**<u>REMINDER</u> – The Deadline to Submit a Claim Form for the Wellpoint/Anthem Settlement is November 17, 2005.**

As part of the settlement, Wellpoint has agreed to make a settlement payment of $135 million which together with accrued interest from July 15, 2005, will be distributed to physicians who are members of the Class Action and who file a timely claim form. If the settlement is approved by the United States District Court in Miami Florida, the members of the Class will be entitled to payments in accordance with formulas described below.

Question: Who are members of the Class?

Answer: Any and all Physicians, Physician Groups and Physician Organizations who provided Covered Services to any Plan Member or any other individual enrolled in or covered by a plan offered or administered by any of the named defendants in the class action lawsuit or by any of their respective current or former Subsidiaries or Affiliates, in each case from August 4, 1990 through July 15, 2005 (the Court Preliminary Approval Date), and who have not opted out of the settlement. The defendant health plans include: Aetna, Anthem, Coventry, CIGNA, Humana, HealthNet, United Healthcare, Pacificare, Prudential and Wellpoint.

Question: What if I never treated a Wellpoint/Anthem enrollee?

Answer: Even if a physician has never treated a Wellpoint/Anthem enrollee (which may be the case for most N.Y. physicians) you are entitled to claim the Base Amount if you are a Class Member. Check the 1st box in Section C of the claim form, or, if retired, claim as a retired physician pursuant to Section B of the claim form.

Question: What is a Retired Physician?

Answer: This category covers a Class Member who has retired from the practice of medicine subsequent to August 4, 1990 or who is the legal heir or representative of a deceased class member. Retired physicians will receive a pro rata amount of the settlement fund allocated to inactive, retired or deceased physicians, about 2x the "Base Amount", regardless of the amount they received for treating Wellpoint/Anthem members.

Question: What is the payment formula for Active Physicians?

Answer: Based on gross receipts for calendar years 2002, 2003, 2004 for providing covered services to Wellpoint/Anthem plan members in the aggregate.

- Gross receipts – zero to less than $5,000 = Base amount
- Gross receipts of at least $5,000 but less than $50,000 = 5x the Base Amount
- Gross receipts of $50,000 or greater = 10x the Base Amount

Question: Is any documentation necessary?

Answer: No documentation is necessary if you base the claim on revenue received between 2002-2004. Just check one of the first three boxes in Section C as appropriate to reflect the amount of your receipts.

Alternatively, if your maximum revenue for providing covered services to Wellpoint/Anthem members occurred during any other 3 year period from January 1, 1996 through December 31, 2004, submit appropriate documentation.

Documentation Required – 1099s, accounting, records, or other documentation reflecting payments from Wellpoint/Anthem and a letter certifying what percentage of that payment was from Wellpoint/Anthem and/or its subsidiaries or affiliates.

Question: How can I get a Claim Form?

Answer: Claim forms are available at www.hmosettlements.com or by calling toll-free 1-866-686-8696. Link directly to claim form.

Your claim must be postmarked no later than November 17, 2005.

Question – May a Group Practice submit a claim on behalf of its employed physicians?

Answer: Physician groups may submit claims on behalf of physicians employed or otherwise working with them at the time the claims were submitted, but only to the extent these physicians do not submit their own individual claims. Physician groups should file the claim form using the group's tax ID number and address, and attach a list of the names and Social Security Number of the individual physicians on whose behalf the group is claiming, and the category of gross receipts applicable to each physician as discussed above. The claim form should be signed by the medical group's president or by another individual who has the authority to represent the listed physicians.

Question: What about a deceased physician?

Answer: A family member or personal representative of a deceased physician class member is eligible to collect payment on behalf of the physician. Representatives should file the claim form using their own information (name, address, SSN, etc.) because the check will be made out to them. They should include a note with the claim form indicating on whose behalf they are collecting. Finally, they should attach a copy of the physician's death certificate, as well as a copy of a document that confirms their status as the physician's beneficiary, executor, or legal heir (this may be a copy of a page from a will or trust, power of attorney, etc.).

Question: How much is the Base Amount?

Answer: This will depend upon the number of claims that are timely filed.

11/12/05

# CLAIM FORM FOR THE WELLPOINT/ANTHEM SETTLEMENT FUND AND ELECTION OF CONTRIBUTION TO CHARITABLE FOUNDATION

You must read the Notice of Proposed Settlement and Claim Instructions before completing this Claim Form.

**SECTION A: CLAIMANT INFORMATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION.**

☐ **Physician Group/Organization** Please indicate the number of physicians on your list _____

| *Physician Group or Organization Name* | |
|---|---|
| *Name and Title of Person Filing* | *Phone* |

* Groups/Organizations Must Attach a list of Active Physicians with key data elements. See Instructions.

☐ **An Individual Physician** Please indicate your physician type (e.g., MD or DO) _____

| *Name of Physician* | |
|---|---|
| *Name of Representative (if Physician is Deceased)* | *Phone* |

* If you are the legal heir or representative of a deceased Class Member, you must attach documentation such as a death certificate or letters of administration for an estate to confirm your status. The Tax ID requested in Section E is that of the heir or estate.

**Mailing Address for Group or Individual Claimant**

| *Mailing Address (Street, PO Box, Suite or Office Number, as applicable)* | | | |
|---|---|---|---|
| *City* | *State* | *Zip Code* | *WellPoint Provider Number (if applicable)* |

Please check the appropriate box in SECTION B or SECTION C to indicate of which category you are a member.

**SECTION B: I AM A MEMBER OF THE CLASS WHO HAS RETIRED FROM THE PRACTICE OF MEDICINE SUBSEQUENT TO AUGUST 4, 1990 OR I AM THE LEGAL HEIR OR REPRESENTATIVE OF A DECEASED CLASS MEMBER.**

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and that I am either a Class Member (as described in the enclosed Notice of Proposed Settlement) who has retired from the practice of medicine subsequent to August 4, 1990 or that I am the legal heir or representative of a deceased Class Member.

**SECTION C: I AM A MEMBER OF THE CLASS AND AN ACTIVE PHYSICIAN.**

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and that I am a Class Member (as described in the enclosed Notice of Proposed Settlement) and that I am an Active Physician.

Active Physicians check **ONLY ONE** of the boxes below to designate the range of gross receipts that are the basis of this claim. Groups need to attach a list that designates the range of gross receipts for each Active Physician group member. *For purposes of determining this amount, "WellPoint" means any of the present or former affiliates as listed in the Notice.*

I. ☐ By checking this box, I certify that I received no payments from WellPoint/Anthem or that my gross receipts for providing covered services to WellPoint /Anthem members during the three calendar year period of 2002, 2003 and 2004 were less than $5,000.

II. ☐ By checking this box, I certify that my gross receipts for providing covered services to WellPoint/Anthem members during the three calendar year period of 2002, 2003 and 2004 were at least $5,000 but less than $50,000.

III. ☐ By checking this box, I certify that my gross receipts for providing covered services to WellPoint/Anthem members during the three calendar year period of 2002, 2003 and 2004 were $50,000 or greater.

IV. ☐ By checking this box, I certify that my gross receipts for providing covered services to WellPoint/Anthem members during another consecutive three-year period between January 1, 1996 and December 31, 2004 were in the amount shown on Page 2 and are supported by the enclosed documents evidencing such receipts.

**If you checked boxes I, II or III in Section C on Page 1, please move to Section D.**

**If you checked box IV in Section C on Page 1, please complete the table below.**

If you checked Box IV in Section C, please indicate in the table below the dates of the three-year period that are the basis of your claim and check the appropriate box to indicate for this three-year period the range of gross receipts you received for providing covered services to WellPoint/Anthem members. You must attach your proof or receipts and write a description of the proof you attached in the box below.

| | ☐ under $5,000 | ☐ $5,000 - <$50,000 | ☐ $50,000 or over |
|---|---|---|---|
| *Dates of the 3 – Year Period* | *Description of the Proof Attached.* | | |

## SECTION D: INSTRUCTIONS FOR PAYMENT – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

☐ By checking this box, I am directing the Settlement Administrator to remit payment of the *pro rata* portion of the settlement fund for an eligible claim directly to me (i.e., to the Class Member completing this claim, which may be an individual or group/organization).

☐ By checking this box, I am directing the Settlement Administrator to donate the *pro rata* portion of the settlement fund for an eligible claim to the charitable foundation that I have selected from the List of Charitable Foundations found on the bottom of Page 2 of the Claim Form Instructions (select only one charitable foundation).

**CLEARLY print the number preceding the Foundation you are selecting from the List of Charitable Foundations found on the bottom of Page 2 of the Claim Form Instructions.**

*Foundation Designation Number*

## SECTION E: SUBSTITUTE W-9 – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

On the appropriate line, enter the Social Security Number or Employer Identification Number of the claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For other entities, this is your Employer Identification Number (EIN).

_____ - _____ - _____ **OR** _____ - _____

Social Security Number (SSN) Employer Identification Number (EIN)

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this claimant; and

2. The claimant is not subject to backup withholding because the claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the claimant that the claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

## SECTION F: CERTIFICATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION

I do declare and certify as follows:

- I am a Class Member or an authorized representative of the Physician Group or Organization identified above; and
- All of the statements and information provided in this Claim Form are true, correct and complete.

**NOTE: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications in Section E required to avoid backup withholding.**

_____ _____

Signature of Class Member or Authorized Representative Date

**Any Claim Form postmarked after November 17, 2005 is not a Valid Claim Form and will be denied by the Settlement Administrator.**

**Claims must be sent to the Settlement Administrator at PO Box 3560; Portland, OR 97208-3560.**

**If you have any questions, please call the Administrator at 1-866-686-8696.**