

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

Company will add all functionality now available through a dial-up connection to the provider website no later than twelve (12) months from the Implementation Date.

7.3. Availability of Fee Schedules and Scheduled Payment Dates.

Company shall develop and implement as soon as practical a plan reasonably designed to permit a Participating Physician or Participating Physician Group that, in each case, has entered into a written contract directly with Company to view, on the Provider Website, on a confidential basis, the complete fee schedule applicable to such Participating Physician pursuant to that Participating Physician's direct written agreement with Company. Each such fee schedule shall state the dollar amount or RVUs allowable for each CPT® code for Covered Services rendered by such Participating Physician's office. Company will distribute conversion factors to Participating Physicians by mail on a routine basis. This capability will be available in all other regions by twelve months after the Implementation Date. In the Rochester region, this website capability already exists. Commencing with the Implementation Date and continuing beyond implementation of the initiative described above, Company, upon written or electronic request from a Participating Physician or Participating Physician Group in the non-Rochester regions that, in each case, has entered into a written contract directly with Company, will provide via e-mail or hard copy the fee schedule for up to fifty CPT® high volume codes for their particular specialty, for such Participating Physician. Company will provide to any Participating Physician who requests more than fifty CPT© codes where more than fifty CPT© codes is standard and reasonable for the particular specialty. Company will use its best efforts to prepare and provide responsive information to requests within ten business days of receiving them.

7.4. Investments in Initiatives to Improve Provider Relations

Since the inception of this Litigation, and through the Termination Date, Company has and will expend significant amounts of money and other resources to improve its relations with those providing health care services and supplies to Plan Members and in particular to carry out the initiatives described in § 7.1, §

7.2, § 7.3, § 7.7, § 7.10, § 7.11, § 7.18, § 7.21, § 7.23, § 7.24 and § 11 of this Agreement.

7.5. Reduced Pre-Certification Requirements.

Company has reduced the number of procedures requiring pre-certification by Physicians and by December 2006 for Excellus BlueCross BlueShield products and December 2008 for non-BlueCross BlueShield products (in conjunction with claims processing system migration), will have the capability to permit Physicians to request pre-certification via internet access. For all regions and products, Company will determine which services require pre-certification, also known as pre-authorization, and will, to the extent possible given the differences in product designs, government programs and employer requirements, standardize the requirements. Company will standardize services and supplies for which pre-certification is required across all insured HMO, PPO and POS products with the exception of products under government programs and those targeting low income or uninsured populations for all regions by 18 months after the Implementation Date. This would consist of one standard list for insured HMO, POS and PPO products. Within six months of the Implementation Date, Company will post the pre-authorization requirements on its web site, and update this listing at least annually. Attached hereto as Exhibit H is the current pre-authorization list applicable to Participating Physicians. Not later than six (6) months after the Implementation Date, Company shall disclose on the Provider Website any customized pre-authorization list for one or more Self-Funded Plans administered by the Company applicable to Participating Physicians and shall update such disclosures as needed. The Report to be filed annually and at the end of the Effective Period shall attach a copy of Company's standard pre-certification list as of such date.

7.6. Greater Notice of Policy and Procedure Changes.

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

7.7. Initiatives to Reduce Claims Resubmissions.

Company has begun implementation of a series of initiatives, which have increased the percentage of claim issues resolved on initial review and thereby reduced the percentage of resubmitted claims. These initiatives include an

enhanced Clinical Outreach Program for physicians and their office staff designed to provide in-person education (and gather provider feedback) regarding appropriate billing practices consistent with this Agreement.

Company will follow regulatory requirements to satisfy both HIPAA and NYS Clean Claim regulations. In the event that claims are denied due to missing necessary information, an adjustment request can be completed on-line accessing Quicklink. Quicklink is a service of the Company that enables Provider and Facility offices with capabilities to do many transactions at their computers for which they would normally have to consult with a provider phone representative of the Company. Web development is underway with the focus on developing an on-line adjustment form. This will enable the Participating Physician to access the form via the Web, complete and return it electronically. This enhancement is targeted for deployment by 12 months after the Implementation Date.

In addition, a Provider Outreach program (which will include, in part, visits to physicians offices) will be implemented to increase the use of electronic transactions, reduce redundant claim submissions and improve workflow through provider education. A variety of training alternatives will be offered for providers and their staff. Additionally, an open exchange of ideas and issues designed to enhance interchange of information between Company and their provider partners will be encouraged through the use of focus groups and workteams.

Company agrees to continue these or comparable business practices during the Effective Period. Company agrees to provide evidence of activities that are reasonably designed to enhance the implementation of such practice or practices in the Report to be filed annually and at the end of the Effective Period.

7.8. Disclosure of and Commitments Concerning Claim Payment Practices.

Company shall take actions reasonably necessary on its part to obtain assistance from McKesson Corporation, or comparable software vendors, in order to make available on the Provider Website by December 2006 (Excellus BlueCross BlueShield) and December 2008 (Univera) or as soon thereafter as practicable, a web-based pre-adjudication tool incorporating the McKesson Corporation software product known as "ClaimCheck®" (or other comparable software then used by Company), as customized by Company. Company agrees to design such tool so that it may provide information to Participating Physicians regarding the manner in which Company's claim system adjudicates claims for specific CPT® codes or combinations of such codes without regard to a specific member's benefits, provider fee schedule, employer agreements, or unique provider-specific contractual terms. The Report to be filed annually and at the end of the Effective Period shall describe the efforts made by Company toward this end.

Company agrees to disclose on the Provider Website by December 2006, or as soon thereafter as practicable, its payment rule or approach in each area in which CMS has promulgated a definitive rule or approach that is relevant to payment of Physicians for Covered Services. Company relies on a software vendor for its code source and rule justification, and so will publish an update to the description on an annual basis to satisfy the forgoing obligations, as updates are implemented. The Report to be filed annually and at the end of the Effective Period must include pertinent portions of the Provider Website, or other medium through which it makes such disclosure, as the same exists as of the date of such Report.

a. Not later than December 2006 (Excellus BlueCross BlueShield) and December 2008 (Univera), Company shall publish on the Provider Website a list of each Company-specific customization to the standard claims editing software product then used by Company; provided that no such customization shall be inconsistent with the undertakings set forth in this Agreement.

b. Effective as of the Execution Date, Company shall not routinely require submission of clinical records before or after payment of claims, except for those limited circumstances where claims contain either unlisted codes, claims to which a CPT modifier 22 is appended, or meet criteria for review as stated in Company's medical policies, protocols or billing guidelines. Any other instances for record review not enumerated herein will be identified on the provider website not later than six (6) months after the Implementation Date. Other limited circumstances where records might be requested include: review of quality of care, quality improvement activities (such as HEDIS or other clinical topic review), administration of indemnity or other product contracts. This may include retrospective audit, medical necessity review, review of pre-existing conditions, review for appropriate level of care, care coordination and case management. The Company reserves the right to request records for review and audit. Company shall promptly disclose on the Public Website and the Provider Website any such claim category or categories. Notwithstanding the foregoing, Company may require submission of clinical records before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, Company has reasonable basis for believing that such investigation is warranted. Nothing contained in this § 7.8 is intended, or shall be construed, to limit Company's right to require submission of medical records for pre-certification purposes consistent with § 7.5 herein. Issues regarding submission of medical records shall be addressed through the dispute processes described in § 11.

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

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

7.9. Physician Advisory Committee.

Prior to the later to occur of (i) six months after the Implementation Date, and (ii) selection of the members of the Physician Advisory Committee in accordance with this section of this Agreement, Company shall take all actions necessary on its part to establish a Physician Advisory Committee ("Physician Advisory Committee") to discuss agenda items of Company-wide scope. The Physician Advisory Committee shall meet at least once every six months during the Effective Period. Company shall establish an electronic mail box on the Provider Website or comparable mechanism to enable Participating Physicians to communicate with the Physician Advisory Committee. Non-Participating Physicians may submit written proposals to the Physician Advisory Committee concerning Company's business practices.

The dates of the Physician Advisory Committee's meetings shall be included in the Report to be filed annually and at the end of the Effective Period.

The Physician Advisory Committee shall include eleven (11) members, one of whom shall be Company's Chief Medical Officer or his designee, who shall serve as chairperson of the Physician Advisory Committee. Both the Company and MSSNY can nominate participants. Committee members must be mutually agreed upon by Company and MSSNY (hereinafter referred to as "by consensus") and include a mix of specialists and primary care physicians. Members must be geographically representative of Company's service area. All members must be Board Certified. If Agreement on the Committee Members cannot be reached, the Company shall select three (3) 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 seven shall select the remaining four (4) members not later than 90 days after the Preliminary Approval Date (hereinafter referred to as "by formula"). If a vacancy occurs on the Committee and the Committee is initially chosen by consensus, a replacement will be

selected by the Committee. If instead membership is chosen by the formula above, vacancies shall be filled by the method the individual who has vacated the Committee was chosen. The names of the members of the Physician Advisory Committee shall be included in the Report to be filed annually and at the end of the Effective Period.

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 six (6) members if membership was determined by the consensus process described above. If instead membership was determined by the formula process described above, a quorum shall consist of at least two (2) of the appointees of the Representative Plaintiffs, two (2) of the representatives of Company and two (2) of the representatives selected by the representatives appointed by Company and the Representative Plaintiffs. The Physician Advisory Committee shall have authority to recommend changes to Company's business practices. Company shall consider whether the implementation of any recommendation of the Physician Advisory Committee is commercially feasible and consistent with the best interests of Company's Participating Physicians, Plan Members, customers, 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 Company shall disclose the recommendation and response on written request. Company agrees to include in the Report filed annually and at the end of the Effective Period a listing of all Physician Advisory Committee recommendations made to Company and Company's responses to such recommendations.

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

7.10. External Review 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 Administrator "Billing Dispute External Review Administrator" for resolving disputes with Physicians concerning a particular application of Company's coding and payment rules and methodologies (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

except as set forth in § 7.22. The Billing Dispute External Review Administrator 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 under § 11. of this Agreement and disputes concerning the scope of Covered Services. Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA.

b. After the Physician or Physician Group exhausts Company's internal appeals process, a Physician or Physician Group may submit Billing Disputes to the Billing Dispute External Review Administrator upon payment of a filing fee calculated as set forth in § 7.10 and in accordance with that provision. When the amount in dispute (either a single claim for Covered Services or multiple claims involving similar issues) must be at least $500.00. Company shall post a description of its provider internal appeals process on the Provider Website. The Class Member may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches Five Hundred Dollars ($500.00) and, in that event, the filing fee will be refunded by Company to the Class Member.

1. Each Billing Dispute shall be submitted on a form (the "Billing Dispute Form") and shall include any Clinical Information the Physician or Physician Group believes is relevant to the Billing Dispute. The Physician or Physician Group and Company shall supply appropriate documentation to the Billing Dispute External Review Administrator not later than thirty (30) days after request by the Billing Dispute External Review Administrator. Notwithstanding the foregoing, a Physician or Physician Group may submit a Billing Dispute if less than $500.00 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 Administrator will, at the request of such Physician or Physician Group, defer consideration of such Billing Dispute while the Physician or Physician Group accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Termination Date, the Physician or Physician Group has not accumulated the requisite amount of Billing Disputes and Company has chosen not to continue the Billing Dispute process following the Termination Date, then any rights the Physician or Physician Group had as to such Billing Disputes, including rights to arbitration, shall be tolled

from the date the Billing Dispute was submitted to the Billing Dispute External Review Administrator through and including the Termination 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 Administrator 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 $500.00. In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute External Review Board Administrator 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.f. until the aggregate amount at issue exceeds $1,000 at which time additional filing fees will be payable in accordance with § 7.10.b.4. 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 Administrator; 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 Administrator. Except as otherwise provided in § 7.10.b.2., all Billing Disputes must be submitted to the Billing Dispute External Review Administrator not more than 90 days after a Physician or Physician Group exhausts Company's internal appeals process and the Billing Dispute External Review Administrator 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 Administrator not later than 30 days after request by the Billing Dispute External Review Administrator, 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 $500.00.

c. Except to the extent otherwise specified in this section 7.10, procedures for review by the Billing Dispute External Review Administrator, 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 Administrator, shall be set by agreement between Company and Class Counsel, or their designee, and shall be set forth in the Report filed annually and at the end of the Effective Period. Such procedures shall provide, at minimum, that (i) a Physician submitting a Billing Dispute to the Billing Dispute External Review shall state in the documents submitted to the Billing Dispute External Review Administrator the amount in dispute, and (ii) that the Billing Dispute External Review Administrator shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Physician or Physician Group in the documents submitted to the Billing Dispute External Review Administrator to be in dispute except as discussed.

d. 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 to use the process described in § 11.6.

e. Company and Class Counsel have agreed that Hayes Plus shall be the Billing Dispute External Review Administrator, subject to negotiation of a contract acceptable to the Company. If that does not occur, Company and Class Counsel or their designee, shall select the organization that shall constitute the Billing Dispute External Review Administrator. If Company and Class Counsel, or their designee, cannot agree on the Billing Dispute External Review Administrator within 60 days of the Preliminary Approval Date, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Facilitator. 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, Billing Dispute External Review Administrator shall be bound by the terms of the applicable agreement between the Participating Physician and Company and the provisions of this Agreement. Otherwise, the Billing Dispute External Review Administrator shall resolve Billing Disputes based on generally accepted medical billing standards.

f. For any Billing Dispute that a Physician submits to the Billing Dispute External Review Administrator, the Physician submitting such Billing Dispute shall pay to Company a filing fee calculated as follows: (i) if the amount in dispute is $1,000 or less, the filing fee shall be $50 or (ii) if the amount in dispute exceeds $1,000, the filing fee shall be equal to $50, *plus* 5% of the amount by which the amount in dispute exceeds $1,000, but in no event shall the fee be greater than 50% of the cost of the total dispute. The filing fee shall be returned to Physician in any case in which Physician prevails.

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

h. In the event that the Billing Dispute External Review Administrator issues a decision requiring payment by company, Company shall make such payment within thirty (30) business days after Company receives notice of such decision.

i. Company agrees to record in writing a summary of the results of the review proceedings conducted by the Billing Dispute External Review Administrator, including without limitation the issues presented. Company agrees to include a summary of the dispositions of such proceedings in the Report 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 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.

j. The Billing Dispute External Review process shall be available at the option of the Physician. If such Physician elects to utilize this process, then any decision by the Billing Dispute External Review Administrator shall be binding on Company and the Physician. Billing Disputes that arise after the Implementation Date 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 Administrator so long as such Billing Dispute arises after the establishment of the Billing Dispute External Review Administrator pursuant to Section 7.10.a.

7.11. Appeals of 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 § 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. Internal Appeals of Medical Necessity Denials

With respect to an appeal of a determination that a health care service or supply is not Medically Necessary, Company shall adopt an 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. That process shall insure that only a Physician who is in the same or similar specialty as the Physician providing the treatment or service at issue and who is someone other than the Physician that made the initial determination, 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, shall review and decide the internal appeal in accordance with applicable Company clinical guidelines, which shall be consistent with § 7.16.b.

c. 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.

d. Medical Necessity External Review Process

Following exhaustion of its internal appeal process, Company shall follow the external appeal process set forth in Title II of Article 49 of the New York Insurance Law and Title II of Article 49 of the New York Public Health Law as applicable for its insured business. The New York State external appeal process is not available for Medical Necessity denials issued in connection with self insured products.

With respect to medical necessity disputes pertaining to benefit plans which are administered by Company, the ASO accounts shall have the option (but not the requirement) to provide and use any medical necessity external review process of their own design. If the ASO elects to offer such Medical Necessity External Review, both the cost of the external review and the Company's participation in the process will be at the ASO account's expense.

1. Notwithstanding the provisions of this § 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.

2. Notwithstanding the provisions of this § 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 lack of Medical Necessity grounds. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Class Member's appeal shall be dismissed and may not be brought by or on behalf of the Class Member in any forum; provided that such dismissal shall be without prejudice to any Class Member seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Class Member and not to such Plan Member.

3. Nothing contained in this § 7.11 is intended or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.

4. Notwithstanding the provisions of New York's External Appeal Law, Public Health Law § 4910, *et seq.* and Insurance Law § 4910, *et seq.*, the Company agrees for its insured business, to allow

Physician Class Members, following exhaustion of the Company's internal appeal process, the right to seek external appeal for a prospective or concurrent denial for lack of medical necessity when authorized in writing by the Plan Member, so long as the Plan Member has not been billed for the service and agrees not to seek an external appeal or commence litigation regarding such denial and the Company's internal appeals process has been exhausted. The statutory timeframes set forth in New York's External Appeal Law shall apply to any such prospective or concurrent external appeals by a Physician Class Member.

5. For such appeals, Company will contract with an independent external review organization to conduct such external appeals. To access the Company's medical necessity external appeal process, the Physician Class Member shall pay a filing fee of $50.00; provided that if the matter involves services or supplies for which Company requires pre-certification, then the filing fee shall be the lesser of $250.00 or 50% of the Medical Necessity Independent Review Organization's fees.

6. Company and Class Counsel have agreed that Hayes Plus shall be the Medical Necessity Independent Review Organization, subject to negotiation of a contract acceptable to the Company. If that does not occur, Company and Class Counsel or their designee shall select the organization that shall constitute the Medical Necessity Independent Review Organization.

7. The filing fee shall be returned to Physician in any case in which Physician prevails.

8. 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 § 7.18 of this Agreement, less any portion of allowed charges that is payable by the Plan Member under his or her Plan Documents; provided that the interest described in § 7.18 of this Agreement will be payable unless the Class Member introduces material new information to the Medical Necessity External Review Process that was not provided to Company during the internal appeal process. Company shall cause any contract it may enter into with any Medical Necessity External Review Organization to be consistent with the terms of this § 7.11.

9. If a Physician elects to utilize the Medical Necessity External Review process, then any decision by the Medical Necessity Independent Review Organization shall be binding on both the Company and the Physician.

7.12. Electronic Remittance Advice and Electronic Fund Transfers.

Company shall create the ability to securely transmit electronic remittances and electronic fund transfers. This will enable providers to view remittances through a web portal. Providers will be notified via e-mail that there was an update to their account in the secure repository. The provider would then go to secure repository to access remittance and deposit information. This function will be available by 12 months after the Implementation Date.

a. Company will publicize on the Provider Website its electronic remittance advice and electronic funds transfer capabilities. Company will also make reasonable investments, to conduct educational seminars and other programs, as Company deems appropriate, to educate Participating Physicians about Electronic Remittance Advice and Electronic Fund Transfers (ERA/EFT) capabilities.

b. The educational activities provided through the most recently practicable date shall be included in the Report to be filed annually and at the end of the Effective Period.

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 complete primary source verification and notify the Physician as to (i) whether he or she is credentialed within ninety (90) days of receiving a Physician's completed application to be a Participating Physician or (ii) whether additional time is warranted in spite of Company's best efforts or because of a failure of a third party to provide necessary documentation or non-routine circumstances reasonably requiring additional review, such as questionable references, unusually high number of malpractice cases, Professional Medical Conduct or allegations of sexual misconduct. Company shall make every effort to obtain such information as soon as possible. Company commits that the Credentialing Committee for each market shall meet at least once every forty-five (45) days to consider credentialing applications for which primary source

verification has been completed. If a Physician is already credentialed by Company but changes employment or 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.

b. All Products Clauses.

Company agrees that it will permit a physician to alter the contract at the time the contract is initially signed to decline without financial penalty participation in any entire product line (such as all HMO products). Company shall also permit a Participating Physician to subsequently terminate participation without financial penalty in any entire product line if Company makes a Material Adverse Change affecting that product line, provided that a Participating Physician shall, where applicable, provide continuing care after termination for current patients pursuant to the requirements of NYSDOH or any applicable statute. Participating providers will be notified in writing in advance of implementation of a new product line and will have the right to opt out before the line is implemented or within thirty days of roll-out of the new product line. Existing product lines are: Managed Care (all gatekeeper, HMO and Point of Service programs); Indemnity, including PPO; Medicare; Medicaid Managed Care; Workers' Compensation; and special programs for low income and uninsured.

c. Termination Upon Material Adverse Change

If a Participating Physician provides notice of termination of such contract not more than thirty (30) calendar days after receipt of notice of Material Adverse Change, contract shall terminate coincident with the Implementation Date of such Material Adverse Change. Company shall continue to have the right to negotiate and enter into contracts with Physician Organizations and Physician Groups consisting of five or more Participating Physicians allowing termination only for cause during the contract's initial term. A Participating Physician shall, where applicable, provide continuing care after termination for current patients pursuant to the requirements of NYSDOH or any applicable statute.

d. Rights of Class Members to Refuse to Accept Additional Patients.

Company will not prohibit Class Members from declining to accept Company's members as new patients provided the Class Members close their practices to all new patients for all other non-governmental health plans. However, if a patient of the Class Member 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 Class Member must be allowed to continue as the patient's Physician. Furthermore,

Company will not prevent Class Members from closing their practices to all new patients for all payors.

7.14. Fee Schedule Changes

a. Notices Regarding Fee Schedules

Company agrees not to reduce its fee schedule for a Participating Physician more than once a calendar year except as provided below in this § 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 between such annual changes, 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 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 reflect any applicable interim revisions made by CMS. In the first year of a Physician's contract, a change in fee schedule may be made before the end of the year in which the contract became effective. Nothing contained herein shall prevent Company from maintaining, altering or expanding the use of capitation or other compensation methodologies. The requirements in this Section may be altered pursuant to the terms in Individually Negotiated Contracts.

Notwithstanding the provisions above, in the event new fee schedules are installed for use but a clerical error is made by Company so the amount listed on the fee schedule is not the amount intended by the Company, the clerical error may be corrected without waiting for the twelve month period to end. Company will provide affected Physicians with timely notice of any such corrections.

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

Company agrees to pay a fee (per the applicable fee schedule for Participating Physicians and an established fee for services provided by Non-Participating Physicians where services of Non-Participating Physicians are covered under the plan) for the administration of vaccines and injectibles in addition to paying the appropriate provider for such vaccines and injectibles. Company agrees to pay Participating Physicians for the cost of injectibles and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time. With respect to capitated Participating Primary Care Physicians, Company agrees to continue to pay fees (in addition to contractually agreed-upon capitation payments) for vaccines administered

pursuant to the schedules recommended by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices, as applicable; provided that if the primary care Participating Physician so requests, Company may include such fees within the scope of capitated services. 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 as part of the Company's ongoing Medical Policy review process. A physician may send their recommendation to the chair of the Medical Policy Committee, via the web or in writing. These requests will be presented to the Company's existing Medical Policy Committee no later than 120 days after receipt. Extensions of this time may occur in periods of heavy volume. The Medical Policy Committee is made up of more than 40 practitioners, of which more than two thirds are practicing physicians. Members represent a broad array of specialties as well as primary care practitioners and reflect the Company's geographic distribution. Company agrees to list in the Report to be filed annually and at the end of the Effective Period the dates on which such policy updates are completed and to include in such Report any written policies and procedures it has developed regarding payments for the administration of vaccines and injectibles.

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 all such data used by Company to determine the "reasonable and customary" charge for that service or supply.

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

Company may alter or modify the agreements and undertakings set forth in § 7 only to the extent provided in this § 7.15, unless otherwise provided. Company may spend less than the minimum amounts set forth in § 7.31 if Company devises programs or plans that are reasonably designed to achieve comparable results or systems functionality at a lower cost. In that event, subject to appropriate confidentiality provisions, Company shall (i) file any such revised business program or plan with the Physician Advisory Committee not less than 30 days before implementation of such revised program or plan, together with the prior business program or plan and a statement of the Internal Compliance Officer that

the revision is consistent with the preceding sentence and (ii) concurrently therewith give notice to Representative Class Counsel (or their designee) of such filing and meet and confer with Representative Class Counsel (or their designee) with respect thereto, if requested. Company may modify any undertaking in particular geographic markets as reasonably needed to compete in the applicable marketplace. In that event, Company shall notify the Physician Advisory Committee and Class Counsel, or their designee, not less than 60 days prior to implementing any such change and (ii) concurrently therewith, give notice to Class Counsel (or their designee) of such filing and meet and confer with Class Counsel (or their designee) with respect thereto, if requested. In the event that Company substantially modifies any provision of § 7 pursuant to this § 7.15, then the covenant not to sue that is set forth in § 13 shall be of no further force and effect solely with respect to the business practice that is the subject of such modification and solely, to the extent of such modification.

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

a. Patient-Specific Issues Involving Clinical Judgment.

1. Medical Necessity Definition

Company shall apply and include in its agreements with Participating Physicians the following definition of "Medically Necessary" or comparable term in each such agreement: **"Medically Necessary"** or **"Medical Necessity"** shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and (d) 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 the patient's illness, injury or disease. "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 when available, Physician Specialty Society recommendations, the views of prudent Physicians practicing in relevant clinical areas, and any other clinically relevant factors.

2. Medical Necessity Denial Rate

For the calendar year beginning after the Implementation Date, and thereafter during the Effective Period, Company shall make an annual, aggregate disclosure of the percentage of Covered Services recommended or provided by treating Physicians that Company, in accordance with § 7.11 denies payment or authorization of on grounds of lack of medical necessity. Company shall make this disclosure by means of the Provider Website or other comparable electronic medium. In calculating this percentage, neither denial or reduction in payment for other reasons (e.g., benefit exclusion or limitation, bundling, calculation of prevailing or usual and customary rate) nor reduction in hospital or other facility charges shall be treated as a medical necessity denial for purposes of the preceding sentence, and denials by Independent Practice Associations and IPA-like entities shall not be included in this disclosure. Company shall include in the denominator for such calculations all pre-authorization requests and all claims, submitted directly to Company (i.e. not through IPA and IPA-like entities) by Physicians. Copies of the annual disclosures specified in this paragraph shall be included in the Report to be filed annually and at the end of the Effective Period.

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 medical community, and shall take into account Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. Company shall continue to make such policies readily available to Members and Participating Physicians via the Public Website or by other electronic means. Promptly after adoption, Company shall file a copy of each new policy or guideline with the Physician's Advisory and Monitoring 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 § 7.16.2.c. is not intended and shall not be construed to limit Company's ability to implement any such program on a pilot or experimental basis, base exemptions on any Company

determined basis, or otherwise to implement one or more programs in only some markets.

d. Application of Experimental and Investigational Exclusions

In applying experimental and investigational exclusions in a Plan, Company shall consider the status or outcome of any governmental approvals sought or received, and will take into account credible scientific literature published in peer-reviewed medical literature generally recognized by the medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas, the individual clinical circumstances of the particular Plan Member, the views of the treating Physician and any other relevant factors. In considering the above, if in the individual Plan member's circumstances, the treatment, service or procedure is medically appropriate, then Company will pay for said treatment, service or procedure.

For Plan Members suffering from life threatening or debilitating disease for which there are limited or no other treatment options, the Company will approve coverage for care provided in approved clinical trials as described in the Company's Medical Protocol 11.01.10, as may be amended from time to time. The Company will also cover the off label use of FDA-approved drugs according to the Company's Medical Protocol 5.01.03, as may be amended from time to time, and New York State Insurance Law 4303 (q).

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 and IPA and other IPA-like entities that they adopt the 120 day time period referenced in the preceding sentence. Company may 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 for in the first sentence of this § 7.17, nothing herein shall limit Company's ability to provide incentives for prompt submission of bills. The Report to be filed annually and at the end of the Effective Period shall include copies of the training and policy manuals enacted by Company to effectuate this commitment.

b. Electronic Claims Submission.

In regard to electronic claims, Company agrees to accept properly completed electronic claims populated with information in HIPAA-compliant format or fields. 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, § 7.10, § 7.11, § 7.18, § 7.19 and § 7.20 provided that nothing in this sentence is intended or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning Company's ability to make requests for medical records in connection with adjudication of claims. Company shall disclose on the Provider Website and the Public Website its policies and procedures regarding the appropriate format for claims submissions and requests for additional information. The Report to be filed at the end of the Effective Period shall include a description of Company's policies and procedures regarding the appropriate format for claims submissions and requests for additional claim information.

7.18. Timelines for Processing and Payment of Complete Claims.

Subject to the provisions and timetable set forth herein, Company shall generate, at the Physician's direction, the issuance of an electronic funds transfer, wire transfer or check in payment for Complete Claims for Covered Services within the following time periods, in each case measured from the later of Company's receipt of such claim from a physician or clearinghouse 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; 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.b: 15 days for claims that Physicians submit electronically and 30 days for claims that Physicians submit on paper forms.

Company represents that an extensive amount of work and expense is required to implement the forgoing due to the status of the capabilities of its disparate claims systems, which systems do not presently permit Company to distinguish between Complete Claims and those that are not Complete Claims. In addition, there are a variety of check payment cycles programmed into the claims payment systems which also hamper administration to these standards, as well as tracking of timeliness. Extensive system modifications are required.

The Company's ability to meet these standards will be aided significantly if Class Members increase the percentage of claims submitted electronically. Such a result is in both Class Members' and Company's interests due to enhanced

speed and efficiency. MSSNY will take reasonable steps to educate its membership through such measures as its newsletter about the benefits of such electronic submissions.

Company shall take the following steps in order to implement the required changes and to meet the standards provided above:

- Immediately following the Implementation Date, begin the programming work deemed necessary by the Company to comply with the standards provided herein.
- There shall be an interim claims payment standard of 30 days for electronic claims and 45 days for paper claims only on the Company's LRSP, TOPPS and Facets claim systems beginning twelve months following the Implementation Date.
- The 15/30 day standards described in the first paragraph of this section shall be implemented and effective for all of the Company's systems then still in use twenty-four months following the Implementation Date.

Following the Implementation Dates specified above, the Company will pay simple interest of six percent (6%) per annum on the balance due on all Complete Claims submitted by Class Members that are processed and finalized for payment beyond the timeframes above. Notwithstanding the proceeding, such 6% interest shall only apply to that portion of the timeframe prior to when a higher interest rate is required by state law, at which point, the higher interest rate required by law will apply.

Interest shall, at the Company's election, either be included in the electronic fund transfer, wire transfer or check or be remitted in a separate electronic fund transfer, wire transfer or check. Interest does not apply in cases where (i) the Class Member, within thirty (30) days of the submission of an original claim, submits a duplicate claim while the original claim is still being processed; (ii) adjustments subsequently made to the amount of payment previously made, so long as the original payment was made within the applicable required timeframe; (iii) where the class member inappropriately bills a Company Member for the balance due from the Company, (iv) the claim is pursuant to the Blue Cross Blue Shield Association (BCBSA) Inter-Plan Program, or (v) where the Company has an agreement with an IPA or physician organization which requires prepayment reviews of claims by the IPA or physician organization or requires reviews above and beyond the usual prepayment review conducted by the Company. In addition, with respect to interest payments that total less than two dollars ($2.00) on any single claim, no interest payment shall be required during the period of time the 30/45 day interim claims payment standard is in effect (but such interest shall be required to be paid once the 15/30 day standard described in the first paragraph of this section takes effect).

Company shall attempt to include in its contracts with each clearinghouse with which Company contracts a requirement that each such clearinghouse transmit claims to Company by the next business day after such clearinghouse's receipt thereof.

If the Company determines that there is any defect or error in a claim, it shall notify the Physician within thirty days (30) of receipt of claim.

7.19. No Automatic Downcoding of Evaluation and Management Claims.

As of the Implementation Date, Company shall not automatically reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"). Notwithstanding the foregoing sentence, Company shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of the information in the written medical record at the time the service was rendered for particular claims, a review of information derived from Company's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of evaluation and management services; provided that the decision to reduce is based at least in part on a review of the clinical record.

7.20. Bundling and Other Computerized Claim Editing.

Company agrees to process and make eligible for payment all physician claims pursuant to and consistent with the current version of CPT® codes, guidelines and conventions as interpreted in the current volumes of the American Medical Association's Current Procedural Terminology, Principles of CPT® Coding CPT ® Assistant and CPT ® Changes.

7.21. EOB and Remittance Advice Content

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

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

Company's EOBs currently display the name and number of the member, the date the services were rendered, procedure code of the service, the adjustment detail and an explanation pertaining to the adjustment, in accordance with HIPAA requirements. There are plans to enhance the adjustment explanations to be more concise and consistent across all systems. This will be completed by the end of 2005. When Company is the primary carrier line level disposition is displayed on the EOBs. All appropriate address and phone numbers for inquiries from providers are also supplied on the EOBs and remittances. By the end of 2005, Company will review all explanations on EOBs and remittances for clarity. Company agrees to continue to provide EOBs in accordance with all state and federal regulations with respect to the content and issuance requirements. In accordance with all applicable administrative directives from the New York State Insurance Department, the Company agrees to update its common platform systems that are expected to be operational for a period of not less than two years by December 31, 2005. In early 2006 Company will begin conducting focus groups with providers and members asking for their input on modifications that are needed on EOBs in order to enhance the look and information supplied on the EOB. All work will be complete in December 2008.

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

7.22. Overpayment Recovery Procedures

Company shall initiate or continue to take actions reasonably designed to reduce Overpayments (see § 1.51), and it shall publish on its Website an address

and procedures for Class Members to return Overpayments to Company. In addition, other than for recovery of duplicate payments, Company shall provide Class Members with thirty (30) days written notice before seeking Overpayment recovery, whether or not the Overpayment occurred during the Class Period or afterward. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation of the basis for Overpayment recovery sought and other information (including without limitation procedure code, where appropriate) giving Class Members reasonably specific notice of the proposed adjustment. Company shall not initiate Overpayment recovery efforts more than twenty-four (24) months after the original payment for the first 18 months after the Implementation Date and then twelve (12) months after the original payment thereafter for at least four years (this commitment will remain in effect after the Termination Date of this Agreement); provided that no time limit shall apply to initiation of Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Insured Plan; and in the event that a Class Member asserts a claim of underpayment, Company may defend or set off such claim or it may counterclaim based on Overpayments going back in time as far as the claimed underpayment.

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

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

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 more timely and accurate basis.

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

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

e. Developing metrics for Company's internal eligibility personnel to measure performance and reward behaviors that reduce the impact of retroactive termination of Plan Members on claims payments. The performance measures may include, without limitation, such behaviors as: (i) the timely delivery of reports to third party eligibility administrators/plan sponsors relating to terminated Plan Members; (ii) timely follow-up with such third party eligibility administrators/plan sponsors on such reports to verify the Plan Member's termination; and (iii) timely error correction.

f. Contacting employer accounts by telephone prior to their contract renewal date to determine as best as is practicable whether the customer intends to terminate or renew coverage for its employees with Company.

g. The Company will not seek reimbursement from providers for covered services provided to insured members whose coverage is terminated retrospectively more than 120 days after the event should have occurred when the Company has previously verified the member is eligible for benefits. Company shall recommend that this policy be followed by self-funded groups at their expense. MSSNY and Company agree to encourage and educate physicians on the need to inquire at each patient encounter the current status of each patient's employment and health insurance. Class Members agree to provide such information to the Company in support of the Company's recovery efforts, to the extent that the Class Members are in possession of such information.

h. The Report filed annually and at the end of the Effective Period shall include the policy and training manuals promulgated to effectuate the commitments set forth in § 7.23.b. and § 7.23.f. and any other relevant materials.

7.24. Provider Service Centers.

Company shall establish a reasonable number of dedicated provider service centers, or shall take other actions reasonably designed to improve the speed, accuracy and efficiency of responses to Physician inquiries and concerns. The amount of such expenditure shall be recorded in the Report to be filed annually and at the end of the Effective Period and the Report shall specify, on an aggregate annual basis, the percentage of calls to the provider service centers (or equivalent organization) that are answered within 45 seconds.

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

Company agrees that if Company certifies, in accordance with § 7.16 of this Agreement, that a proposed treatment is medically necessary for a particular Plan Member, Company shall not subsequently revoke that medical necessity

determination or contend that the treatment was not covered or that the Plan Member was not eligible absent evidence of fraud, expiration of the time frames specified in the authorization, a change in provider status from participating to non-participating (subject to state law governing continuity of care), a change in the member's benefit plan, evidence that the information submitted was materially erroneous or incomplete, or evidence of material change in the Plan Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment inappropriate for such Plan Member. In the event that Company certifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and Company's denial of such request shall not be deemed to be inconsistent with the preceding sentence. Any policies and procedures promulgated to effectuate this commitment and in effect at the end of the Effective Period shall be included in the Report to be filed annually and at the end of the Effective Period. Company agrees to this provision as long as the patient has a benefit for the service and is an eligible Plan Member at time of treatment. If the treatment is not obtained during the period of time or other limitation, then new certification will need to be obtained.

7.26. Electronic Connectivity.

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

7.27. Information About Physicians on the Public Website.

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

effectuate this goal shall be included in the Report to be filed annually and at the end of the Effective Period.

7.28. Capitation and Physician Organization-Specific Issues.

a. Capitation Reporting.

Company agrees to provide monthly reports to Participating Physicians, Physician Groups and Physician Organizations that receive capitation. These monthly reports will include membership information to allow reconciliation by Participating Physicians, Physician Groups and Physician Organizations, as applicable, of capitation payments, including without limitation Plan Member identification number or the equivalent, name, age, gender, medical group/Physician Organization number, co-payment, monthly capitation amount, primary care Physician, 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. Copies of the forms of relevant reports in use by Company during the Effective Period shall be attached to the Report to be filed annually and at the end of the Effective Period.

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

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

7.29. Miscellaneous.

a. "Gag" Clauses.

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

b. Ownership of Medical Records.

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

c. Arbitration.

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

2. Company agrees not to include language in any agreement with a Physician, Physician Group or Physician Organization (A) preventing class arbitration, (B) requiring that an arbitration panel have multiple members, (C) preventing the recovery of any statutorily or otherwise legally available scope or standard of review, (E) shortening the statute of limitations period, (F) prohibiting discovery, or (G) requiring that any arbitration proceeding occur more than fifty (50) miles from the

principal office of the Physician, Physician Group or Physician Organization.

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

Company's standard agreements and/or ancillary documents shall incorporate or be consistent with the commitments and undertakings Company makes in this Agreement. To the extent that Company's existing standard agreements with Participating Physicians, Physician Groups or Physician Organizations, contain provisions inconsistent with the terms hereof, Company shall administer such agreements consistent with the terms set forth in this Agreement; provided that where Company and a Participating Physician, Participating Physician Group or Participating Physician Organization have an Individually Negotiated Contract, this Agreement shall not modify or nullify the individually negotiated terms of such Individually Negotiated Contracts unless the Participating Physician, Participating Physician Group or Participating Physician Organization notifies Company in writing, specifically setting forth the negotiated terms it seeks to have modified or nullified by this Agreement. Nothing herein shall preclude or prevent the Company and a Participating Physician, Participating Physician Group or Participating Physician Organization from negotiating and agreeing to an Individually Negotiated Contract which does not include some or all of the provisions of this Settlement Agreement. Furthermore, Company upon request may separately agree with individual Participating Physicians, Participating Physician Groups or Participating Physician Organizations on customized rates and/or payment methodologies that deviate from the terms of its standard agreements.

e. Impact of this Agreement on Covered Services

Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this § 7.29 shall supercede or otherwise alter the scope of Covered Services of any Plan.

f. Privacy of Records.

Company shall safeguard the confidentiality of Plan Member medical records in accordance with HIPAA, state and other federal law and any other applicable legal requirements; 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.

g. Pharmacy Risk Pools.

Company shall not require the use of pharmacy risk pools. The training and policy manual materials promulgated to effectuate this commitment and in effect during the Effective Period shall be included in the Report to be filed annually and at the end of the Effective Period.

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

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

i. Pharmacy Provisions.

Company shall disclose to Plan Members whether that Plan Member's health plan uses a formulary and, if so, explain what a formulary is, how Company determines which prescription medications are included in the formulary, and how often Company reviews the formulary list. When Company provides pharmacy coverage, Company shall make formulary information available to Plan Members. Company shall maintain the process, as reasonably amended, for covering formulary-excluded medications when medically necessary that is in place on the Execution Date. Company shall cover drugs prescribed for Plan-approved, medically necessary use except to the extent that the applicable Plan Member's Plan expressly excludes such prescriptions; provided that Company shall retain the right to pre-certify coverage of specific medications. This may vary if the product Company is administering must be different because it is following the rules of Medicare, Medicaid, Workers Compensation or another government program. Company's disclosure concerning pre-certification and potential restrictions on non-approved use of prescription medications shall be similar in substance to disclosure concerning formularies, as described above. The training and policy manual materials promulgated and training efforts implemented to effectuate the commitment set forth in this § 7.29 (i), as well as any disclosure forms or methods, shall be included in the Report to be filed annually and at the end of the Effective Period.

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 to those functions or activities performed directly by Company and its employees, or agents.

l. Most Favored Nations Clause

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

m. Copies of Contract.

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

n. State and Federal Laws and Regulations.

Nothing contained in this Agreement is intended to, or shall, in any way waive reduce, eliminate or supercede any Party's obligation to comply with applicable provisions of relevant state and federal law and regulations, and Company shall comply with state and federal law and regulations. Nothing herein is intended to give rise to or should be construed as giving rise to any private right of action (other than through the Compliance Dispute procedure in § 11) 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.

o. Ability of Company to Modify Means of Disclosure.

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

p. Limitations on Obligations of Non-Participating Physicians.

No affirmative obligation that this Agreement imposes on Physicians shall apply to any Non-Participating Physician unless and until, and then only to the extent that such Non-Participating Physician attempts to avail himself or herself to the benefits of this Agreement to the extent applicable to Non-Participating Physicians.

q. Limitation on Rental Networks

Company agrees that it will not rent its networks to any other managed care company or health insurer, physician network developer, entity involved in pass-through networks, entity which could be defined as a rental network, or developer thereof, under any state or federal legislation for the purpose of providing health care services or supplies to any person who is not a Company Plan member, without 180 days notice to affected Class Members, excluding Inter-Plan obligations required by the Company's licensing agreement with the Blue Cross Blue Shield Association and its member plans and excluding Company's subsidiaries and affiliates.

1. Except for the Blue Card Program, Company agrees that whenever it uses a network or fee schedule negotiated or established by another entity in connection with its dealings with Physicians, Company will disclose on each EOB or remittance advice the identity and phone number of the network. Payment will be pursuant to the Physician's agreement with the Network. Remits will be updated to include network identification as part of the improvements described in § 7.21.

r. Effect of Assignment of Benefits.

The existence of an Assignment of Benefits authorization, whether or not submitted by the Non-Participating Physician to Company, does not constitute in and of itself full or partial payment of Physician's fee, does not create an implied contract between Physician and Company, and does not limit Physician's fee to any fee schedule. Non-Participating Physicians may collect Physician's full fee from the Plan Member.

7.30. Compliance With Applicable Law, Blue Cross Blue Shield Licensee Agreement and Requirements of Government Contracts.

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

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

Company does not believe that any provision in this Agreement jeopardizes its Blue Cross Blue Shield Association (BCBSA) licensee status under the terms of Company's BCBSA License Agreement, Inter-Plan Program, BCBSA regulations or other BCBSA requirement. Company agrees that it will not encourage or support any change in BCBSA requirements, rules or regulations that might conflict with any provision of this Agreement. If Company becomes aware of any BCBSA requirement, rule or regulation that jeopardizes its BCBSA licensee status if Company continues to comply with any term of this Agreement, then it will promptly provide notice to Class Counsel and meet and confer with Plaintiffs' counsel in an attempt to reach agreement as to the action to be taken, if any, to avoid jeopardizing Company's BCBSA licensee status. If no agreement is reached, and if a provision of this Agreement in fact jeopardizes Company's BCBSA licensee status, then that provision of this Agreement is superseded. If the Plaintiffs contest the action taken by Company, as not jeopardizing Company's licensure status, they may bring a compliance dispute under § 11 of this Agreement. However, even if the compliance dispute against the Company is resolved, that resolution will have no effect if the Blue Cross Blue Shield Association gives notice of an action against the Company for licensure violation. If any settlement is reached in the Thomas Action (see page 2) that affects the BCBSA Inter-Plan Program terms, then Company agrees to comply with those terms affected by any settlement in the Thomas action, but only as to Blue Cross Blue Shield Association Inter-Plan programs.

7.31. Estimated Value of Section 7 Initiatives.

The Parties estimate that the approximate aggregate value of the initiatives and other commitments with respect to Company's business practices set forth in § 7 of this Agreement is fifty-three million dollars $53,000,000. This includes both expenses from commencement of this suit and estimated costs for the entire settlement period. Company's expenses to implement its obligations herein shall be at no cost to Class Members unless otherwise indicated.

7.32. Force Majeure.

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

7.33. Managed Care Issues Relating to Mental Health and Substance Abuse

If Company outsources mental health services, Company will provide ninety (90) days notice of same via its provider website.

a. Company agrees that it's definition of medical necessity shall apply to services provided for psychiatric illness and treatment in the same manner in which it applies the definition of medical necessity to all medical conditions.

b. Company agrees that any definition of mental health services shall include substance abuse services.

c. Company agrees that all participating psychiatrists shall be listed in Company's provider directories and on any web location where Company lists other participating medical doctors. Company further agrees that access to psychiatrists shall be in the same manner and form as a member of a Company health plan can access any Participating provider. In this regard, Company will allow its primary care physicians to make direct referrals to Company's in-network psychiatrists.

d. Company agrees to reimburse psychiatrists for covered, medically necessary services that are appropriately coded with the correct CPT©, HCPCs, revenue codes, pursuant to AMA CPT© codes, guidelines and conventions.

e. Company agrees that psychiatrists shall be allowed to provide medically necessary covered psychotherapy for Company's enrollees without discrimination toward other specialties. The Company reserves the right to direct patients to the most cost effective care practitioner for their individual needs if such treatment is at least as likely to produce an equivalent therapeutic or diagnostic result.

f. Company agrees that to the extent that it requires medical information with respect to a mental health patient, it will obtain an authorization signed by the patient who specifies the records requested and the time period of treatment.

g. Company agrees that, where a psychiatrist is not a salaried employee of a hospital or facility, it will reimburse the psychiatrist his or her

appropriately billed professional CPT, HCPCs or revenue codes, pursuant to nationally recognized coding guidelines and conventions, for example, AMA CPT© or CMS, exclusive of any fee paid to the hospital.

h. Company agrees that it will allow Physicians to make admitting decisions based upon medical necessity for a psychiatric patient in the same manner as the physician is allowed to make in hospital admission decisions for any medical patient as long as hospital policies and legal requirements are met. Any pre-certification requirement will be the same requirement as for any medical patient.

8. Other Settlement Consideration.

In addition to the business initiatives set forth in § § 7 through 7.33 of the Agreement, the settlement consideration shall also include a Settlement Fund having a value of seven million dollars ($7,000,000). Of that amount, (i) five million dollars ($5,000,000) will be used to underwrite the Company's offering of an in-kind benefit based on their pro rata share of the fund for each Active Physician who has not Opted-Out of this Agreement and who claims such benefit ("Active Physician Benefit"); (ii) half a million dollars ($500,000) will be dedicated to the payment of a per capita payment to all Retired Physician Class Members who have not Opted-Out of this Agreement; (iii) one and one quarter million dollars ($1,250,000) will be used to fund certain Community Health Initiatives as described in more detail in § 8.c. below; and (iv) one quarter million dollars ($250,000) will be used to fund Medical Liability Advocacy as discussed in § 8.d. below.

Except for the funds to be paid for the Community Health Initiatives as set forth below in Section 8(c), the funds provided for in Sections 8(a) and 8(b) will be paid by Defendant within thirty (30) days after the Implementation Date to the Claims Administrator via a certified check or wire transfer and the funds provided for in Section 8(d) will be paid by the Defendant within thirty (30) days after the Implementation Date via a certified check or wire transfer to MSSNY.

a. Active Physician Benefit

From the In-Kind Benefit Menu attached hereto as Exhibit I, all non-Opting-Out Active Physicians may select an in-kind benefit based on their pro rata share of the fund. In lieu of receiving an in-kind benefit, an Active Physician eligible for such benefit may elect instead to donate the value thereof to the fund established to pay for the Community Health Initiatives.

b. Retired Physician Amount

Each Retired Physician Class Member who has not Opted Out of this Agreement shall be entitled to a per capita payment of approximately $625 from the Company. In lieu of receiving said payment, a Retired Physician eligible for such per capita payment may elect to donate said amount to the Community Health Initiatives. If the aggregate amount of monies paid out in per capita payments to eligible retired and deceased Class Members along with any amounts designated to be donated to the Community Health Initiatives by such Class Members is less than the half a million dollars ($500,000) earmarked for the per capita payments to retired and deceased eligible Class Members, then such amount remaining shall revert to the fund established to pay for the Community Health Initiatives.

c. Community Health Initiatives

The Community Health Initiatives shall be one or more community health projects in one or more of Excellus' service areas which project(s) shall be mutually agreed upon by MSSNY and the Company. The funding for the Community Health Initiatives, which, at the option of the Company, may be spent over the four (4) year term of the Agreement, shall be one and one-quarter million dollars ($1,250,000), plus all donated and reversionary amounts from the non-Opting Out eligible Retiree and Active Physician Class Members.

d. Medical Liability Advocacy

Medical liability is an issue of great concern to MSSNY, Plaintiffs and Excellus, impacts physicians' practices and affects the overall delivery of healthcare to patients. Therefore, Excellus will donate two hundred fifty thousand dollars ($250,000) to MSSNY for specific medical liability advocacy efforts.

9. Attorneys' Fees, and Representative Plaintiffs' Fees

Class Counsel intend to apply to the Court for an award of Attorneys' Fees and expenses in an amount not to exceed $3 Million, which application the Company agrees not to oppose. The Company will pay such fees to Class Counsel in the amount awarded by the Court up to a maximum of $3 million. If the Court awards Attorneys' Fees in excess of $3 Million, Class Counsel, on behalf of themselves and the Class, hereby agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind 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.

Thirty (30) days following the Implementation Date, Defendant shall pay to Representative Class Counsel (see Section 20) via certified check or wire transfer made payable to Milberg Weiss Bershad & Schulman LLP, the Attorneys' Fees awarded by the Court. It shall be within the sole discretion of Representative Class Counsel as to how the Attorneys' Fees are to be allocated amongst Class Counsel representing Plaintiffs. Representative Class Counsel represents that the Attorneys' Fees awarded shall be the total fees paid to Class Counsel and each law firm serving as Class Counsel will not seek any other fees or expenses.

In addition to Attorneys' Fees, Class Counsel intends to apply to the Court for an award of fees for each representative plaintiff in the amount of $14,000 which the Company agrees not to oppose. The Company will pay such fees to the Representative Plaintiffs in the amount awarded by the Court up to a maximum of $14,000 a piece.

The fees the Representative Plaintiffs agree to be paid pursuant to this section are in addition to the other consideration afforded the Class Members who have not validly and timely requested to Opt-Out of this Agreement. 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.

The payment to the Representative Plaintiffs will be paid by the Defendant within thirty (30) days after the Implementation Date.

10. Application to Fully Insured and Self Insured Plans

Unless otherwise indicated herein, or required by applicable law, the provisions of this Agreement shall apply equally to Fully-Insured and Self-Insured Plans.

11. Compliance Disputes Arising Under This Agreement.

11.1. 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 shall instead be resolved pursuant to the provisions of this section. The proposed Order and Final Judgment in the Actions 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 § 11.3, § 11.6, and subject to § 11.5, the Compliance Dispute Facilitator shall refer Compliance Disputes that satisfy the requirements of § 11.2 to the Compliance Dispute Review Officer for resolution. The Compliance Dispute Facilitator is to be designated by Class Counsel. Company shall publish on the Public Website the name and address of the Compliance Dispute Facilitator. The Compliance Dispute Review Officer shall and be agreed upon by Company and Class Counsel within 30 days of the Preliminary Approval Date. If the Compliance Dispute Review Officer is no longer able to serve in such role for any reason, then a replacement shall be chosen by mutual agreement of Class Counsel, or their designee, and Company. If Class Counsel, or their designee, and Company cannot mutually agree on such replacement Compliance Dispute Review Officer, such replacement Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Implementation Date (the "First Alternate"). If the First Alternate is unable or unwilling to serve in such role for any reason, then such replacement Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Implementation Date (the "Second Alternate"). If the Second Alternate is unable or unwilling to serve in such role for any reason, then such Compliance Dispute Review Officer shall be a Person to be agreed upon by Company and Class Counsel prior to the Implementation Date.

c. Company shall pay the fees and costs of the Compliance Dispute Facilitator and the Compliance Dispute Review Officer, which it shall fund yearly in amounts to be agreed upon prior to the Implementation Date by Company and the Compliance Dispute Facilitator, subject to review by Class Counsel. If these agreed-upon amounts shall be exceeded in any year, Company and Class Counsel (or their designee) shall meet and confer in good faith to determine whether mutually acceptable additional funding amounts can be agreed. If the parties are unable to reach agreement following such good faith conferral, each party reserves the right to apply to the Court for relief relating exclusively to this § 11.1.c.

11.2. Who May Petition the Compliance Dispute Facilitator.

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

a. any Class Member who has not validly and timely requested to Opt-Out of this Agreement and that, based on particular facts, contends that Company has materially failed to perform specific obligations under § 7 of this Agreement, and that such Class Member is adversely affected by Company's failure to comply with such specific obligations under § 7; and

b. MSSNY, so long as MSSNY identifies in its petition to the Compliance Dispute Facilitator a Class Member who has not validly and timely requested to Opt-Out of this Agreement and who satisfies the requirements of § 11.2.a. brings the Compliance Dispute solely on behalf of such Class Member, unless MSSNY can otherwise show that there is a live controversy with the Company with respect to a violation of this Agreement.

c. Nothing in subsections (a) and (b) of this § 11.2 is intended or shall be construed to limit the remedies that the Compliance Dispute Review Officer Facilitator may order pursuant to § 11.6 herein.

11.3. 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 § (a) of this Agreement, the Compliance Dispute Facilitator must determine that:

(i) the Petitioner has satisfied the requirements of § 11.2;

(ii) the Petitioner has submitted a properly completed Submission not later than 90 days after such Compliance Dispute arose; and

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

(a) is not frivolous,

(b) sufficiently alleges adverse impact to the Petitioner (or the identified Class Member in the case where MSSNY serves as the Petitioner for such Class Member) or, in the case where MSSNY is the petitioner, the Class Member identified in the Submission and on whose behalf the Compliance Dispute is brought, in each case resulting from the alleged material failure by Company to comply with an obligation under § 7 of this Agreement to the Petitioner,

(c) is not properly the subject of a proceeding pursuant to § 7.10 or § 7.11 of this Agreement.

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

11.4. Rejection of Frivolous Claims.

The Compliance Dispute Facilitator may reject as frivolous, and 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 stating the grounds for denial of Petitioner's Compliance Dispute. Petitioner shall have no right to appeal the Compliance Dispute Facilitator's decision.

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

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 and Company's Internal Compliance Officer in these efforts.

11.6. Procedure for Compliance Dispute Facilitator for Determination of Compliance Disputes.

a. Initial Negotiation.

In the event that a Compliance Dispute is received, the Compliance Dispute Facilitator will verify that the Dispute meets the requisite criteria for review. If so, the Compliance Dispute Facilitator (see §11.7 below) will notify the Company's Internal Compliance Officer of the Compliance Dispute and forward all applicable materials to the Company's Internal Compliance Officer within twenty days of receipt of all materials from the Petitioner needed to resolve the matter. The Compliance Dispute Facilitator and the Company's Internal Compliance Officer are charged with working collaboratively to resolve all disputes brought to their attention using resources within their respective organizations as needed. If they are not able to solve the dispute within forty-five (45) days using internal resources, they may jointly agree that the assistance of a subject matter expert is necessary to resolve the matter. The Compliance Dispute Officer and the Company's Internal Compliance Officer may also agree to extend the forty-five (45) day limit as needed. However, Compliance Dispute Facilitator and the Company's Internal Compliance Officer must agree on the subject matter expert(s) used. In this case, the external subject matter expert would act as a binding third party arbitrator. If no External Subject Matter Expert exists, or the Compliance Dispute Facilitator and Company's Internal Compliance Officer cannot agree on the subject matter expert, then the dispute would be referred to the Compliance Dispute Review Officer for binding Third Party Arbitration. The Compliance Dispute Facilitator and the Company's Internal Compliance Officer are charged with encouraging a philosophy of payor/provider collaboration within their respective organizations. It is expected that most all disputes will be able to be resolved by the Compliance Dispute Facilitator and the Company's Internal Compliance Officer through this collaborative process. 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.

b. Decisions by the Compliance Dispute Review Officer or External Subject Matter Expert.

In resolving a Compliance Dispute, the External Subject Matter Expert or Compliance Dispute Review Officer shall decide, based on the written submissions, and any other information that the

Compliance Dispute Review Officer or External Subject Matter Expert in his or her sole discretion deems necessary, whether Company has failed to materially comply with its obligations under § 7 of this Agreement, and if so, direct what actions are to be taken by Company. In no event shall the Compliance Dispute Review Officer or the External Subject Matter Expert direct that Company spend amounts or take actions above or below Company's obligations under § 7 of this Agreement. The Compliance Dispute Review Officer or External Subject Matter Expert must, at the time he or she announces his or her decision, issue a written opinion setting forth the basis of the decision.

c. Rehearing by the Compliance Dispute Review Officer.

After the Compliance Dispute Review Officer or External Subject Matter Expert has issued a written opinion in accordance with § 11.6 (b), the Petitioner or Company, or both, may petition the Compliance Dispute Review Officer or External Subject Matter Expert (whoever decided the dispute) within ten (10) days from receipt of the decision, in writing, for rehearing on the question of whether a material violation has occurred and whether the remedies (if any) required by the Compliance Dispute Review Officer or External Subject Matter Expert are appropriate. The Compliance Dispute Review Officer or External Subject Matter Expert may deny the petition for rehearing or issue a new written opinion after considering such a petition.

d. Systemic Violations.

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

e. Finality of the Compliance Dispute Review Officer's Decision.

Upon the issuance of the Compliance Dispute Review Officer's or External Subject Matter Expert's decision after a rehearing, if any, the decision of the Compliance Dispute Review Officer or External Subject Matter Expert shall be final unless appealed to the Court, and such decision shall not be appealed by Petitioner or Company to any other federal court, any state court, any State Medical Society, any arbitration panel or any other binding or non-binding dispute resolution mechanism. In the event that Petitioner or Company seeks review in the Court of a final decision of the Compliance Dispute Review Officer or External Subject Matter Expert, the Court shall

consider only whether the Compliance Dispute Review Officer's or External Subject Matter Expert'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 § 11.6.b. 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 § 11.6.b. of this Agreement, the Court may remand the Dispute to the Compliance Dispute Review Officer or External Subject Matter Expert for further proceedings.

f. 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 authorized remedy ordered by the Compliance Dispute Review Officer, such Person shall have 90 days from the date of such certification to cure the non-compliance. If after such 90 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 90 day period, the other Person (Company or Petitioner, as the case may be) may petition the Court for enforcement.

11.7. 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 implementation and compliance with the obligations set forth and assist in resolving Compliance Disputes. The Internal Compliance Officer shall report through the 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 120 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 Facilitator and, upon written request, Class Counsel summarizing the Internal Compliance Officer's activities during the prior year and evaluating any problems or difficulties that Company encountered in complying with the terms of this Agreement, and shall simultaneously provide a copy of such report to the Physician Advisory Committee as described in § 7.9. Each annual report shall contain all the items required to be reported under this Agreement at the end of the

Effective Period; provided that following the initial annual report, subsequent reports may incorporate by reference any materials in prior year's reports that remain operative and have not been amended during the interim.

12. Limited Liability.

The Billing Dispute External Review Administrator (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 Administrator, 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.

13. Release and Covenant Not to Sue and Dismissal With Prejudice

13.1. Upon entry of the Final Order and Judgment in the Actions, the Releasing Parties and each of them shall hereby be deemed to have, and by operation of the Judgment shall have, fully, finally, and forever, remised, released, relinquished, compromised and discharged all Released Claims against each Released Person with prejudice.

13.2. Releasing Parties hereby release and forever discharge Released Parties from any and all Released Claims.

13.3. The Releasing Parties and each of them agree and covenant not to sue or prosecute, institute, facilitate or cooperate in the institution, commencement, filing, or prosecution of any suit based upon or related to any Released Claim or Released Rights against any Released Person.

13.4. Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment for Covered Services arising on or after the date of Final Approval to the extent, (i) no claim with respect to such Covered Services has been filed with Company and the contractual period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with Company but such claim has not been finally adjudicated by Company (the "Retained Claims"). For purposes of clause (ii), above, final adjudication shall include completion of Company's internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to Final Approval,

such claim shall constitute a Retained Claim if a Physician seeks relief under § 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 provisions of § 7.10 of this Agreement.

13.5. Upon Final Approval and until the Termination Date, each Releasing Party shall be deemed to have covenanted and agreed not to sue with respect to, or assert, against any Released Person, in any forum any Released Claim and any other claim that 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 this agreement; provided however, that the Parties shall retain the right to prosecute (i) any Retained Claim, (ii) any dispute subject to § 7.12, or (iii) any Compliance Dispute, which, respectively, shall be asserted and pursued only pursuant to the provisions of § 7.10, § 7.12 and § 11 this Agreement (it being understood that this § 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 § 11; provided that any such claim shall be prosecuted on an individual basis only and not otherwise).

13.6. Notwithstanding the foregoing, Releasing Parties shall retain the right to enforce Company's obligations under § 7.29.n. pursuant to the procedures set forth in § 11 of this Agreement.

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

13.8. 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.

13.9. MSSNY agrees that if the Company seeks legislation or regulations to require all New York health plans to comply with one or more elements of this Settlement Agreement as a public policy issue to standardize industry practices and avoid competitive disadvantages, then MSSNY will support these efforts and promote them through its own lobbying efforts.

14. Not Evidence; No Admission of Liability.

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

15. Entire Agreement.

With the exception of the commitment and agreement not to name the Company as a party in the Thomas et al. vs. BCBSA et al. litigation, 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 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 MSSNY regarding the subject matter of the Action or this Agreement. This Agreement shall not be modified in any respect except as otherwise provided herein or in a writing executed by all the Parties.

16. 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.

17. Related Action

As to any action that is now pending or hereafter may be filed in any court that asserts any Claim against the Released Parties on behalf of any Class Member who has not timely-Opted Out, Representative Plaintiffs, MSSNY, and Class Counsel agree that they will cooperate by filing appropriate documents with the court to the extent reasonably practicable, in such Released Party'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 such Released Party to the extent necessary to effectuate the other provisions of this Agreement.

In the event that Class Counsel are engaged, or engage in the future, in settlement negotiations with other Blue Cross Blue Shield Plans in similar actions, including but not limited to, Thomas et al., v. Blue Cross and Blue Shield Association, et al., the parties agree that with the exception of the Inter-Plan Program, no attempt by Class Counsel will be made to impose as part of those settlement negotiations any obligation or requirement that BCBSA amend or modify its License Agreements Regulations so as to apply the terms of any such settlement to Company.

Plaintiffs and Class Counsel hereby agree that the Company shall only be bound by the terms of this Settlement Agreement and shall not be bound by any terms of a possible future Settlement Agreement reached in Thomas et al. v. BCBSA, et al., except and unless there are new requirements for the Inter-Plan Program.

18. Continuing Jurisdiction and Exclusive Venue.

18.1. Continuing Jurisdiction.

Except as otherwise provided in § 5 and § 5.1, it is expressly agreed and stipulated that the Court 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, MSSNY 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 Court for any suit, action, proceeding, case, controversy, or dispute relating to this Agreement and/or Exhibits hereto and negotiation, performance or breach of same.

18.2. Parties Shall Not Contest Jurisdiction.

In the event of a case, controversy, or dispute arising out of the negotiation of, approval of, performance of, or breach of this Agreement, the Parties hereby agree to pay, and the Court is authorized to award, attorneys' fees and costs to the prevailing party. Solely for purposes for such suit, action or proceeding, to the fullest extent that they may effectively do so under applicable law, the Parties irrevocably waive and agree not to assert, by way of motion, as a defense or otherwise, any claim or objection that they are not subject to the jurisdiction of such Court, or that such Court is in any way an improper venue or an inconvenient forum. Furthermore, the Parties shall jointly urge the Court to include the provisions of this § 18.2 in its order finally approving this Agreement.

19. Cooperation.

MSSNY, 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.

20. Representative Class Counsel

Given the large number of Class Counsel, MSSNY, Representative Plaintiffs, the Company and Class Counsel agree that Class Counsel shall designate and have a Representative Class Counsel who has full authority to bind and act for and on behalf of all Class Counsel. The Representative Class Counsel will be Edith Kallas or Joseph Guglielmo of Milberg Weiss. If there is a change in the Representative Class Counsel, timely written notice of same shall be given to Company's Counsel, Kimberly Lawrence of Hinman Straub P.C. All parties and counsel hereby agree that the Company's reliance on the acts and representations of the Representative Class Counsel shall be sufficient and binding on Plaintiffs and all Class Counsel.

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. Successors and Assigns.

The provisions of this Agreement shall be binding upon and inure to the benefit of the Company and its respective successors and assigns; provided that

the Company may not assign, delegate or otherwise transfer any of its rights or obligations under this Agreement without the consent of Class Counsel.

23. Governing Law.

Company, MSSNY and Class Members agree that, with respect to disputes arising between and among such Parties, this Agreement shall be governed by and construed in accordance with the laws of the State of New York, without regard to the conflicts of law rules of such state.

24. Termination

24.1. If one or more notices of appeal are filed from the Final Order and Judgment, the Company shall have the right, in its sole and absolute discretion, to provide notice that it shall thereafter be bound by this Agreement and the Parties shall perform their respective obligations as if Final Approval had occurred. If the Final Order and Judgment are not affirmed in their entirety on any such appeal or discretionary review, the Company may terminate this Agreement by delivering a notice of termination to Notice Counsel. If the Company does not elect to so terminate this Agreement, the Company shall be entitled, in its sole and absolute discretion, to provide notice to Representative Class Counsel that it shall be bound by the terms of this Agreement (if the Company has not already done so pursuant to the first sentence of this Section) 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.

24.2. This Agreement shall terminate (the "Termination Date") upon the earlier to occur of (i) termination of this Agreement by the Company pursuant to the terms hereof, and (ii) the four year anniversary of the date of the entry of the Implementation Date. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability on the part of any of the Parties, except for willful or knowing breaches of this Agreement prior to the time of such termination; provided that in the event of a termination of this Agreement contemplated by clause (ii) of this § 24.2; (A) the provisions of §§ 13.1, 13.2, 13.3, 13.5, 14, 16, 17, 18 and 23 shall survive such termination indefinitely, (B) the provisions of § 7.10 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 in the Billing Dispute External Review Process as of the date of such termination and (C) 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, shall survive such termination only with

respect to, and only for so long as is necessary to resolve any such disputes, (D) the provisions of § 11 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. In the event of termination of this Agreement as contemplated by clause (ii) of this § 24.2, the Company agrees to file as of the Termination Date a document (the "Final Report") with the Compliance Dispute Review Officer enumerating the items described elsewhere in this Agreement as required elements of such Final Report. The Company shall provide a copy of such Final Report to the members of the Physicians Advisory Committee. Upon filing of the duly completed Final Report by the Company on the Termination Date, all of the Company's obligations under this Agreement shall be satisfied. No decision or ruling of the Compliance Dispute Review Officer shall (except with respect to Clause "(D)" above) have any force on the Parties after the Termination Date and the Company shall be under no obligation to continue performance of any kind under this Agreement except where otherwise expressly noted. The 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.

EXECUTED and DELIVERED on May 23, 2005.

COMPANY:

By: _____
Kimberly C. Lawrence, Esq.
HINMAN STRAUB, P.C.
121 State Street
Albany, New York 12207
(518) 436-0751
(518) 436-4751

REPRESENTATIVE PLAINTIFFS:

By: _____
William Dolan, M.D.

By: _____
Sylvia Norton, M.D.

MEDICAL SOCIETY OF THE STATE OF NEW YORK:

By: _____
On Behalf of the MEDICAL SOCIETY OF
THE STATE OF NEW YORK

Title: _____

COMPANY:

By:_____
Kimberly C. Lawrence, Esq.
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By:_____
Sylvia Norton, M.D.

MEDICAL SOCIETY OF THE STATE OF NEW YORK:

By: Robert A Sicher, MD
On Behalf of the MEDICAL SOCIETY OF
THE STATE OF NEW YORK

Title: President

CLASS COUNSEL:

By: _____

Edith M. Kallas, Esq.
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