

SETTLEMENT AGREEMENT

dated as of

April 27, 2007

by and among

BLUE CROSS AND BLUE SHIELD ASSOCIATION
BLUE CROSS AND BLUE SHIELD OF ALABAMA
PREMERA BLUE CROSS
ALSO DBA PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
CAREFIRST, INC.
GROUP HOSPITALIZATION AND MEDICAL SERVICES INC.
CAREFIRST OF MARYLAND, INC.
BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
HAWAII MEDICAL SERVICE ASSOCIATION
THE REGENCE GROUP
REGENCE BLUESHIELD
REGENCE BLUESHIELD OF IDAHO, INC.
REGENCE BLUECROSS BLUESHIELD OREGON
REGENCE BLUECROSS BLUESHIELD OF UTAH
WELLMARK, INC. DBA WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA
WELLMARK OF SOUTH DAKOTA, INC.
DBA WELLMARK BLUE CROSS AND BLUE SHIELD OF SOUTH DAKOTA
LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY,
DBA BLUE CROSS AND BLUE SHIELD OF LOUISIANA
HMO LOUISIANA, INC.
BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC.
BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS HMO BLUE, INC.
BLUE CROSS BLUE SHIELD OF MICHIGAN, INC.
BCBSM, INC., DBA BLUECROSS BLUESHIELD OF MINNESOTA
HMO OF MISSISSIPPI, INC.
BLUE CROSS & BLUE SHIELD OF MISSISSIPPI
BLUE CROSS AND BLUE SHIELD OF MONTANA, INC.
HORIZON HEALTH CARE SERVICES, INC., DBA
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
EMPIRE HEALTHCHOICE ASSURANCE, INC., DBA
EMPIRE BLUE CROSS BLUE SHIELD

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA
HOSPITAL SERVICE ASSOCIATION OF NORTHEASTERN PENNSYLVANIA
TRIPLE-S, INC.

TRIPLE-S, INC. OF PUERTO RICO
BLUE CROSS BLUE SHIELD OF RHODE ISLAND
BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
TENNESSEE HEALTH CARE NETWORK, INC.
HEALTH CARE SERVICE CORPORATION
INDEPENDENCE BLUE CROSS
AMERIHEALTH HMO, INC.
LACRUZ AZUL DE PUERTO RICO
KEYSTONE HEALTH PLAN EAST, INC.

And other Subsidiaries listed on the Signature Pages

THE REPRESENTATIVE PLAINTIFFS,
THE SIGNATORY MEDICAL SOCIETIES,
AND CLASS COUNSEL

SETTLEMENT AGREEMENT

This Agreement is made and entered into as of the Execution Date by and among the Representative Plaintiffs in the Action (on behalf of themselves and each of the Class Members (as defined below)), by and through Class Counsel, Blue Cross Blue Shield Association, Blue Plans, and those medical societies identified on the signature pages hereto (such medical societies are herein collectively referred to as the “**Signatory Medical Societies**”) (the Representative Plaintiffs, the Class Members, Blue Parties and the Signatory Medical Societies are herein collectively referred to as the “**Parties**”). The Parties intend this Agreement to resolve, discharge and settle the Released Claims, fully, finally and forever according to the terms and conditions set forth below.

WITNESSETH:

WHEREAS, certain Representative Plaintiffs in the Action filed the Complaint;

WHEREAS, Blue Parties deny the material factual allegations and legal claims asserted in the Complaint, including without limitation any and all charges of wrongdoing or liability arising out of any of the conduct, statements, acts or omissions alleged, or that could have been alleged, in the Complaint including without limitation the allegations that the Representative Plaintiffs and/or other Class Members have suffered damages; that Blue Parties improperly manipulated claim procedures or capitation payments or any other payments; that Blue Parties paid at incorrect rates or improperly applied reimbursement policies; that Blue Parties fraudulently misrepresented the criteria for insurance coverage determination, treatment decisions, claims payments and adequacy of capitation payments; that Blue Parties conspired with or aided and abetted wrongful conduct of any other Person; and that the Representative Plaintiffs and/or other Class Members were harmed by the conduct alleged in the Complaints;

WHEREAS, Blue Parties have asserted a number of defenses to the claims set forth in the Complaint that Blue Parties believe are meritorious; nonetheless, Blue Parties have a desire to make more transparent, simplify and otherwise improve the systems through which they conduct business with Class Members and have concluded that further conduct of the Action would be protracted and expensive and that it is desirable that the Action be fully and finally settled in the manner and upon the terms and conditions set forth in this Agreement;

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

WHEREAS, Representative Plaintiffs and Class Counsel also have taken into account the uncertain outcome and the risk of any class action, especially in complex actions such as the Action, 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 Blue Parties' compliance with the terms of this Agreement is beneficial to Class Members and that such compliance does not and shall not violate any legal right of Class Members, the Representative Plaintiffs and Class Counsel have determined that this Agreement is in the best interests of themselves and the other Class Members; and

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

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED by and among the Parties that, subject to the approval of the Court, the Action and the Released Claims shall be finally and fully resolved, compromised, discharged and settled under the following terms and conditions:

1. Definitions.

As used in this Agreement and all exhibits to this Agreement, the following terms have the meaning specified.

1.1 "Action" means *Love, et al. v. Blue Cross Blue Shield Association, et al.*, (formerly *Thomas, et al. v. Blue Cross Blue Shield Association, et al.*), Civil Action No. CV-03-21296-MORENO/SIMONTON in the United States District Court for the Southern District of Florida, Miami Division.

1.2 "Active Physician" means a Class Member who is a Physician and who is not a Retired Physician as of the Preliminary Approval Date.

1.3 "Active Physician Amount" shall have the meaning assigned to that term in § 8.3(b) of this Agreement.

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

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

1.6 "Agreement" means this Settlement Agreement, inclusive of all exhibits hereto.

- 1.7 “AMA” means the American Medical Association.
- 1.8 “Attorneys’ Fees” means the funds for attorneys’ fees and expenses that may be awarded by the Court to Class Counsel.
- 1.9 “Bar Order” means an order of the Court barring the assertion of claims against the Released Parties for contribution, indemnity or other similar claims by other Persons in the form included as part of the Final Order and Judgment.
- 1.10 “Base Amount” shall have the meaning assigned to that term in § 8.3(d) of this Agreement.
- 1.11 “BCBSA” means the Blue Cross and Blue Shield Association.
- 1.12 “Billing Dispute” shall have the meaning assigned to that term in § 7.10(a) of this Agreement.
- 1.13 “Billing Dispute Reviewer” shall have the meaning assigned to that term in § 7.10 of this Agreement. The Billing Dispute Reviewer shall have the requisite skill, experience and independence to carry out the functions set forth in § 7.10.
- 1.14 “BlueCard Program” means the program governed by BCBSA that requires licensees of BCBSA to use certain policies, procedures and/or technology to service Blue Cross and/or Blue Shield members located outside of a licensee’s service area.
- 1.15 “Blue Compliance Dispute Facilitator” shall have the meaning assigned to that term in § 12.1(a) of this Agreement.
- 1.16 “Blue Parties” means BCBSA and all of the Blue Plans, and “Blue Party” means any one of the Blue Parties.
- 1.17 “Blue Plan” means an entity identified as such on the signature pages hereto and its Subsidiaries.
- 1.18 “Capitation” means the payment by a Blue Plan to Physicians, Physician Groups or Physician Organizations of a per member per month amount (including but not limited to percentage of premium) by which a Blue Plan transfers to the Physicians, Physician Groups or Physician Organizations the financial risk for those Covered Services as set forth in the contract between the Blue Plan and the Physicians, Physician Groups or Physician Organizations.
- 1.19 “CCI” means CMS’s published list of edits and adjustments that are made to health care providers’ claims submitted for services or supplies provided to patients insured under the federal Medicare program and/or under other federal insurance programs.
- 1.20 “Claim” shall have the meaning assigned to that term in § 13.1(a) of this Agreement.

1.21 “Claim Form” shall have the meaning assigned to that term in § 8.3(h) of this Agreement.

1.22 “Claim Form Instructions” shall have the meaning assigned to that term in § 8.3(h) of this Agreement.

1.23 “Class” means any and all Physicians, Physician Groups and Physician Organizations who provided Covered Services to any Plan Member or services to any individual enrolled in or covered by a Plan offered or administered by any Person named as a defendant in the Complaint or by any other primary licensee of the BCBSA or by any of their respective current or former subsidiaries or Affiliates, in each case from May 22, 1999 through the Preliminary Approval Date. The Class shall exclude: (i) all Persons who, in accordance with the terms of this Agreement, execute a timely request for exclusion (Opt-Out) from the Class; and (ii) the Blue Parties, their Affiliates and any of their officers, directors and employees.

1.24 “Class Compliance Dispute Facilitator” shall have the meaning assigned to that term in § 12.1(a) of this Agreement.

1.25 “Class Counsel” means those persons identified in § 5 as Class Counsel.

1.26 “Class Member” means any Person who is a member of the Class.

1.27 “Clinical Information” means clinical, operative or other medical records and reports kept in the ordinary course of a Physician’s, Physician Group’s or Physician Organization’s business, and, where applicable, requested statements of Medical Necessity.

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

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

1.30 “Complaint” means the initial complaint and any and all subsequent complaints filed in the Action.

1.31 “Complete Claim” means a claim for Covered Services that (a) is timely received by the Blue Plan, (b) has a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (c) meets all the requirements of § 7.17(b), (d) (i) when submitted via paper has all the elements of the CMS-1500 (or successor standard) forms or (ii) when submitted via an electronic transaction, uses only permitted standard code sets (e.g., CPT®-4, ICD-9, HCPCS) and has all the elements of the standard electronic formats, as required by applicable federal authority and state regulatory authority, (e) is a claim for which the Blue Plan is the primary payor or its responsibility as a secondary payor has been established, (f) contains no defect or error that would affect the

adjudication of the claim, (g) includes supporting documentation consistent with this Agreement sufficient for the Blue Plan to make a payment determination, and (h) is under a Plan for which all applicable premiums have been paid.

1.32 “Compliance Dispute” means any claim that a Blue Party has failed to carry out any of its obligations under § 7 of this Agreement and Exhibit H to this Agreement; provided, however, that none of the following shall be deemed a Compliance Dispute: (a) a Released Claim, (b) a Retained Claim, (c) a Billing Dispute, or (d) a claim for which the review process for Adverse Determinations set forth in § 7.11 is available.

1.33 “Compliance Dispute Claim Form” means a document in substantially the same form as Exhibit C, attached hereto.

1.34 “Compliance Dispute Facilitator” means the individuals selected to be the Class Compliance Dispute Facilitator, the Blue Compliance Dispute Facilitator or both, as the term is used herein.

1.35 “Compliance Dispute Officer” shall have the meaning assigned to that term in § 12 of this Agreement.

1.36 “Court” means the United States District Court for the Southern District of Florida.

1.37 “Covered Services” means, with respect to a particular Blue Plan, a health care benefit that is within the coverage described in the Plan Documents applicable to an eligible Plan Member of such Blue Plan.

1.38 “CPT®”, “CPT® Codes” or “AMA CPT® book” means medical nomenclature in the publication entitled “CPT, Standard Edition”, “CPT® Professional Edition”, “CPT Assistant” and “Principals of CPT Coding” published by the AMA containing a systematic listing and coding of procedures and services provided to patients by physicians and certain non-physician health professionals. When used herein, “CPT®”, “CPT® Codes” or “AMA CPT® book” refers to such medical nomenclature in the publication as it exists as of the date of this Agreement and as it may be amended, modified or superseded thereafter during the term of this Agreement.

1.39 “CPT® Conventions” mean rules for the application of codes that go across all sections and subsections of the AMA CPT book, e.g. indented codes and add on codes.

1.40 “CPT® Guidelines” mean those guidelines set out in the introduction, in the beginning to each of the six major sections, in the subsections and in the code level parenthetical statements and cross references (excluding from this definition any reference to another publication that is not subject to the existing CPT Editorial Panel process, such as, but not limited to “CPT Assistant” or “Principles of CPT Coding”) contained in the AMA publication “CPT, Professional Edition”.

1.41 “Credentialing Committee” means any committee maintained by a Blue Plan that has decision-making authority regarding credentialing and re-credentialing of individual Physicians as Participating Physicians with the Blue Plan.

1.42 “Delegated Entity” (1) as the term applies to arrangements in California with respect to which a Blue Plan is operating as a Blue Cross and/or Blue Shield licensee, means (i) a risk-bearing organization, organized delivery system, limited or specialized licensed health plan or other risk-bearing entity as defined by California law, or (ii) a full service licensed health plan where it is reasonably necessary because a Blue Plan does not have reasonable capacity to provide or administer coverage in those geographic areas or specialty services; and (2) as the term applies otherwise, means, with respect to a particular Blue Plan, an entity that: (i) is not an Affiliate of such Blue Plan and is not another licensee of BCBSA, (ii) maintains its own contracts with Physicians separate from any contracts between such Blue Plan and Physicians, and (iii) by agreement with such Blue Plan, (A) agrees to provide Plan Members with access to such Physicians pursuant to terms of such agreements, and (B) performs some or all of the functions with respect to Plans which otherwise would be performed by such Blue Plan, including without limitation claims adjudication, utilization review, utilizations management and Physician credentialing.

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

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

1.45 “Effective Date” shall have the meaning assigned to that term in § 14.4 of this Agreement.

1.46 “Effective Period” shall have the meaning assigned to that term in the preamble to § 7 of this Agreement.

1.47 “Enrollment” or “Enrollment Date” shall mean the date upon which a Plan Member becomes eligible to receive Covered Services.

1.48 “EOB” means an Explanation of Benefit or any comparable form or statement communicating to a Plan Member the results of a Blue Plan’s adjudication of claim(s) with respect to or on behalf of such Plan Member.

- 1.49 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.
- 1.50 “Execution Date” means the later of (i) the date on which the signatures of all Blue Parties have been delivered to Class Counsel, and (ii) the date on which the signatures of all Representative Plaintiffs, Signatory Medical Societies and Class Counsel have been delivered to all Blue Parties.
- 1.51 “External Review” shall have the meaning assigned to that term in § 7.11(e)(i) of this Agreement.
- 1.52 “FDA” means the U.S. Food and Drug Administration.
- 1.53 “FEHBA” means the Federal Employees Health Benefits Act and the rules and regulations and contracts promulgated or entered thereunder.
- 1.54 “Final Order and Judgment” means the order and form of judgment approving this Agreement and dismissing the Blue Parties, with prejudice, in the Action in the form attached hereto as Exhibit D.
- 1.55 “Final Order Date” means the date on which the Court enters the Final Order and Judgment.
- 1.56 “Foundation” shall have the meaning assigned to that term in § 8.3(g) of this Agreement.
- 1.57 “Force Majeure” shall have the meaning assigned to that term in § 7.32 of this Agreement.
- 1.58 “Fully-Insured Plan” means a Plan as to which a Blue Plan assumes all or a majority of healthcare cost and/or utilization risk.
- 1.59 “HCPCS Level II Codes” means alphanumeric codes used to identify those codes not included in CPT® and that are commonly referred to as Healthcare Common Procedure Coding System Level II Codes.
- 1.60 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996.
- 1.61 “Implementation Date” shall have the meaning assigned to that term in the preamble to § 7 of this Agreement.
- 1.62 “Independent Review Organization” shall have the meaning assigned to that term in § 7.11(e)(i).
- 1.63 “Individually Negotiated Contract” means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to one or more modifications to the terms of a Blue Plan’s applicable standard form agreement that substantially modify the standard form agreement and that are made to individually suit, in whole or in part, the needs of a Participating Physician,

Participating Physician Group or Participating Physician Organization (including but not limited to higher or customized rates and/or other customized payment methodologies).

1.64 “Intellectual Property Claim” means any claim of patent, copyright, or trademark infringement or trade secret or other proprietary rights asserted or threatened against a Blue Party.

1.65 “Interest Rate” means a 4.75% annual rate of return without compounding.

1.66 “Joint Compliance Dispute Program” shall have the meaning assigned to that term in § 12.1(c) of this Agreement.

1.67 “Mailed Notice” means the form of the notice attached hereto as Exhibit E.

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

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

1.70 “NASCO” means National Account Service Company, LLC.

1.71 “Negotiated Purchaser” shall have the meaning assigned to that term in § 7.36 of this Agreement.

1.72 “Non-Participating” means, with respect to a Physician, Physician Group, or Physician Organization, a Physician, Physician Group, or Physician Organization that is not a Participating Physician, Participating Physician Group, or Participating Physician Organization.

1.73 “Notice Administrator” shall mean the Person appointed to administer the provisions relating to Notice to potential Class Members, under § 6.

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

1.75 “Objection Date” shall have the meaning assigned to that term in § 6 of this Agreement.

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

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

1.78 “Overpayment” means, with respect to a claim submitted by or on behalf of a Physician, Physician Group or Physician Organization, any erroneous or excess payment that a Blue Plan makes for any reason including, but not limited to, (i) payment at an incorrect rate, (ii) duplicate payments for the same Physician Service, (iii) payment with respect to an individual who was not a Plan Member on the date the Physician provided the Physician Service(s) that are the subject of such payment, and (iv) payment for any non-Covered Service.

1.79 “Participating Physician” means a Physician who has entered into a valid written contract with a Blue Plan (or who has agreed pursuant to an arrangement with a Physician Group, Physician Organization or other entity which has a valid written contract with a Blue Plan) to provide Covered Services to that Blue Plan’s Plan Members and, where applicable, who meets the Blue Plan’s credentialing requirements, during the effective period of such a contract. The fact that a Physician has entered into an agreement with a rental network does not make that Physician a Participating Physician.

1.80 “Participating Physician Group” means a Physician Group that has entered into a valid written contract with a Blue Plan to provide Covered Services to that Blue Plan’s Plan Members.

1.81 “Participating Physician Organization” means a Physician Organization that has entered into a valid written contract with a Blue Plan to provide Covered Services to that Blue Plan’s Plan Members.

1.82 “Participating Psychiatrist” means a Psychiatrist who is a Participating Physician.

1.83 “Parties”, each a “Party” shall have meaning assigned to that term in the preamble of this Agreement.

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

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

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

1.87 “Physician Group” means two or more Physicians, and those claiming by or through them, who practice under a single taxpayer identification number.

1.88 “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 to Plan Members by Physicians organized under multiple taxpayer identification numbers.

1.89 “Physician Services” means Covered Services that a Physician provides to a Plan Member, as specified in applicable agreements with a Blue Plan or otherwise.

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

1.91 “Plan” means a benefit plan through which a Plan Member obtains health care benefits set forth in pertinent Plan Documents.

1.92 “Plan Documents” means the documents defining the health care benefits available to a Plan Member, including the Plan Member’s summary plan description, certificate of coverage or other applicable coverage document, and the terms and conditions under which such benefits are available under the Plan.

1.93 “Plan Member” means an individual enrolled in or covered by a Plan offered and administered by a Blue Plan.

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

1.95 “Precertification” (“Precertify” or “Precertifies”) means the prior approval by a Blue Plan that the service or supply is Medically Necessary and/or not experimental or investigational.

1.96 “Preliminary Approval Date” means the date the Preliminary Approval Order is entered by the Court.

1.97 “Preliminary Approval Hearing” shall have the meaning assigned to that term in § 4 of this Agreement.

1.98 “Preliminary Approval Order” means the preliminary approval order as attached hereto at Exhibit F.

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

1.100 “Product Network” means a network of Participating Physicians who, pursuant to contracts with a Blue Plan, provide Covered Services to Plan Members for one or more products or types of products offered by the Blue Plan (e.g., HMO, PPO, POS, Indemnity) in exchange for a specified type of compensation (e.g., fee for service, Capitation).

1.101 “Programs” shall have the meaning assigned to that term in § 7.29(k)(iii) of this Agreement.

1.102 “Provider Website” means the secure (password protected) online resources for Participating Physicians to obtain information about a Blue Plan, its products and policies and other information described in more detail in this Agreement.

1.103 “Psychiatrist” means a Physician who is duly licensed by a state licensing board to provide mental health services and shall include without limitation both Participating Physicians and Non-Participating Physicians.

1.104 “Public Website” means the online resources for the public to obtain information about a Blue Party, its products and policies and other information.

1.105 “Published Notice” means the form of notice attached hereto as Exhibit G.

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

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

1.108 “Released Claims” shall have the meaning assigned to that term in § 13.1(c) of this Agreement.

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

1.110 “Remittance Advice” means the form sent by a Blue Plan to health care providers explaining the Blue Plan’s computation of benefits and payment amounts on a claim. The Remittance Advice is sometimes referred to as an “Explanation of Payment” form or “EOP.”

1.111 “Representative Plaintiffs” means collectively Rick Love, M.D, Joe Frank Smith, M.D., Scott Elledge, M.D., and Andreas Melendez-Desos, M.D.

1.112 “Representative Plaintiffs in Other Actions” means collectively Maxwell Cooper, M.D., Michon Morita, M.D., Andrew Cheng, M.D., Charles Rothberg, M.D., Mitchell Garden, M.D., Miriam Levitt, M.D., Robert J. Hughes, M.D., Joseph K. Newsom, M.D., Joseph K. Newsom, Jr., M.D., Robert Waters, M.D., John R. Nobles, M.D., Zachary Rosenberg, M.D., Dewayne P. Darby, M.D., Donald S. Horner, M.D., Amity Obstetrics & Gynecology Associates, P.A., G. William Haggerson, M.D., Forsyth Surgical Associates, P.A., and Lakeland Anesthesia, Inc.

1.113 “Retained Claims” shall have the meaning assigned to that term in § 13.6 of this Agreement.

1.114 “Retired Physician” means a Class Member who, subsequent to May 22, 1999, has become an inactive Physician, has retired from the practice of, or has otherwise ceased to practice, medicine or has died as of the Preliminary Approval Date.

1.115 “Retired Physician Amount” shall have the meaning assigned to that term in § 8.3(a) of this Agreement.

1.116 “Reversion Amount” shall have the meaning assigned to that term in § 8.4 of this Agreement.

1.117 “Self-Insured Plan” means any Plan other than a Fully-Insured Plan.

1.118 “Settlement Administration Account” shall have the meaning assigned to that term in § 8.2(b) of this Agreement.

1.119 “Settlement Administrator” shall have the meaning assigned to that term in § 8.3 of this Agreement.

1.120 “Settlement Amount” shall have the meaning assigned to that term in § 8.2 of this Agreement.

1.121 “Settlement Fund” shall have the meaning assigned to that term in § 8.2 of this Agreement.

1.122 “Settlement Fund Payment” shall have the meaning assigned to that term in § 8.2(a) of this Agreement.

1.123 “Settlement Hearing” shall have the meaning assigned to that term in § 6.2 of this Agreement.

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

1.125 “Shane” shall mean *Shane v. Humana, Inc., et al.*, Master File No. 00-1334 MDL-Moreno (“Shane I”) and *Shane v. Humana, Inc., et al.*, Case No. 04-21589-CIV-Moreno (“Shane II”) in the United States District Court for the Southern District of Florida, Miami Division.

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

1.127 “Significant Edit” means an Edit that a Blue Plan reasonably believes, based on its experience with submitted claims, will cause, on the initial review of submitted claims, the denial of or reduction in payment for a particular CPT® Code or HCPCS Level II Code more than two-hundred and fifty (250) times per year in any state in which the Blue Plan operates.

1.128 “Subsidiary” or “Subsidiaries” shall mean the entity or entities identified as such on the signature page of this Agreement.

1.129 “Tag Along Actions” shall have the meaning set forth in § 15.1.

1.130 “Terminating Blue Plan” shall have the meaning set forth in § 14.2(h).

1.131 “Termination Date” shall have the meaning assigned to that term in § 14.6 of this Agreement.

1.132 “TriCare” shall have the meaning assigned to that term in § 7.30(b) of this Agreement.

1.133 “Unopposed Amount” shall have the meaning assigned to that term in § 9.1 of this Agreement.

2. Intentionally Left Blank

3. Commitment to Support and Communications with Class Members

The Parties agree that it is in their best interests to consummate this Agreement and all the terms and conditions contained herein and to cooperate with each other and to take all actions reasonably necessary to obtain Court approval of this Agreement and entry of the orders of the Court that are required to implement its provisions. They also agree to support this Agreement in accordance with and subject to the provisions of this Agreement.

Class Counsel and Representative Plaintiffs and Representative Plaintiffs in Other Actions 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 § 12.

Representative Plaintiffs, Representative Plaintiffs in Other Actions, Class Counsel and Blue Parties agree that Blue Parties may communicate with putative Class Members regarding the provisions of this Agreement, so long as such communications are not inconsistent with the Mailed Notice or other agreed upon communications concerning the Agreement. Blue Parties will refer to the Settlement Administrator or to Class Counsel any inquiries from Class Members about claims to be filed under this Agreement.

4. Preliminary Approval of Settlement

Pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, the Parties shall submit this Agreement, together with the exhibits attached hereto, to the Court as soon as practicable following the Execution Date at a hearing (the “**Preliminary Approval Hearing**”) for, among other things, its conditional certification of a settlement class, preliminary approval of the Agreement, the Mailed Notice, the Published Notice and the Claim Form and shall apply to the Court for an order of preliminary approval and conditional class certification, substantially in the form of Exhibit F (“**Preliminary Approval Order**”).

5. Notice to Putative 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 putative 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 putative Class Members.

Class Counsel and Blue Parties shall be jointly responsible for identifying names and addresses of putative Class Members and shall cooperate with each other and the Notice Administrator to make such identifications and determinations.

Blue Parties shall pay the reasonable cost of notice to putative 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 Blue Parties of the cost of the Mailed Notice shall be non-refundable and shall be in addition to the other agreements made herein. Blue Parties shall pay for the cost to publish the Published Notice three times in the legal notices section in the national editions of THE WALL STREET JOURNAL and USA TODAY. If publication in one or more of said publications on the foregoing schedule is determined not to be practicable, then either Class Counsel or Blue Parties may apply to the Court for alternative notice by publication. Each Blue Plan shall also publish the Mailed Notice on its Public Website. The Blue Parties shall, to the extent feasible, also publish the Published Notice in a nationwide periodical addressing issues of concern to Physicians such as The Journal of the American Medical Association or The American Medical News. Each Blue Plan shall maintain the Public Website notices at such Blue Plan's cost through at least the Objection Date.

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

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

Class Counsel:

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

Harley S. Tropin
Janet L. Humphreys
Adam M. Moskowitz
Kozyak Tropin & Throckmorton, PA

Birmingham, AL 35203

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Podhurst Orseck, PA
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Eyster Key Tubb Weaver & Roth, LLP
402 East Moulton Street, SE
Eyster Building
Decatur, AL 35601

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

Robert Foote
FOOTE & MEYERS
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James B. Tilghman
STEWART TILGHMAN FOX &
BIANCHI
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Dennis G. Pantazis
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PANTAZIS
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Othni J. Lathram
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J. Mark White
WHITE ANDREWS ARNOLD & DOWD
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Guido Saveri
R. Alexander Saveri
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San Francisco, CA 94111-5619

Kenneth S. Canfield
Ralph Knowles
DOFFERMYRE SHIELDS CANFIELD
KNOWLES & DEVINE
1355 Peachtree St., Ste 1600
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James E. Hartley, Jr.
DRUBNER HARTLEY & O'CONNOR
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STROM LAW FIRM LLC
2110 N. Beltline Boulevard
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 GROSSMAN & GROSS
 100 Park Avenue
 New York, New York 10017-5516

David L. Steed
 CORNELIUS & COLLINS
 Suite 1500 Nashville City Center
 511 Union Street, P.O. Box 190695
 Nashville, Tennessee 37219-0695

MCCUTCHEN BLANTON JOHNSON &
 BARNETTE LLP
 1414 Lady Street
 P.O. Drawer 11209
 Columbia, South Carolina 29211

Blue Parties:

Blue Cross and Blue Shield Association	Chester T. Kamin JENNER & BLOCK LLP 330 North Wabash Chicago, IL 60611	Daniel A. Engel Blue Cross and Blue Shield Association 225 North Michigan Avenue Chicago, IL 60601
Blue Cross and Blue Shield of Alabama	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	Grey Till, Esquire Blue Cross and Blue Shield of Alabama 450 River Chase Parkway East Birmingham, Alabama 35244
Premera Blue Cross, also dba Premera Blue Cross Blue Shield of Alaska	Gwendolyn C. Payton LANE, POWELL PC 1420 5th Avenue, Suite 4100 Seattle, WA 98101	
CareFirst, Inc.; Group Hospitalization and Medical Services Inc.; CareFirst of Maryland, Inc.	Daly D. E. Temchine EPSTEIN, BECKER & GREEN, P.C. 1227 25th Street, N.W., Suite 700 Washington, D.C. 20037	

Blue Cross and Blue Shield of Florida, Inc.	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Hawaii Medical Service Association	Jess H. Griffiths GODBEY GRIFFITHS REISS 1001 Bishop St., 2300 Pauahi Tower Honolulu, HI 96813	
The Regence Group Regence BlueShield; Regence BlueShield of Idaho, Inc.; Regence BlueCross BlueShield Oregon; Regence BlueCross BlueShield of Utah	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Wellmark, Inc. dba Wellmark Blue Cross Blue Shield of Iowa; Wellmark of South Dakota, Inc. dba Wellmark Blue Cross and Blue Shield of South Dakota	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Louisiana Health Service & Indemnity Company dba Blue Cross and Blue Shield of Louisiana; HMO Louisiana, Inc.	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Blue Cross and Blue Shield of Massachusetts, Inc.; Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Daly D. E. Temchine EPSTEIN, BECKER & GREEN, P.C. 1227 25th Street, N.W., Suite 700 Washington, D.C. 20037	

Blue Cross Blue Shield of Michigan, Inc.	Joseph A. Fink Dickinson Wright PLLC 215 S. Washington Square Suite 200 Lansing, MI 48933	
BCBSM, Inc., dba BlueCross BlueShield of Minnesota	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
HMO of Mississippi, Inc.; Blue Cross & Blue Shield of Mississippi	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Blue Cross and Blue Shield of Montana, Inc.	Daly D. E. Temchine EPSTEIN, BECKER & GREEN, P.C. 1227 25th Street, N.W., Suite 700 Washington, D.C. 20037	
Horizon Blue Cross Blue Shield of New Jersey	Daly D. E. Temchine EPSTEIN, BECKER & GREEN, P.C. 1227 25th Street, N.W., Suite 700 Washington, D.C. 20037	
Empire Blue Cross Blue Shield	Daly D. E. Temchine EPSTEIN, BECKER & GREEN, P.C. 1227 25th Street, N.W., Suite 700 Washington, D.C. 20037	
Blue Cross and Blue Shield of North Carolina	Emily M. Yinger HOGAN & HARTSON L.L.P. 8300 Greensboro Drive, Suite 1100 McLean, VA 22102	
Hospital Service Association of Northeastern Pennsylvania	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	

Triple-S, Inc.; Triple-S, Inc. of Puerto Rico	Cesar Alcover, Esq. Casellas Alcover & Burgos Popular Center Bldg Suite 1400 208 Ponce de León Avenue San Juan, Puerto Rico 00918 P.O. Box 364924 San Juan, Puerto Rico 00936-4924	
Blue Cross Blue Shield of Rhode Island	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Blue Cross and Blue Shield of South Carolina	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Health Care Service Corporation	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
BlueCross BlueShield of Tennessee, Inc.; Tennessee Health Care Network, Inc.	Michael A. Pope MCDERMOTT WILL & EMERY LLP 227 W. Monroe Street Chicago, IL 60606	
Independence Blue Cross; AmeriHealth HMO, Inc.; LaCruz Azul de Puerto Rico; Keystone Health Plan East, Inc.	Edward F. Mannino, Esq. David L. Comerford, Esq. Katherine M. Katchen, Esq. AKIN GUMP STRAUSS HAUER & FELD LLP 2005 Market Street, Suite 2200 Philadelphia, PA 19103-7013	

In the event that any Party receives a notice from any other Party (in accordance with the provisions of § 5 of this Agreement and as required by any other provision of this Agreement), for which there is a written acknowledgement of receipt, and such receiving Party does not respond to such notice within thirty (30) days of receipt thereof (unless a different time is set forth in this Agreement), such receiving Party shall be deemed to have accepted any proposal made by the

notifying Party in such notice and shall be deemed to have waived any rights under this Agreement with respect to the matter that is the subject of such notice.

6. Procedure for Final Approval; Limited Waiver

Following the dissemination of the Mailed Notice and Published Notice as described in § 5, Representative Plaintiffs, Signatory Medical Societies, Class Counsel and the Blue Parties shall seek the Court's final approval of this Agreement. Putative 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 a date that is at least seventy-five (75) days after the Notice Date (the "**Objection Date**").

6.1 Opt-Out Timing and Rights

The Parties will jointly request of the Court that the Mailed Notice and the Published Notice be disseminated no earlier than 30 days and no later than 60 days after the Preliminary Approval Date, except that publication in The Journal of the American Medical Association and The American Medical News shall occur within 75 days after the Preliminary Approval Date. The Notice Date (the "**Notice Date**") shall be the date on which the notice is first mailed or published.

The Mailed Notice and the Published Notice shall provide that putative Class Members may request exclusion from the Class by providing notice, in the manner specified in the Notice, on or before a date set by the Court as the Opt-Out Deadline. Representative Plaintiffs, Class Counsel and the Blue Parties 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**").

Putative Class Members have the right to exclude themselves ("**Opt-Out**") from this Agreement and from the Class by timely submitting a request to Opt-Out and otherwise complying with the agreed upon Opt-Out procedure approved by the Court. Putative Class Members who are Physician Groups or Physician Organizations shall be entitled to exclude themselves, as distinct legal entities, from the Class, but shall have no right to exercise the Opt-Out rights of individual Physicians practicing under their auspices, unless the Physician Group or Physician Organization has written authorization to act on behalf of the Physician which has been submitted to the Notice Administrator; otherwise, in order to Opt-Out, individual Physicians associated with a Physician Group or Physician Organization must submit a request to Opt-Out in the manner specified in the Notice by the Opt-Out Deadline. Putative Class Members who so timely request to Opt-Out shall be excluded from this Agreement and from the Class. Any putative Class Member who does not submit a request to Opt-Out in the manner specified in the Notice by the Opt-Out Deadline or who does not otherwise comply with the agreed upon Opt-Out procedure approved by the Court shall be a Class Member and shall be

bound by the terms of this Agreement and the Final Order and Judgment. Any Class Member shall be deemed to have taken all actions necessary to withdraw and revoke the assignment to any Person of any claim against the Blue Parties.

Any putative Class Member who timely submits a request to Opt-Out shall have until the Settlement Hearing Date to deliver to the Notice Administrator a written revocation of such putative Class Member's request to Opt-Out. The Notice Administrator shall timely apprise the Parties of such revocations as of that date. The Parties shall timely apprise the Court of all such revocations.

Within fifteen (15) days after the Opt-Out Deadline, the Notice Administrator shall furnish the Blue Parties with a complete list in machine-readable form of all Opt-Out requests submitted by the Opt-Out Deadline. Within ten (10) days after the Settlement Hearing Date, the Notice Administrator shall furnish the Blue Parties with a complete list, in machine readable form, of all Opt-Out requests submitted by the Opt-Out deadline and not withdrawn by the Settlement Hearing Date. The Blue Parties shall pay costs of obtaining a copy of the Opt-Out requests.

6.2 Setting the Settlement Hearing Date and Settlement Hearing Proceedings

The Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and the Blue Parties agree to urge the Court to hold a hearing to consider final approval of this Agreement (the "**Settlement Hearing**") on a date that is at least 120 days and is as soon as practicable after the Notice Date (the "**Settlement Hearing Date**"), and to work together to identify and submit any evidence that may be required by the Court to satisfy the burden of proof for obtaining approval of this Agreement and the orders of the Court that are necessary to effectuate the provisions of this Agreement, including without limitation, the Final Order and Judgment and the orders contained therein. At the Settlement Hearing, the Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and the Blue Parties shall present evidence necessary and appropriate to obtain the Court's approval of this Agreement, the Final Order and Judgment and the orders contained therein (including without limitation the Bar Order), and shall meet and confer prior to the Settlement Hearing to coordinate their presentation to the Court in support of Court approval thereof.

7. Settlement Consideration: Business Practice Initiatives

The settlement consideration to the Class Members includes, among other things, initiatives and other commitments with respect to the Blue Plans' business practices. The Parties agree that the business practice initiatives and other commitments set forth below, which absent this Agreement Blue Plans would be

under no obligation to undertake, constitute substantial value, and will enhance and facilitate the delivery of Physician Services by Class Members. Many of the Blue Plans have investigated and begun to implement certain of the business practice initiatives described in or contemplated by this § 7 after the Action began and/or while the Parties were engaged in discussions to resolve the Action. Such initial and partial implementation, which shows the Parties' good faith desire to resolve the Action, were undertaken to form part of the consideration of the settlement. Blue Plans shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives described in or contemplated by this § 7 to Physicians, if any, who Opt-Out of the Agreement. Without in any way qualifying or limiting the foregoing, Blue Plans (a) are informed that it is not uncommon for some members of a class action to opt out for a variety of reasons independent of, among other things, the substantive allegations in the complaint or the terms of a proposed settlement, and (b) state their present intention to exercise, in whole or in part, the rights referred to in the immediately preceding sentence to Persons eligible to become Class Members who nevertheless Opt-Out.

Each Blue Plan covenants and agrees that, during the period from and after the Execution Date and until the Preliminary Approval Date, they shall not effect any material changes in the business practices that are the subject of the Complaint and governed by the provisions of this Agreement, except changes to such business practices that are contemplated by or otherwise consistent with this Agreement.

Except as otherwise provided in Exhibit H, each Blue Party shall be obligated to implement those commitments applicable to it as provided in this § 7 and to commence such implementation as set forth in Exhibit I (the applicable "**Implementation Date**"). Each Blue Party shall continue implementing each such commitment until the Termination Date, except as and only to the extent that a term of this Agreement has been extended by a Blue Party as provided in § 14.6(b). With respect to each commitment of a Blue Party set forth in this § 7 (and not otherwise amended, modified, limited or excluded by Exhibit H), the "**Effective Period**" shall be the period of time beginning on the Implementation Date shown on Exhibit I and ending as specified in § 14.6(b). Notwithstanding anything to the contrary contained in this Agreement, with respect to each commitment set forth in this § 7 (and as otherwise amended, modified, limited or excluded by Exhibit H), from and after the Termination Date, a Blue Party shall be under no obligation whatsoever to continue to implement such commitment, except as provided in § 14.6(b).

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7.3 Availability of Fee Schedules and Scheduled Payment Dates

Each Blue Plan shall develop and implement a plan not later than twelve (12) months after the Final Order Date reasonably designed to permit its Participating Physician, Participating Physician Group, or Participating Physician Organization that, in each case, has entered into a written contract directly with the Blue Plan, to the extent the Participating Physician, Participating Physician Group or Participating Physician Organization is compensated on a non-capitated basis, to view, by CD-ROM or electronically (at the Blue Plan's option), on a confidential basis, complete fee information showing the applicable fee schedule amounts for such Participating Physician, Participating Physician Group, or Participating Physician Organization pursuant to that Participating Physician's, Participating Physician Group's, or Participating Physician Organization's direct written agreement with the Blue Plan. A Participating Physician, Participating Physician Group or Participating Physician Organization may elect to receive a hard copy of the fee schedule in lieu of the foregoing. The fee schedule information will be provided by the fee for service dollar amount allowable for each CPT® Code for those CPT® Codes that a Participating Physician, Participating Physician Group, or Participating Physician Organization in the same specialty typically uses in providing Covered Services. A Participating Physician, Participating Physician Group or Participating Physician Organization may request and the Blue Plan will provide the fee for service dollar amount allowable for other CPT® Codes that its Participating Physician, Participating Physician Group or Participating Physician Organization actually bills the Blue Plan. A Blue Plan may base actual compensation on the Blue Plan's maximum allowable amount and/or other contract adjustments. Commencing with the Final Order Date and continuing until implementation of the initiative described above, each Blue Plan, upon written request from a Participating Physician, Participating Physician Group, or Participating Physician Organization that, in each case, has entered into a written contract directly with that Blue Plan, will provide, by hard copy, the fee schedule for up to one hundred (100) CPT® Codes customarily and routinely used by such Participating Physician, Participating Physician Group, or Participating Physician Organization, as specified by such Participating Physician, Participating Physician Group, or Participating Physician Organization. Each Blue Plan shall be obligated to honor only two such requests made annually by such Participating Physician, Participating Physician Group, or Participating Physician Organization. Each Blue Plan will attempt to include provisions in its agreements with Delegated Entities that require comparable disclosure. Each Blue Plan will not require its Participating Physicians, Participating Physician Groups, or Participating Physician Organizations to provide that Blue Plan with billing rates as a precondition to that Blue Plan providing fee information pursuant to this section.

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7.5 Reduced Precertification Requirements

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

7.6 Greater Notice of Policy and Procedure Changes

Each Blue Plan shall, if it intends to make a material adverse change(s) in the terms of its contracts (including policies and procedures incorporated by reference therein) with its Participating Physicians, Participating Physician Groups, or Participating Physician Organizations, give at least ninety (90) days written notice to each Participating Physician, Participating Physician Group, or Participating Physician Organization affected thereby with whom the Blue Plan has directly contracted (except to the extent that a shorter notice period is required to comply with changes in applicable law), which notice shall reasonably apprise its Participating Physician, Participating Physician Group, or Participating Physician Organization of such change(s), and the change(s) shall not become effective before the conclusion of the notice period. If a Participating Physician, Participating Physician Group, or Participating Physician Organization objects to the change(s) that is subject to the notice, the Participating Physician, Participating Physician Group, or Participating Physician Organization must, within thirty (30) days of the date of the notice (which shall be the date the notice is sent by United States mail, by facsimile, or, if the Blue Plan offers it, electronically at the

option of the Physician, Physician Group, or Physician Organization), give written notice to terminate his, her, or its contract with the Blue Plan, which termination shall be effective at the end of the notice period of the material adverse change unless, within sixty-five (65) days of the date of the original notice of change(s), the Blue Plan gives written notice to the objecting Participating Physician, Participating Physician Group, or Participating Physician Organization that it will not implement, as to the objecting Participating Physician, Participating Physician Group, or Participating Physician Organization, the material adverse change(s) to which the Participating Physician, Participating Physician Group, or Participating Physician Organization objected. The continuation of care provisions in § 7.13(c) shall apply to any contract termination pursuant to this § 7.6.

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7.8 Disclosure of and Commitments Concerning Claims Payment Practices

- (a) Each Blue Plan recognizes the benefit of greater standardization in its claims systems and, to that end, each Blue Plan expects to consolidate its claims systems in certain of its multi-state regions, where applicable, which will result in greater consistency with respect to its automated “bundling” and other claims payment rules within those regions.
- (b) Each Blue Plan agrees that, except for Medicaid, State Childrens’ Health Insurance Programs, and other similar government programs for low-income persons and/or for members of state-established high risk pools, its automated “bundling” and other claims payment rules shall be consistent in all material respects, within each state in which such Blue Plan operates as a Blue Cross and/or Blue Shield licensee, for claims submitted by or on behalf of such Blue Plan’s Plan Members.
- (c) Intentionally Left Blank
- (d) Each Blue Plan agrees to disclose its Significant Edits on its Provider Website by not later than six (6) months after the Final Order Date, or as soon thereafter as practicable. Each Blue Plan agrees to update its disclosure of Significant Edits once per calendar year to reflect changes in the Blue Plan’s Significant Edits and the Blue Plan’s experience with submitted claims; provided that the Blue Plan shall promptly disclose newly-adopted Significant Edits.
 - (i) Not later than six (6) months after the Final Order Date or as soon thereafter as practicable, each Blue Plan shall

publish on its Provider Website, for each commercially available claims editing software product then in use by the Blue Plan, a list identifying each customized Edit added to the standard claims editing software product at the Blue Plan's request.

- (ii) Not later than the Final Order Date, a Blue Plan shall not routinely require submission of Clinical Information, before or after payment of claims, in connection with that Blue Plan's adjudication of a Physician's claims for payment, except as to claims for unlisted codes, claims to which a modifier 22 is appended, and other limited categories of claims as to which the Blue Plan determines that routine review of Clinical Information is appropriate; provided that the Blue Plan shall disclose any of its categories of such nature on its Public Website and its Provider Website. Notwithstanding the foregoing, a Blue Plan may require submission of Clinical Information in connection with a Blue Plan's adjudication of a Physician's claims for payment for the purpose of investigating fraudulent or abusive (whether intentional or unintentional) billing practices, but only so long as, and only during such times as, the Blue Plan has a reasonable basis for believing that such investigation is warranted. A Participating Physician may contest, in accordance with § 12, any requirement that the Participating Physician submit Clinical Information in connection with a Blue Plan's adjudication of the Participating Physician's claims for payment for the purpose of investigating fraudulent or abusive (whether intentional or unintentional) billing practices. Nothing in this Agreement is intended or shall be construed to limit a Blue Plan's right to require submission of Clinical Information when such requirement is not in connection with a Blue Plan's adjudication of a Physician's claims for payment or is otherwise permitted by this Agreement, including, but not limited to, the right to require submission of Clinical Information for Precertification purposes consistent with § 7.5.
- (iii) Not later than six (6) months after the Final Order Date, each Blue Plan shall publish on its Provider Website those limited code combinations as to which it has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers and the Blue Plan's application of the rule differs from CPT® Codes; provided that no such determination shall be inconsistent with the undertakings set forth in this Agreement.

- (e) Each Blue Plan shall promptly update the disclosures required by § 7.8(d)(i), (d)(ii) and (d)(iii) when changes are made to the policies, procedures, or determinations referenced therein.

7.9 Physician Advisory Committee

- (a) Prior to the later to occur of (i) three (3) months after the Final Order Date and (ii) selection of the members of the Physician Advisory Committee in accordance with § 7.9(b) of this Agreement, each Blue Plan shall take all actions reasonably necessary on its part to establish a Physician Advisory Committee (“**Physician Advisory Committee**”) to discuss issues arising from or related to the relationships and interactions between and among Physicians, their patients, and the Blue Plan. These issues may include, but are not limited to: (a) improvement of health care and clinical quality; (b) improvement of communications, relations and cooperation between Physicians and the Blue Plan; and/or (c) matters of a clinical or administrative nature that impact the interaction between Physicians and the Blue Plan. The Physician Advisory Committee shall meet at least once every six months during the Effective Period. All communications to the Physician Advisory Committee by Participating Physicians and/or Non-Participating Physicians shall be accomplished through members of the Physician Advisory Committee who shall represent the interests of such Participating and/or Non-Participating Physicians and whose contact information shall be posted on the Provider Website.
- (b) The Physician Advisory Committee shall include twelve (12) members, one of whom shall be the Blue Plan’s Chief Medical Officer or his designee, who shall serve as chairperson of the Physician Advisory Committee.

Except as otherwise provided in this § 7.9(b), the remaining members of the Physician Advisory Committee shall be Participating Physicians.

The Blue Plan shall select three (3) members in addition to its Chief Medical Officer not later than sixty (60) days after the Preliminary Approval Date. The state medical society shall select four (4) members of a Blue Plan’s Physician Advisory Committee with consultation, as such state society deems necessary, with appropriate organized medical and Physician professional organizations. The state medical society selected Physicians shall include at least one board-certified primary care Participating Physician, at least one board-certified specialist Participating Physician, and at least one Participating Physician who occupies a leadership position with a specialty medical society, state or local medical society, or large free-standing or hospital based group

Physician practice. Those eight (8) members shall select the remaining four (4) members, one of whom may be a Non-Participating Physician. All members of the Physician Advisory Committee for a Blue Plan must practice or reside within the service area of such Blue Plan.

The Blue Plan and state medical society as provided above shall strive to select Physicians who are committed to the Physician Advisory Committee functioning as a constructive and collaborative body. If any member discontinues serving on the Physician Advisory Committee, that member's position shall be filled in the same manner as the member was originally selected.

The names of the members of the Physician Advisory Committee and the dates of the Physician Advisory Committee meetings shall be posted on the Blue Plan's Provider Website.

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

For purposes of this subparagraph (c), "quorum" shall mean seven (7) or more voting members of the Physician Advisory Committee of which at least two (2) members were selected by the state medical society as provided in § 7.9(b), two (2) members were selected by the Blue Plan, and two (2) members were selected by the members selected by the Blue Plan and the state medical society as provided in § 7.9(b).

Upon a majority vote of the voting members of the Physician Advisory Committee, the Physician Advisory Committee may make recommendations to the Blue Plan, provided that such recommendations are within the Physician Advisory Committee's purview as described in § 7.9(a).

The Blue Plan shall consider whether the implementation of any recommendation of the Physician Advisory Committee is: (a) reasonable considering the opportunities and constraints of the current health care financing/administration marketplace; (b) consistent with the best interests of the Blue Plan's Participating Physicians, Plan Members, customers, shareholders and other constituents; and (c) in furtherance of scientifically and clinically sound medical care. If the Blue Plan decides not to accept a recommendation of the Physician Advisory Committee, the Blue Plan shall communicate that decision in writing to the Committee with an explanation of the Blue Plan's reasons, and the Blue Plan

shall also disclose the recommendation and response on its Provider Website. The Blue Plan agrees to post on its Provider Website a listing of all Physician Advisory Committee recommendations made to the Blue Plan and the Blue Plan's responses to such recommendations.

- (d) Each member of the Physician Advisory Committee shall agree to maintain and treat as confidential any proprietary information reasonably designated as such by the Blue Plan. No member of the Physician Advisory Committee shall serve as a member of an advisory or similar committee established by any other managed care company or health insurer, but this provision is not meant to exclude Physicians who serve on credentialing or similar committees for other companies.
- (e) Each Blue Plan shall develop and implement reasonable payment provisions for the expenses of members of its Physician Advisory Committee, including without limitation a reasonable per diem to be set by the Blue Plan. Such payment provisions shall be consistent with the Blue Plan's typical payment provisions for Physicians serving on its existing committees of this type.

7.10 New Dispute Resolution Process for Physician Billing Disputes

- (a) Not later than four (4) months after the Final Order Date, each of the Blue Plans shall take actions necessary to establish a Billing Dispute External Review Process. The Billing Dispute External Review Process shall provide for a Billing Dispute Reviewer, to resolve disputes with Physicians and Physician Groups arising from Covered Services provided to the Blue Plan's Plan Members by such Physicians and/or Physician Groups concerning (i) the Blue Plan's application of the Blue Plan's coding and payment rules and methodologies for fee for service claims (including without limitation any bundling, Downcoding, application of a CPT® modifier, and/or other reassignment of a code by the Blue Plan) 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, or (ii) any Retained Claims, so long as such Retained Claims are submitted by the Physician to the Billing Dispute Reviewer prior to the later to occur of (x) ninety (90) days after the Final Order Date, or (y) thirty (30) days after exhaustion of the Blue Plan's internal appeals process. Each such matter shall be a "**Billing Dispute.**" The Billing Dispute Reviewer shall not have jurisdiction over any other disputes, including without limitation those disputes that fall within the scope of the External Review process set forth in § 7.11 of this Agreement, Compliance Disputes and disputes concerning the scope of Covered Services;

nor shall any Billing Dispute Reviewer have jurisdiction or authority to revise or establish any reimbursement policy of the Blue Plan.

- (b)** Nothing contained in this § 7.10 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Plan Member under § 502(a) of ERISA or to supersede in any respect the claims procedures for Plan Members of § 503 of ERISA, or required by applicable state or federal law or regulation. In the case of: (i) a state or federal law that requires the Blue Plan and Physician to use an external billing dispute review process, (ii) a state or federal law that requires the Blue Plan to establish and make available an external review process, and such process provides at least substantially the same procedural protections and rights as the process set forth in this § 7.10, and is a process that provides for disputes to be resolved at a cost to the Physicians that is not substantially greater than the cost set forth in this § 7.10 in time frames not materially longer than the time frames set forth in this § 7.10 and that any determinations are rendered by an independent, external person or entity, or (iii) an external review process that is established by a state or federal governmental body that the Blue Plan is required to make available and such process provides at least substantially the same procedural protection and rights as the process set forth in this § 7.10, only the program described in subclauses (i)-(iii) shall be utilized for Billing Disputes with respect to Plan Members covered by such process. Notwithstanding the foregoing, if there is any state or federal external review process that does not meet the requirements for use set forth herein, but is otherwise available to a Physician or Physician Group, the Physician or Physician Group shall be limited to bringing an appeal either under the process set forth in this § 7.10 or the available state or federal process, but not both.
- (c)** Any individual Physician or Physician Group may submit a Billing Dispute to the Billing Dispute Reviewer after the Physician or Physician Group exhausts the Blue Plan's internal appeals process, and when the amount in dispute exceeds \$500. Billing Disputes may be submitted only by individual Physicians and Physician Groups. Each Blue Plan shall post a description of its Physician internal appeals process on its Provider Website.

 - (1)** Notwithstanding the foregoing, an individual Physician or Physician Group may submit a Billing Dispute with an amount in dispute less than \$500 if such Physician or Physician Group notifies the Billing Dispute Reviewer that the 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. The Billing Dispute Reviewer will defer consideration of such Billing Dispute while the Physician or Physician Group accumulates such additional similar 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 the Blue Plan 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 Reviewer through and including the Termination Date.

- (2) In the event additional similar Billing Disputes (x) are not submitted within one (1) year of the original Billing Dispute, or (y) do not involve disputes that in aggregate exceed \$500, the Billing Dispute Reviewer shall dismiss the original Billing Dispute and any such additional Billing Disputes.
- (3) The Physician or Physician Group must exhaust the Blue Plan's internal appeals process before submitting a Billing Dispute to the Billing Dispute Reviewer. A Physician or Physician Group shall be deemed to have exhausted the Blue Plan's internal appeals process if the Blue Plan does not communicate a decision on an internal appeal within thirty (30) days of the Blue Plan's receipt of all documentation reasonably needed to decide the internal appeal. In the event the Blue Plan and 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 Reviewer. Except as otherwise provided in this § 7.10(c), all Billing Disputes must be submitted to the Billing Dispute Reviewer no more than ninety (90) days after a Physician or Physician Group exhausts the Blue Plan's internal appeals process, and the Billing Dispute Reviewer shall not hear or decide any Billing Dispute submitted more than ninety (90) days after the Blue Plan's internal appeals process has been exhausted. The Blue Plan shall supply appropriate documentation to the Billing Dispute Reviewer not later than thirty (30) days after requested by the Billing Dispute Reviewer, which request shall not be made, if Billing Disputes are submitted pursuant to this § 7.10(c)(1),

until Billing Disputes have been submitted with amounts in dispute that in aggregate exceed \$500.

- (4) Except to the extent otherwise specified in this § 7.10(c), procedures for review by the Billing Dispute Reviewer, including without limitation the documentation to be supplied to the reviewer and the prohibition on *ex parte* communications between any party and the Billing Dispute Reviewer, shall be set by agreement between the Blue Plan and Class Counsel, or their designee, with input from the Billing Dispute Reviewer. Such procedures shall provide that (x) a Physician or Physician Group submitting a Billing Dispute to the Billing Dispute Reviewer shall state in the documents submitted the amount in dispute, and (y) that the Billing Dispute Reviewer shall not be permitted to issue an award that exceeds the greater of the amount in dispute stated by such Physician or Physician Group in the documents submitted to the Billing Dispute Reviewer or the amount payable under the terms of the applicable contract between the Blue Plan and the Physician or Physician Group.
- (d) Each Blue Plan and Class Counsel shall select the person(s) or organization(s) that shall serve as the Billing Dispute Reviewer (on a local, regional or national basis). If the Blue Plan and Class Counsel cannot agree on the Billing Dispute Reviewer within 120 days of the Preliminary Approval Date, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Officer. Billing Disputes shall be stayed and any time limitation shall be tolled pending resolution of such Compliance Dispute. Beginning one (1) year after any Billing Dispute Reviewer is selected by the Blue Plan and Class Counsel, either of Class Counsel or the Blue Plan may request the appointment of a new Billing Dispute Reviewer. The new person or organization to serve as the Billing Dispute Reviewer shall be selected within thirty (30) days of written notice of any such request. If the Blue Plan and Class Counsel cannot agree on the selection, the matter shall be deemed a Compliance Dispute and referred to the Compliance Dispute Review Officer. In deciding Billing Disputes, the Billing Dispute Reviewer shall be bound by the terms of the applicable Plan, any applicable agreement between the Physician or Physician Group and the Blue Plan, and the provisions of this Agreement. If the dispute cannot be resolved by reference to the foregoing documents, then the Billing Dispute Reviewer shall resolve Billing Disputes by determining, first, whether the billing was coded and submitted properly based on generally accepted medical coding standards, including but not limited to CPT®

Coding and CCI/CMS guidelines, and second, whether the Blue Plan's reimbursement policies were properly applied, including those reimbursement policies required or permitted under this Agreement, including without limitation reimbursement policies posted by the Blue Plan pursuant to § 7.8(d).

- (e) A Blue Plan's contract(s) with the person(s) or organization(s) selected to serve as a Billing Dispute Reviewer shall require decisions to be rendered not later than thirty (30) days after receipt of the documents necessary for the review and to provide notice of such decision to the parties promptly thereafter.
- (f) In the event that the Billing Dispute Reviewer issues a decision requiring payment by the Blue Plan, that Blue Plan shall make such payment within fifteen (15) days after the Blue Plan receives notice of such decision.
- (g) Any decision under this § 7.10 shall be binding on the Blue Plan and the Physician or Physician Group. For Retained Claims, all Billing Disputes shall be directed not to the Court nor to any other state court, federal court, arbitration panel (except as hereinafter provided) or any other binding or non-binding dispute resolution mechanism but instead shall be submitted to final and binding resolution before the Billing Dispute Reviewer so long as such Billing Dispute arises after the selection of the Billing Dispute Reviewer pursuant to § 7.10(d). Retained Claims as defined in § 13.6 shall not be barred as untimely so long as they are submitted within thirty (30) days of the selection of the Billing Dispute Reviewer.
- (h) For any Billing Dispute that a Physician or Physician Group submits to the Billing Dispute Reviewer, the Physician or Physician Group submitting such Billing Dispute shall pay to the Blue Plan a filing fee calculated as follows: (i) if the amount in dispute is \$1,000 or less, the filing fee shall be equal to \$50; or (ii) if the amount in dispute exceeds \$1,000, the filing fee shall be equal to \$50 plus 5% of the amount by which the amount in dispute exceeds \$1,000, but in no event shall the fee be greater than 50% of the cost of the review. The Blue Plan shall refund the applicable filing fee paid by a Physician or Physician Group who submits a Billing Dispute to the Billing Dispute External Reviewer in the event the Physician or Physician Group is the prevailing party with respect to such Billing Dispute.
- (i) The determination made with respect to any Billing Dispute pursuant to this section shall not act as precedent as to any other Billing Dispute under this section or any other proceeding brought outside of this § 7.10, provided that evidence of the determination

may be received in a Compliance Dispute involving a systemic remedy under § 12.6(f) of the Agreement.

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

(a) Initial Determinations

A Physician designated by each Blue Plan shall be responsible for making the initial determination for such Blue Plan whether proposed health care services or supplies are Medically Necessary or experimental or investigational in nature. A nurse or other health care professional, acting for a medical director, may approve any proposed health care service or supply as being Medically Necessary, but only a Physician designated by the Blue Plan may deny any such service or supply as being not Medically Necessary or experimental or investigational in nature.

(b) Plan Member Internal Appeal and External Review Process

- (i) Each Blue Plan shall maintain an internal appeal and external review process permitting its Plan Members to seek internal and independent external review of any determination made by the Blue Plan that certain services provided to the Blue Plan's Plan Members by Physicians are not Covered Services because they are not Medically Necessary or are experimental or investigational in nature ("**Adverse Determination**") where the Blue Plan both makes the Adverse Determination and administers its Plan Member appeals and external review processes.
- (ii) As set forth in this § 7.11, each Blue Plan will establish and maintain an internal appeal and external review process for Physicians with respect to Adverse Determinations to the extent the Blue Plan both makes the Adverse Determination and administers its Plan Member appeals and/or external review processes.
- (iii) Except where any applicable law or regulation requires a different definition, each Blue Plan shall use the definition of Medical Necessity set forth in § 7.16 (a) of this Agreement in the internal appeal and external review processes set forth in this § 7.11; provided, however, that nothing in this Agreement shall: (a) limit or prevent the Blue Plan from denying coverage on the grounds that services are experimental or investigational; or (b) alter or restrict the Blue Plan's rights under its contracts with

Participating Physicians to restrict or prohibit them from billing the Blue Plan's Plan Member for services determined to be not Medically Necessary or experimental or investigational. Each Blue Plan agrees that Physicians may bill its Plan Members for services determined to be not Medically Necessary or experimental or investigational when the Physician provides the Blue Plan's Plan Member with advance written notice that (a) identifies the proposed services, (b) informs that Plan Member that such services may be deemed by the Blue Plan to be not Medically Necessary or experimental or investigational, and (c) provides an estimate of the cost to that Plan Member for such services and that Plan Member agrees in writing in advance of receiving such services to assume financial responsibility for such services.

- (iv) In applying experimental and investigational exclusions in a Plan to either proposed health care services or as part of a Post-Service Appeal to the Blue Plan, each Blue Plan shall consider credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, the individual clinical circumstances of the particular Blue Plan's Plan Member, the views of the treating Physician and any other relevant factors.

(c) Physician Internal Appeals of Adverse Determinations.

(i) Pre-Service Appeals.

Physicians shall have the right to file an appeal of an Adverse Determination prior to rendering the service ("**Pre-Service Appeals**"), if they are appealing on behalf of the Blue Plan's Plan Member. For urgent Pre-Service Appeals, the Physician shall be automatically deemed the authorized representative of the Blue Plan's Plan Member. For all other Pre-Service Appeals, authorization must be obtained from the Blue Plan's Plan Member in writing. Pre-Service Appeals filed by Physicians on behalf of the Blue Plan's Plan Member will be handled by the Blue Plan under the appeal process available to its Plan Member based on the terms of that Plan Member's Plan and the applicable state and federal laws and regulations.

(ii) Post-Service Appeals

- (A) With respect to an appeal of an Adverse Determination made after the service has been

rendered (“**Post-Service Appeals**”), each Blue Plan shall adopt a one level internal appeal process for Physicians. That process shall ensure that only a Physician in the same specialty, as defined in subsection (B) below, as the Physician who treated the condition (hereinafter “**Qualified Reviewer**”), other than the Physician that made the initial Adverse Determination, may deny the appeal of the Physician who treated the condition. A nurse or other health care professional employed by the Blue Plan may review the internal appeal and may grant but not deny the appeal. If the nurse or other healthcare professional does not grant the appeal, then a Qualified Reviewer, designated by the Blue Plan, other than the one that made the initial Adverse Determination, shall review and decide the internal appeal in accordance with the Blue Plan’s health care clinical guidelines.

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

(C) Prior to requesting an internal Post-Service Appeal, the Physician shall use best efforts to first seek written authorization to proceed as the representative of the Blue Plan’s Plan Member. If the Physician obtains consent to proceed on behalf of the Blue Plan’s Plan Member, then the Physician’s appeal rights are those of the Blue Plan’s Plan Member and the Physician is bound by the decision rendered in the Plan Member’s appeal process.

(d) Timeframes for Physician Internal Appeals of Adverse Determinations

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

(e) Adverse Determination External Review Process for Physicians

- (i) If a Blue Plan upholds its initial Adverse Determination through the internal Post-Service Appeals process and the cost of the service at issue exceeds the threshold amount, if any, the Blue Plan's Plan Member would need to satisfy in order to seek external review under the terms of the applicable health benefit plan, the Blue Plan shall make available to its Physicians the option to seek external review of the Adverse Determination through an independent review organization ("**Independent Review Organization**") identified by the Blue Plan ("**External Review**"). The Physician shall have the option to submit a written request for External Review within sixty (60) days from the date of the internal Post-Service Appeal denial decision by the Blue Plan. Election to pursue External Review under this § 7.11 is at the option of the Physician, who may instead choose any other remedy available as a matter of law or contract.
- (ii) External Review is not available for a Physician before that Physician has exhausted the Blue Plan's internal Post-Service Appeal process unless both the Blue Plan and the Physician agree to forego the internal Post-Service Appeal and proceed directly to External Review, or the Blue Plan cannot provide a Qualified Reviewer for internal appeal.
- (iii) Physicians seeking External Review shall pay the Blue Plan a filing fee of fifty dollars (\$50) if the amount in dispute is \$1,000 or less or \$250 if the amount in dispute exceeds \$1,000. Payment must be submitted along with the External Review request; provided, however, that the Physician shall be entitled to a refund of such payment in the event that the Physician prevails in the Blue Plan's External Review process.
- (iv) Any decision issued pursuant to an External Review process, regardless of whether such External Review process is initiated and pursued by the Blue Plan's Plan Member or the Physician, shall be binding upon both the Physician and the Blue Plan.
- (v) The Blue Plan will contract with the Independent Review Organization (on a local, regional, or national basis) to conduct a de novo review of the case. For coverage issues other than a determination of Medical Necessity, the Plan Documents of the Blue Plan's Plan Member will control. In the event an External Review process is initiated, the Blue Plan shall promptly, but in any event no later than ten (10) business days following receipt of the request, submit documentation pertaining to the appeal to the Independent Review Organization. The Blue Plan shall require that the

Independent Review Organization provide a decision within thirty (30) days of the Blue Plan's submission of all necessary information. The external reviewer designated to conduct the review by the Independent Review Organization shall be of the same specialty (but not necessarily the same sub-specialty) as the appealing Physician.

- (vi) The Independent Review Organization's compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified Independent Review Organizations will not create any incentives for Independent Review Organizations to make decisions in a biased manner.
- (vii) In the event that: (A)(i) a state or federal law requires the Blue Plan and Physician to use an external review process, (ii) a state or federal law requires the Blue Plan to establish and make available an external review process, and such process provides at least substantially the same procedural protections and rights as the process set forth in this § 7.11, and is a process that provides for disputes to be resolved at a cost to the Physicians that is not substantially greater than the cost set forth in this § 7.11(e) in time frames not materially longer than the time frames set forth in this § 7.11(e), and that any determinations are rendered by an independent, external person or entity, or (iii) an external review process is established by a state or federal governmental body that the Blue Plan is required to make available, and such process provides at least substantially the same procedural protections and rights as the process set forth in this § 7.11, as set forth in § 7.11 (e)(ii) above, and (B) any of these processes are: (i) made available to Physicians without the written authorization of the Blue Plan's Plan Member, or (ii) available to the Physician with the written authorization of the Blue Plan's Plan Member and the Physician has obtained such written authorization, then the Physician shall be required to use the state or federal external review process in lieu of the external review process established in this § 7.11. Notwithstanding the foregoing, if there is any state or federal external review process that does not meet the requirements for use set forth herein, but is otherwise available to a Physician or Physician Group, the Physician or Physician Group shall be limited to bringing an appeal either under the process set forth in this § 7.11 or the available state or federal process, but not both.
- (viii) Notwithstanding the preceding provisions of this § 7.11, and in addition to any requirements contained above, the

Physician may not initiate an internal Post-Service Appeal or External Review of any denied service if:

- (A) The Blue Plan's Plan Member (or his or her representative) or the Physician (either independently where the Blue Plan is required to accept an independent Physician appeal by state law or as the representative of the Blue Plan's Plan Member) filed a Pre-Service Appeal pertaining to the same denied service; or
- (B) The Blue Plan's Plan Member (or his or her representative) is currently seeking or has sought review related to the same denied service. In the event both Blue Plan's Plan Member (or his or her representative) and the Physician seek review of the same denied service, the Plan Member's review shall go forward and the Physician's request for review will be dismissed;
- (C) As to External Review only, the Blue Plan's Plan Member is covered under a Self-Insured Plan and the Plan sponsor has not agreed by contract to participate in the Blue Plan's External Review program set forth in this § 7.11(e); or
- (D) The Blue Plan's 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 regarding an Adverse Determination. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Physician's claims shall be dismissed and may not be brought by or on behalf of the Physician in any forum; provided that such dismissal shall be without prejudice to any Physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Physician and not to such Blue Plan's Plan Member.
- (E) 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.

(f) Precedential Effect

The determination made with respect to any Adverse Determination pursuant to any internal appeal and External Review

process referenced in this § 7.11 shall not act as precedent as to any other Medical Necessity or experimental or investigational determination under this § 7.11 or any other proceeding brought outside of this § 7.11, provided that evidence of the determination may be received in a Compliance Dispute involving a systemic remedy under § 12.6(f) of the Agreement.

7.12 Intentionally Left Blank

7.13 Participating in Blue Plans' Networks

(a) Credentialing of Physicians

Each Blue Plan 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 within the Blue Plan's service area. The Blue Plan shall complete primary source verification and notify the Physician as to whether he or she is credentialed within ninety (90) days of receiving a Physician's completed application to be a Participating Physician unless in spite of the Blue Plan's best efforts and because of a failure of a third party to provide necessary documentation, the Blue Plan cannot obtain the necessary information to make a decision within ninety (90) days. In such event, the Blue Plan shall make every effort to obtain such information as soon as possible. Each Blue Plan commits that the Credentialing Committee for its service area 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 the Blue Plan but changes employment or changes location, the Blue Plan 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

Each Blue Plan agrees that it shall not require a Participating Physician to participate in a capitated fee arrangement in order to participate in Product Networks in which such Participating Physician is compensated on a fee for service basis. Each Blue Plan further agrees that it shall not require a Participating Physician to participate in its Medicare Advantage or Medicaid Product Networks in order to participate in its commercial Product Networks. Except where a Participating Physician (or

Participating Physician Group comprised of Participating Physicians or Participating Physician Organization) has agreed in an Individually Negotiated Contract to participate in more than one Product Network for a specified period of time (in which case the terms of such Individually Negotiated Contract shall govern), if a Participating Physician (or Participating Physician Group comprised of Participating Physicians or Participating Physician Organization) either (a) chooses not to participate in all of the Blue Plan's Product Networks or (b) terminates participation in some of the Blue Plan's Product Networks, then the reimbursement levels (e.g., fee for service maximum allowable amount, Capitation rate or other reimbursement methodology) offered to or applied by the Blue Plan to such Participating Physician (or Participating Physician Group or Participating Physician Organization) for the Product Network(s) in which such Participating Physician (or Participating Physician Group or Participating Physician Organization) continues to participate shall not be lower than the Blue Plan's standard reimbursement levels (e.g., fee for service maximum allowable amount, Capitation rate or other reimbursement methodology) in that geographic market. Notwithstanding the foregoing, the Blue Plan may offer a higher reimbursement level (e.g., fee for service maximum allowable amount, Capitation rate or other reimbursement methodology) or other incentive to any Participating Physician (or Participating Physician Group or Participating Physician Organization) who elects to participate (or elects to continue participation) in more than one of the Blue Plan's Product Networks. Nothing in this paragraph shall obligate a Blue Plan to pay more than the lesser of the Participating Physician's billed charges or the Blue Plan's applicable fee for service amount.

(c) Termination Without Cause

Unless an Individually Negotiated Contract between a Blue Plan and a Participating Physician, Participating Physician Group, or Participating Physician Organization specifies a different period of notice, or specifies that the contract may not be terminated except for cause during a defined period of time, either party to a contract between a Blue Plan and a Participating Physician, Participating Physician Group, or Participating Physician Organization shall have the right to terminate the contract without cause upon prior written notice provided to the other party which notice shall be a definite period set forth in such agreement, which period shall be no less than sixty (60) or more than one hundred and twenty (120) calendar days.

In the event of a contract termination by either party, the following obligations shall apply with respect to the continuation of care for

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

Notwithstanding the foregoing obligations, a Blue Plan's obligations under this § 7.13(c) shall not apply to the extent that other Participating Physicians, Participating Physician Groups, or Participating Physician Organizations are not available to replace the terminating Physician, Physician Group, or Physician Organization due to: (i) geographic or travel-time barriers; or (ii) contractual provisions between the terminating Physician, Physician Group, or Physician Organization and a facility at which the Blue Plan's Plan Member receives care that limits or precludes other Participating Physicians, Participating Physician Groups, or Participating Physician Organizations from rendering replacement services to the Blue Plan's Plan Members (e.g., an exclusive services agreement between the terminating Physician, Physician Group, or Physician Organization and a facility where Plan Member receives services).

7.14 Fee Schedule Changes

(a) Notices Regarding Fee Schedules

Each Blue Plan agrees to establish and operate one or more standard fee schedules of fee for service payments to its Participating Physicians, Participating Physician Groups, and Participating Physician Organizations for each geographic market

in which the Blue Plan maintains a Product Network. Each Blue Plan also agrees, effective January 1 of the year following the Effective Date, not to reduce the fees set forth in such fee schedules more than once per calendar year except as otherwise provided in this § 7.14(a). Each Blue Plan further agrees that it shall give notice of any such reductions in fees as a material adverse change subject to the provisions of § 7.6 hereof; provided, however, that to the extent a fee schedule is directly tied to the CMS fee schedules or state Medicaid fee schedules currently in effect, it shall adjust automatically to reflect applicable interim and annual revisions made by CMS or the state Medicaid agency without notice to the Physician. If an annual revision made by CMS or a state Medicaid agency results in a reduction in the fees in a fee schedule that is directly tied to the CMS fee schedules or state Medicaid fee schedules, a Participating Physician shall have the right to terminate his or her contract with the Blue Plan by giving the Blue Plan written notice of termination within thirty (30) days of the date on which CMS or the state Medicaid agency published notice of the annual revision, which termination shall be effective ninety (90) days after the date that such notice was published, subject to the continuation of care obligations described in § 7.13(c). Notwithstanding the foregoing, the Blue Plan may increase or reduce the fees set forth in such fee schedules by updating its fee schedules at any time (i) to reflect changes in market prices for vaccines, injectibles, pharmaceuticals, durable medical supplies, other goods, and non-Physician services, (ii) to add payment rates for newly-adopted CPT® Codes, (iii) to add payment rates for new technologies and new uses of established technologies that the Blue Plan concludes are eligible for payment, and (iv) to reflect applicable interim revisions made by CMS. Nothing contained in this § 7.14(a) shall prevent the Blue Plan from maintaining, altering or expanding the use of Capitation or other compensation methodologies. If an Individually Negotiated Contract has a term greater than one (1) year and has specific provisions for compensation that substantially differ from the standard fee schedule and that do not permit reduction in the compensation more frequently than once per year, then the provisions of § 7.14(a) shall not apply to such Individually Negotiated Contract.

(b) Payment Rules for Injectibles, DME, Administration of Vaccines, and Review of New Technologies

Each Blue Plan agrees to pay a fee for the administration of vaccines and injectibles by a Participating Physician. The Blue Plan also agrees to pay for the vaccines and injectibles themselves. The Blue Plan shall pay for newly recommended vaccines as of the effective date of a recommendation made by any of the following:

the U.S. Preventive Services Task Force; the American Academy of Pediatrics; and the Advisory Committee on Immunization Practices. Other than as specified in the preceding sentence with respect to newly recommended vaccines, if a Physician Specialty Society recommends as an appropriate standard of care a new technology or treatment, or a new use for an established technology or treatment, the Blue Plan shall evaluate such recommendation and issue a coverage statement not later than 120 days after the Blue Plan learns of such Physician Specialty Society recommendation.

(c) Usual, Reasonable, and Customary Appeals

At least until the Termination Date, in the event the Plan Documents require that a Blue Plan utilize a usual, reasonable and customary standard for purposes of reimbursement to a Plan Member for services rendered by Non-Participating Physicians, and if a Non-Participating Physician initiates a dispute using a Blue Plan's internal dispute resolution procedures over how the Blue Plan has determined the usual, reasonable and customary amount for a given health care service or supply, and, consequently, over how the Blue Plan has computed the amount payable for that health care service or supply, the Blue Plan shall disclose to the Non-Participating Physician initiating the dispute the general methodology, including the percentile of included charge data on which the usual, reasonable and customary amount is based, and source of data used by the Blue Plan to determine the usual, reasonable and customary amount for that service or supply.

(d) Usual, Reasonable and Customary Determinations

Each Blue Plan agrees that, to the extent it uses Physician charge data to determine the usual, reasonable and customary amount to be paid for services performed by Non-Participating Physicians, it will not use any internal claims database that: (i) systematically under-reports the number of claims paid for procedures in the geographic area used by the Blue Plan to determine such amount; (ii) eliminates or excludes the highest charges for paid claims for any procedures in the geographic area used by the Blue Plan to determine such fees, provided, however, that such charges may be excluded if the Blue Plan excludes an equivalent number or percentage of the lowest charges for such procedures, or reasonably determines that any such charges are the result of erroneous data; (iii) includes charges for procedures performed in a geographic area other than the one used by the Blue Plan to determine such amount, provided, however, that such charges may be considered where the Blue Plan determines there is an insufficient number of charges in the relevant geographic area to

reasonably determine a usual, reasonable and customary amount; (iv) calculates the usual, reasonable and customary amount based upon fees paid under a discounted fee schedule rather than billed charges; and (v) lacks quality controls sufficient to reasonably test the validity of the data included in the database.

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

(a) Patient-specific Issues Involving Clinical Judgment

Medical Necessity Definition

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

Adverse Determination Denial Rate

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

(b) Policy Issues Involving Clinical Judgment

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

(c) Future Consideration by Blue Plans of an Administrative Exemption Program

Each Blue Plan 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. No Blue Plan shall be obliged to implement any such exemption process during the term hereof, and this § 7.16(c) is not intended and shall not be construed to limit a Blue Plan's ability to implement any such program on a pilot or experimental basis, base exemptions on any Blue Plan determined basis, or otherwise to implement one or more programs in only some markets.

7.17 Billing and Payment

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

No Blue Plan shall contest the timeliness of bills for Covered Services provided under a Fully-Insured Plan if such bills are received by the Blue Plan within 180 days after: (i) the date of service when the Blue Plan is the primary payor; or (ii) the date of the Physician's receipt of the EOB from the primary payor when the Blue Plan is the secondary payor. Each Blue Plan shall propose to Self-Insured Plan sponsors that they adopt the 180 day time period referenced in the preceding sentence, in the event that a Self-Insured Plan has a more restrictive time period. Each Blue Plan shall extend the 180 day time period for a reasonable period, on a case by case basis, in the event that a Physician provides notice to the Blue Plan, along with appropriate evidence, of circumstances reasonably beyond the Physician's control that resulted in the delayed submission. The Blue Plan shall determine

such circumstances and the reasonableness of the submission date. Nothing in this § 7.17(a) shall limit a Blue Plan's ability to provide incentives for prompt submission of bills.

(b) Claims Submission

Each Blue Plan agrees to accept from Participating Physicians and Non-Participating Physicians properly completed paper claims submitted on Form CMS-1500 or the equivalent. Each Blue Plan also agrees to accept electronic claims populated with similar information in HIPAA-compliant format using HIPAA-compliant code sets, subject to the Blue Plan's reasonable requirements pertaining to the exchange of electronic transactions. Each Blue Plan shall allow any of its Participating Physicians, at the Physician's election, to engage in any electronic transaction for which a standard transaction has been established by the HIPAA Standard Transactions and Code Sets Rule. If a Physician elects not to be compliant with the portions of HIPAA relating to the electronic submission of claims, no Blue Plan shall require such Physician to use electronic transactions or otherwise require such Physician to become compliant with HIPAA. Instead, the Blue Plan will maintain reasonable non-electronic systems to serve the information needs of such Physicians. Notwithstanding the above, a Blue Plan may continue to require submission of Clinical Information and other additional information in connection with its review of specific claims and as contemplated elsewhere in this Agreement, including without limitation §§ 7.5 and 7.8(d)(ii); provided, however, that nothing in this sentence is intended or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning the Blue Plan's ability to make requests for Clinical Information in connection with adjudication of claims. Each Blue Plan shall disclose on its Provider Website and its Public Website its policies and procedures regarding (i) the appropriate format for claims submissions, and (ii) requests for Clinical Information.

7.18 Timelines for Processing and Payment of Complete Claims

- (a)** Beginning not later than nine (9) months after the Final Order Date, each Blue Plan shall direct the issuance of a check or an electronic funds transfer in payment for Complete Claims for Covered Services within thirty (30) calendar days following the later of the Blue Plan's receipt of such claim or the date on which the Blue Plan is in receipt of all information needed and in a format required for such claim to constitute a Complete Claim and is in receipt of all documentation which may be requested by a Blue Plan consistent with this Agreement and which is reasonably needed by the Blue Plan: (i) to determine that such claim does not

contain any material defect or error; or (ii) to make a payment determination. Beginning one (1) year following the Effective Date, each Blue Plan shall direct the issuance of a check or an electronic funds transfer in payment for Complete Claims for Covered Services that are submitted electronically by Physicians within fifteen (15) business days following the later of the Blue Plan's receipt of such claim or the date on which the Blue Plan is in receipt of all information needed and in a format required for such claim to constitute a Complete Claim and is in receipt of all documentation which may be requested by a Blue Plan consistent with this Agreement and which is reasonably needed by the Blue Plan: (i) to determine that such claim does not contain any material defect or error; or (ii) to make a payment determination. If direction for the issuance of payment for Complete Claims for Covered Services is not made within the time periods specified in this § 7.18(a), the Blue Plan shall pay interest pursuant to § 7.18(b). For purposes of this § 7.18, where a state provides a definition of "clean claim" or "complete claim" which varies from the definition of Complete Claim provided herein, such definition shall be substituted for the definition of "Complete Claim" herein.

- (b)** For each Complete Claim with respect to which a Blue Plan has directed the issuance of a check or the electronic funds transfer later than the applicable period specified in § 7.18(a), the Blue Plan shall pay interest at the rate of eight percent (8%) per annum on the balance due on each such claim computed from the sixteenth (16th) business day or the thirty-first (31st) calendar day (as appropriate based on the circumstances described in § 7.18(a)) up to the date on which the Blue Plan directs the issuance of the check or the electronic funds transfer for payment of such Complete Claim; provided that to the extent that payment is made later than the period specified by applicable law or regulation, the Blue Plan shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence. Interest paid pursuant to this § 7.18(b) shall, at the Blue Plan's election, either be included in the claim payment check or wire transfer or be remitted periodically (but at least quarterly) in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.
- (c)** No Blue Plan shall have an obligation to make any interest payment pursuant to § 7.18(b) (i) with respect to any Complete Claim if, within thirty (30) days of the submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of such Participating Physician's agreement(s) with the Blue Plan; (iii) with respect to any time period during which a Force Majeure, as defined in § 7.32

of this Agreement, prevents adjudication of claims; or (iv) where payment is made to a Plan Member.

- (d) Each Blue Plan shall affix to or on paper claims for Covered Services, or otherwise maintain a system for determining, the date such claims are received by the Blue Plan. Each Blue Plan shall send an electronic acknowledgement of claims for Covered Services submitted electronically identifying the date such claims are received by the Blue Plan. If a Blue Plan determines that there is any defect or error in a claim that prevents the claim from entering the Blue Plan's adjudication system, it shall provide notice within ten (10) days of receipt of such claim. Nothing contained in this § 7.18 is intended or shall be construed to alter a Blue Plan's ability to request Clinical Information consistent with the provisions of § 7.8(d)(ii) or any other provision of this Agreement.
- (e) Notwithstanding anything in the Agreement to the contrary, the requirements of § 7.18 shall not apply to (i) claims for Covered Services that are processed under the BlueCard Program or any similar national account delivery program governed by the BCBSA (including but not limited to NASCO-to-NASCO arrangements) in which the Blue Plan participates but is not solely responsible for the processing and payment of the claim, and/or (ii) claims for Covered Services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer.
- (f) A claim relating to § 7.18(a), where the claim and any interest payment required under § 7.18(b) has been made, shall not be the basis for a Compliance Dispute.

7.19 No Automatic Downcoding of Evaluation and Management Claims

As of the Final Order Date, no Blue Plan shall automatically reassign or reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"), except that a Blue Plan may reassign a new patient visit code to an established patient visit code based solely on CPT® Codes, CPT® Guidelines, and CPT® Conventions.

Notwithstanding the foregoing sentence, Blue Plans shall continue to have the right to deny, pend or adjust such claims for Covered Services on other bases and shall have the right to reassign or reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of the information in the Clinical Information at the time the service was rendered for the particular claims or a review of information derived from a Blue Plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive (whether intentional or unintentional) billing practices; provided

that the decision to reassign or reduce is based primarily on a review of Clinical Information.

7.20 Bundling and Other Computerized Claim Editing

Each Blue Plan agrees to take actions necessary on the Blue Plan's part to cause the claim-editing software program it uses to continue to produce editing results consistent with the standards set forth in this § 7.20 and, if the Blue Plan has actual knowledge of non-conformity with such standards, to take reasonable actions necessary on its part to promptly modify such software to any extent necessary to conform to such standards; provided that nothing in this paragraph is intended or shall be construed to require a Blue Plan to pay for anything other than Covered Services for its Plan Members, to make payment at any particular rates, to limit a Blue Plan's right to deny, pend or adjust claims based on a reasonable belief of fraudulent or abusive (whether intentional or unintentional) billing practices (so long as the Physician has been given the opportunity to provide Clinical Information and the Blue Plan has reviewed any Clinical Information so provided before denying or adjusting the claims). For purposes of this § 7.20 only, if any change to CPT® affects a Blue Plan's obligations hereunder, the Blue Plan will promptly develop plans to cause its Physician payment practices to be consistent with the commitments set forth in this § 7.20. The obligations set forth below in this § 7.20 shall take effect on the dates set forth in Exhibit I.

For purposes of §§ 7.19 and 7.20, all references to the AMA CPT® book and to CPT® Codes in this Agreement refer to the AMA CPT® book and the CPT® Codes listed in the AMA CPT® book in effect at the time the services were provided; however, notwithstanding anything to the contrary contained in this Agreement, if there is any amendment, modification, or superseding change to the CPT® Codes, CPT® Conventions or CPT® Guidelines, which constitutes a departure from the procedures, criteria or scope of activities historically employed or undertaken by the AMA's CPT Editorial Panel and which materially expands the commitments of a Blue Plan in this Agreement or has a material adverse effect on the Blue Plan, then the Blue Plan may communicate to Physicians its decision not to recognize such modification by posting a notification on its website, or by other form of written or electronic communication to Physicians, and by notifying Class Counsel.

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

- (b) Each Blue Plan will process and separately reimburse codes listed in the AMA CPT® book as add-on billing codes without reducing payment under the Blue Plan’s Multiple Procedure Logic; provided that the AMA CPT® book provides that such add-on CPT® Codes are appropriately billed with proper primary procedure codes.
- (c) (i) No Blue Plan shall require a Physician to submit Clinical Information of their patient encounters solely because the Physician seeks payment for both surgical procedures and CPT® evaluation and management services for the same patient on the same date of service, provided that the correct CPT® evaluation and management code, surgical code and modifier (e.g., CPT® modifiers 25 or 57) are included on the initial claim submission.
- (ii) If a bill contains a CPT® Code for an evaluation and management service, appended with a CPT® modifier 25 and a CPT® Code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and separately eligible for payment, unless the Clinical Information indicates that use of the CPT® modifier 25 was inappropriate or the Blue Plan has disclosed pursuant to § 7.8(d)(iii) the limited number of finite code combinations that are not appropriately reported together. Payment shall only be made for one evaluation and management service for any single day unless payment for more than one is appropriate pursuant to the AMA CPT® book and is supported by appropriate diagnoses in the Clinical Information.
- (iii) Each Blue Plan will remove from its claim review and payment systems any Edits that generally deny payment for CPT® evaluation and management codes with a CPT® modifier 25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service except for a limited number of exceptions, consistent with § 7.20(c)(ii) above, which will be disclosed on the Blue Plan’s Provider Website.
- (iv) Nothing in this Agreement shall (A) prohibit a Blue Plan from requiring use of the appropriate CPT® Code modifiers for evaluation and management billing codes (e.g., CPT® modifiers 25 or 57) on their original claim forms, or (B) preclude a Blue Plan from requiring a Physician, Physician Group or Physician Organization to submit to an audit of claims submitted by such Physician, Physician Group or Physician Organization for payment directly to such Physician, Physician Group or Physician Organization (including, but not limited to, claims for

surgical procedures and evaluation and management services on the same date of service submitted with the appropriate modifier), and to provide their Clinical Information in connection with such an audit.

- (d)** A CPT® Code for supervision and interpretation or radiologic guidance (e.g., fluoroscopic, ultrasound or mammographic) shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that, (i) the associated procedure code does not include supervision and interpretation or radiologic guidance according to the AMA CPT® book, and (ii) for each such procedure (e.g., review of x-ray or biopsy analysis or ultrasound guidance), no Blue Plan shall be required to pay for supervision or interpretation or radiologic guidance by more than one qualified health care professional.
- (e)** With respect to indented codes, no Blue Plan shall reassign any CPT® Code into any other CPT® Code or deem a CPT® Code ineligible for payment based solely on the format of the published CPT® descriptions.
- (f)** CPT® Codes submitted with a modifier 59 attached will be eligible for payment to the extent they follow the AMA CPT® book and they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that: (i) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; and (ii) it would not be more appropriate to append any other CPT® recognized modifier to such CPT® Codes.
- (g)** No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict a Blue Plan from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).
- (h)** No Blue Plan shall automatically change a CPT® Code to one reflecting a reduced intensity of the service when such CPT® Code is one among or across a series that includes without limitation CPT® Codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.
- (i)** Not later than six (6) months after the Final Order Date, or as soon thereafter as is reasonably practicable, each Blue Plan shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or

any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, no Blue Plan shall be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require a Blue Plan to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

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

7.21 EOB and Remittance Advice Content

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

Not later than six (6) months after the Final Order Date or as soon thereafter as practicable, the Physician Remittance Advice or similar forms that each Blue Plan sends to its Participating Physicians communicating the results of claims adjudications shall contain at least: (i) the name of and a number identifying the Blue Plan's Plan Member; (ii) the date of service; (iii) the amount of payment per line item; (iv) the procedure code(s); (v) the amount of payment; (vi) any adjustment to the invoice submitted; (vii) a generic explanation of any adjustment of the invoice submitted that complies with HIPAA requirements; and (viii) any adjustment or change in any code on a line-by-line basis. Each such Physician Remittance Advice or similar form, or documents provided by the Blue Plan to its Participating Physician along with each such Physician Remittance Advice or similar form, also shall specify an address and phone number for questions by the Participating Physician regarding the claim described on such Physician Remittance Advice or similar form. This paragraph is not intended and shall not be construed to limit the Blue Plan's right to replace Physician Remittance Advice or similar forms with electronic Remittance Advices or the equivalent, to the extent such electronic Remittance Advices or the equivalent provide similar information so long as the Blue Plan complies with § 7.17(b).

- (b) This Agreement is not intended to alter or change rights of a Non-Participating Physician to balance bill or bill a Blue Plan's Plan Member at rates and on terms that are agreed to between the Non-Participating Physician and that Plan Member.

7.22 Overpayment Recovery Procedures

As of the Final Order Date, each Blue Plan shall initiate or continue to take actions reasonably designed to reduce Overpayments. Such actions may include, without limitation, system enhancements to identify duplicate invoices prior to payment and construction and maintenance of one or more common Physician databases for use in connection with payment of Physician invoices. Each Blue Plan shall publish on its Public Website and its Provider Website an address and procedures for Physicians to return Overpayments. In addition, other than for recovery of duplicate payments or other similar adjustments including those relating to (i) claims where a Participating Physician has received payment for the same services from another payor whose obligation is primary, or (ii) timing or sequence of claims for the same Plan Member that are received by the Blue Plan out of chronological order in which the services were performed, each Blue Plan shall initiate Overpayment recovery efforts by providing Physicians with at least thirty (30) days written notice before engaging in additional Overpayment recovery efforts. Such notice shall include (i) the patient's name, (ii) the service date, (iii) the payment amount received by Physician, and (iv) a reasonably specific explanation

of the proposed change (including, without limitation, procedure code where appropriate). No Blue Plan shall initiate Overpayment recovery efforts more than eighteen (18) months after the payment was received by Physician; provided, however, that no time limit shall apply to the initiation of Overpayment recovery efforts (a) based on a reasonable belief of fraud or other intentional misconduct, or (b) required by a Self-Insured Plan, or (c) required by a state or federal government program. Notwithstanding the above, in the event that a Physician asserts a claim of underpayment, a Blue Plan may defend or set off such claim based on Overpayments going back in time as far as the claimed underpayment. If a Physician requests an appeal within thirty (30) days of receipt of a request for repayment of an Overpayment, no Blue Plan shall require such Physician to repay the alleged Overpayment before such appeal is concluded. Nothing in this Agreement, including but not limited to the provisions of § 13, shall be deemed to limit a Blue Plan's right to pursue recovery of Overpayments that occurred prior to the Final Order Date where the Blue Plan has provided the Physician with notice of such recovery efforts prior to the Final Order Date.

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

Commencing on the Final Order Date, each Blue Plan shall initiate or continue to take actions reasonably designed to reduce Overpayments and claim denials resulting from inaccurate information about the eligibility of its Plan Members. The Blue Plan may reduce, discontinue, or expand such activities commensurate with their demonstrated effectiveness.

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7.25 Effect of Blue Plan Confirmation of Patient Procedure/Medical Necessity

If the Blue Plan certifies or Precertifies (or approves or pre-approves) that a proposed service is medically necessary for one of its Plan Members, the Blue Plan shall not subsequently revoke that medical necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material change in that Plan Member's health condition between the date that the certification or Precertification was provided and the date of the service that makes the proposed service no longer medically necessary for such Plan Member. In the event that a Blue Plan certifies or Precertifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for services beyond the certified course of treatment shall be deemed to be a new request and that Blue Plan's denial of such request shall not be deemed to be inconsistent with the preceding sentence.

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7.27 Information about Physicians Provided by Blue Parties

Information currently posted on each Blue Plan's Public Website about individual Physicians or contained in printed materials prepared by the Blue Plan is derived from data supplied by those Physicians and from applicable agreements between the Blue Plan and its Participating Physicians or their Participating Physician Groups or Participating Physician Organizations. Upon written notice of an inaccuracy sent to a Blue Plan (pursuant to the direction as to how to give such notice that will be posted on the Blue Plan's Provider Website), if the Blue Plan does not dispute that there is an inaccuracy the Blue Plan shall take steps reasonably necessary to ensure that the Public Website is updated within twenty (20) business days after receipt of such notice and that written materials are revised before the next edition of such materials is printed (to the extent there is sufficient time to make such revisions before the next printing) to reflect any corrections in the Physician information to make it accurate. Upon written notice that a Physician is incorrectly listed as a Participating Physician on a Blue Plan's Public Website or in printed materials prepared by a Blue Plan (pursuant to the direction as to how to give such notice that will be posted on the Blue Plan's Provider Website), if the Blue Plan does not dispute that there is an inaccuracy the Blue Plan shall take steps reasonably necessary to delete any such erroneous reference from the Public Website within twenty (20) business days after receipt of such notice and from any written materials before the next edition of such materials is printed (to the extent there is sufficient time to make such revisions before the next printing), and the Blue Plan shall make corresponding changes in systems affecting the level of payments and generation of EOBs within twenty (20) business days after receipt of such notice. If the Blue Plan disputes that there is an inaccuracy, it will so notify the Physician within the same time periods specified above, including the basis on which it disputes that there is an inaccuracy.

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7.29 Miscellaneous

(a) Gag Clauses

No Blue Plan shall include in its contracts with Participating Physicians, Participating Physician Groups, or Participating Physician Organizations any provision limiting the free, open and unrestricted exchange of information between its Physicians and its Plan Members regarding the nature of the Plan Member's medical conditions or treatment and provider options and the relative risks and benefits and costs to the Plan Member 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 the Blue Plan regarding coverage of treatment that has been recommended or rendered. Each Blue Plan agrees not to penalize or sanction Participating Physicians in any way for engaging in any free, open and unrestricted communication with a Plan Member with respect to the foregoing subjects or for advocating for any service on behalf of a Plan Member.

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(c) Arbitration

(i) With respect to any arbitration proceeding between a Blue Plan and its Participating Physician who practices individually or in a Participating Physician Group of less than six Physicians, the Blue Plan agrees that it shall refund any applicable filing fees and arbitrators' fees paid by such Physician in the event the Physician is the prevailing party with respect to such arbitration proceeding; provided, however, that this paragraph shall not apply with respect to any arbitration proceeding in which the Participating Physician purports to represent any Physician outside of his or her Physician Group.

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

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

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

- (ii) Except for those terms relating to higher or customized rates, length of term of the contract, and/or other customized payment methodologies or as otherwise permitted under §§ 7.13(b), 7.13(c), 7.14(a) and 7.29(r), this Agreement shall be deemed to modify or nullify any inconsistent terms of an Individually Negotiated Contract.
- (iii) With respect to Individually Negotiated Contracts executed after the Preliminary Approval Date, a Blue Plan may agree with individual Participating Physicians, Participating Physician Groups or Participating Physician Organizations on terms that deviate from the terms of this Agreement relating to higher or customized rates, length of term of the contract, and/or other customized payment methodologies or as otherwise permitted under §§ 7.13(b), 7.13(c), 7.14(a) and 7.29(r). In addition, a Blue Plan may agree with individual Participating Physicians, Participating Physician Groups or Participating Physician Organizations on terms that deviate from any other terms of this Agreement upon request of such individual Participating Physicians, Participating Physician Groups or Participating Physician Organizations.

(e) Impact of this Agreement on Covered Services

Nothing contained in this Agreement shall: (i) require a Blue Plan to pay a Participating Physician, Participating Physician Group or Participating Physician Organization at any particular amount, or (ii) prohibit a Blue Plan from utilizing a particular reimbursement methodology. Said payments or reimbursement methodologies shall be implemented consistent with the applicable terms of this Agreement. Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this Agreement shall supersede or otherwise alter the scope of Covered Services of any Plan or require a Blue Plan or any Plan to pay for services that are not Covered Services. In determining whether services provided to one of its Plan Members are Covered Services under a Self-Insured Plan, each Blue Plan shall apply the definition of “Medically Necessary” (or any comparable term) contained in § 7.16(a) except with respect to the limited number of large Self-Insured Plans that require a different definition of “Medically Necessary” (or any comparable term) be applied. With respect to such Self-Insured Plans, each Blue Plan shall recommend that the definition of “Medically Necessary” (or any comparable term) contained in § 7.16(a) apply.

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(i) Pharmacy Provisions

When a Blue Plan provides pharmacy coverage, the Blue Plan shall make formulary information available to its Plan Members. Each Blue Plan shall maintain the process, as reasonably amended, for covering medications not included in the formulary when Medically Necessary that is in place on the Execution Date. When a Blue Plan provides pharmacy coverage, each Blue Plan will continue to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. In reaching a conclusion whether to provide coverage for a drug under the preceding sentence, the Blue Plan will consider supporting documentation in either the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information. Blue Plans shall retain the right to Precertify coverage of specific medications for non-approved use. A Blue Plan's disclosure concerning Precertification and potential restrictions on non-approved use of prescription medications shall be similar in substance to disclosure concerning formularies, as described above.

(j) Restrictive Endorsements

Where a Blue Plan's reimbursement of a Physician for services performed by that Physician is a partial payment of allowable charges, a Physician 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 Blue Parties' Responsibilities

(i) The obligations undertaken by each Blue Party under § 7 of this Agreement shall be applicable only to those functions or activities performed directly by the Blue Party, its employees, and third parties (other than Delegated Entities) performing functions or activities on the Blue Party's behalf. Each Blue Plan shall make a good faith effort to

include in contracts entered into with Delegated Entities subsequent to the Final Order Date terms that are substantially equivalent to the terms of this Agreement; provided that no Blue Party shall be liable under this Agreement in the event any Delegated Entity acts in a manner inconsistent with the terms of this Agreement.

- (ii) The provisions of § 7 of this Agreement shall apply to a Blue Plan's activities in connection with the BlueCard Program or any similar national account delivery program governed by the BCBSA (including but not limited to NASCO-to-NASCO arrangements) only to the extent that the Blue Plan is solely responsible for the activity, with respect to a claim under such a program, that is subject to § 7 of this Agreement.
- (iii) The Blue Parties recognize the desirability of improving Blue Plans' business relationships with Physicians who provide Covered Services to Blue Plans' Plan Members in connection with the BlueCard Program and other similar national account delivery programs governed by BCBSA (including but not limited to NASCO-to-NASCO arrangements) (the "**Programs**"). To that end, the Blue Parties have made investments and undertaken initiatives reasonably designed to streamline and improve the overall efficiency of the claim adjudication process for the Programs. These investments and initiatives seek to improve Physician satisfaction with the Programs by, among other things, working towards the goal of processing and paying claims under these Programs within the times set forth in § 7.18(a). The Blue Parties will continue such initiatives and improvements during the Effective Period. Since 2000 and through the Effective Period, BCBSA's investments in furtherance of these initiatives will exceed \$150,000,000. These investments are in addition to the investments referred to in § 7.31. Examples of those initiatives include, but are not limited to, those set forth in subparagraphs (A) through (C) below.

(A) A multi-year information technology initiative aiming to improve the timeliness of claims processing and payment by implementing enhancements to transaction processing and renovating and upgrading the technologies used by the Blue Parties to improve their information management and web-enabled services. Improvements include the continued upgrading of BlueExchange® and the development and

implementation of Blue²®. BlueExchange is an electronic, inter-Blue Plan system supporting Physicians' ability to make and receive responses to eligibility benefit inquiries, claim status requests, and referral authorizations and remittance advice. Blue²® is a web-based application initiated to facilitate real-time transaction transmission, inventory management related to inter-Blue Plan claims, and inter-Blue Plan claims exception management, including the capability to enable electronic exchanges of claims attachments such as clinical records among Blue Plans.

(B) Measures to better facilitate resolution of Physician issues related to inter-Blue Plan claims through standardized claims inquiry escalation processes among Blue Plans, information technology and management systems to develop, improve and accelerate dispute resolution, such as with respect to Blue Plans' activities pertaining to claims payment and billing issues, requests for Clinical Information, "Medical Necessity" determinations, and related disclosures, and the promotion of "best practices".

(C) Measures to promote overall Physician satisfaction with the handling of inter-Blue Plan claims, including enhanced performance measurements and monitoring capabilities.

The Blue Parties may modify any specific initiatives described in subsections (A)-(C) of this § 7.29(k)(iii), or institute new initiatives to accomplish the same objectives.

- (iv) BCBSA does not have and shall not adopt any requirements, rules, or regulations, or modifications thereof, that would cause any Blue Plan to be in violation of any of the requirements set forth in this Agreement or would cause any representation made herein to become untrue. Each of the Blue Plans agrees that it will not encourage or support any change in BCBSA requirements, rules or regulations that would conflict with the Blue Plan's obligations under this Agreement.

(l) Copies of Contracts

Each Blue Plan shall provide a copy of its contract with a particular Participating Physician (including without limitation a

contract with a Physician Organization or a Physician Group in which such Participating Physician participates) to such Participating Physician, upon receipt by the Blue Plan of a written request by such Participating Physician to provide such copy, except in circumstances where the Blue Plan is restricted from providing a Participating Physician with a copy of the Blue Plan's contract with a Physician Organization or Physician Group specifically because of terms contained in that contract. No Blue Plan shall require that a restriction as described in the previous sentence be included in its contracts with Physician Organizations or Physician Groups.

(m) State and Federal Laws and Regulations

Nothing contained in § 7 of this Agreement is intended to or shall, in any way, reduce, eliminate, or supersede any Party's obligation to comply with applicable provisions of relevant state and federal law and regulations. To the extent state or federal law or regulation imposes, with respect to a specific obligation created by § 7, a greater obligation than that specifically set forth in § 7, the Blue Parties shall comply with said law or regulation. The Compliance Dispute resolution procedures contained in § 12 shall apply with respect to any alleged breach of an obligation created by the preceding sentence. Nothing in this § 7.29(m) is intended to give rise to or should be construed as giving rise to any private right of action for any violation of any federal or state law or regulation (whether under a breach of contract theory, including a claim of breach of this Agreement, or any other theory) where federal or state law or regulation does not allow a Physician a right of action for such violation. The Compliance Dispute Officer shall not take any action inconsistent with any ruling, determination or directive by any court or regulatory agency. Any action taken by the Compliance Dispute Officer that is inconsistent with any subsequent ruling, determination or directive by any court or regulatory agency shall not be binding on a Blue Party as of the effective date of such subsequent ruling, determination or directive. The Compliance Dispute Officer shall not award liquidated, punitive or multiples of damages that might be available under state or federal law or regulations. Further, a Physician shall be required to elect whether to pursue a remedy under this Agreement through the process set forth in § 12, or to pursue any remedy available under such state or federal law or applicable regulations.

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(o) Limitations on Obligations of Non-Participating Physicians

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

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(q) Effect of Assignment of Benefits

The existence, submission, and/or acceptance of an assignment of benefits authorization in favor of a Non-Participating Physician shall not preclude the Non-Participating Physician from collecting from a Blue Plan's Plan Member the difference between the Non-Participating Physician's full fee and the payment (if any) received by the Non-Participating Physician from the Blue Plan. Notwithstanding anything to the contrary contained in this Agreement, nothing contained in this Agreement shall otherwise require the Blue Plan to make payment directly to any Non-Participating Physician.

(r) Most Favored Nations Clauses.

The Blue Plans will not include any "most favored nations" clauses in its contracts with Participating Physicians, Participating Physician Groups and Participating Physician Organizations, except for Individually Negotiated Contracts.

7.30 Compliance with Applicable Law and Requirements of Government Contracts

- (a)** The obligations undertaken in § 7 herein shall be fulfilled by each Blue Plan to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives. If, and during such time as, a Blue Plan is unable to fulfill an obligation under § 7 to the extent contemplated by this Agreement because to do so would require governmental approval or action, the Blue Plan shall perform such obligation to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives, and the Blue Plan shall continue to fulfill its other obligations under § 7 to the extent permitted under applicable laws and regulations, the terms and

conditions of current and future government contracts, and applicable governmental directives. To the extent that any governmental approval is required for any Party to fulfill an obligation under § 7, such Party shall make reasonable efforts to obtain any necessary approvals from the appropriate governmental entities. For any obligation under § 7 that cannot be undertaken without governmental approval, the Effective Period as to that obligation shall be delayed until such approval is granted. Nothing in this § 7 shall apply to a Blue Party's role as a carrier providing administrative services for Medicare Part B or to FEHBA.

- (b) Each Blue Party that contracts directly with the U.S. Department of Defense under the TriCare Program will present the requirements of § 7 of this Agreement to the Tricare Management Activity (“**TriCare**”) for consideration of incorporating such requirements into such Blue Party's TriCare Contract pursuant to the changes clause of such contract. Unless and until such time that a Blue Party and TriCare so amend the Contract, any Blue Party's TriCare Program is exempted from the requirements of this Agreement. The TriCare Program is regulated by the United States Department of Defense. The Department of Defense provides rules, regulations and contract provisions applicable to that Program, including certain mechanisms to enforce those rules, regulations and contract. Where a Blue Party's TriCare Contract has been amended as provided in this subsection, such Blue Party will comply with the rules and regulations related to such amendments, including the mechanisms to enforce those rules and regulations.

7.31 Estimated Value of § 7 Initiatives

Since the inception of this Action and through the Termination Date, the Blue Parties will have spent over \$250,000,000 in order to implement and carry out the initiatives described in § 7 of this Agreement and otherwise to improve relations with Physicians. Such initiatives have included automated adjudication of claims, increased internet and clearinghouse functionality, and functionality to improve responses to Physician inquiries. Taking into account these expenditures, the Parties estimate that the approximate aggregate value of the initiatives and other commitments regarding the Blue Parties' business practices set forth in § 7 of this Agreement is in excess of the amount stated above.

7.32 Force Majeure

No Party hereto shall be required to meet an obligation under this Agreement where the inability to meet such obligation is the result of any act of God, governmental act, act of terrorism, war, fire, flood, earthquake or other natural disaster, explosion or civil commotion (“**Force Majeure**”). The performance of a Party's obligations under this

Agreement, to the extent affected by the delay, shall be suspended for the period during which the cause, or the Party's substantial inability to perform arising from the cause, persists. If the performance of any obligation under this Agreement is excused or delayed by Force Majeure and that obligation is a condition precedent for the performance of an obligation by another Party, performance of the obligation by the second Party shall be excused or delayed to the same extent as the performance of the obligation by the first Party.

7.33 Managed Care Issues Relating to Mental Health and Substance Abuse

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

 - (i)** There is a diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent in ICD-9-CM, or replacement thereof) and an individualized treatment plan appropriate for the Plan Member's illness or condition; and
 - (ii)** There is a reasonable expectation that the Plan Member's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, through treatment known to be effective for the Plan Member's illness; and
 - (iii)** The mental health services are not primarily for the avoidance of incarceration of the Plan Member.
- (b)** Each Blue Plan agrees that its Participating Psychiatrists will be listed in the Blue Plan's provider directory, via the hard-copy directory, via the Blue Plan's Public Website, via a "hot link" on the Blue Plan's Public Website, or otherwise. If a primary care Physician referral is required, each Blue Plan will allow its primary care Participating Physicians to make referrals to the Blue Plan's Participating Psychiatrists, provided that any such referral is subject to the same referral requirements that apply to referrals to other Participating Physicians. Nothing in the preceding sentence shall be construed to remove or change any applicable Plan Member or Physician Precertification requirements.

- (c) Each Blue Plan agrees that, where a Psychiatrist has not entered into a different agreement with the Blue Plan or the hospital or other mental health care facility where the services are rendered, and where the Blue Plan has not entered into a different agreement with such hospital or mental health care facility, the Blue Plan will separately consider and pay for Medically Necessary Covered Services provided to one of the Blue Plan's Plan Members by the Psychiatrist, in accordance with the terms and conditions of the Plan Member's Plan.
- (d) Where applicable, each Blue Plan adheres to state "prudent layperson" laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson standards. An emergency department Physician can make a decision regarding admission or physical or chemical restraints. Each Blue Plan agrees that, where a Physician has not entered into a different agreement with the Blue Plan or the hospital or other mental health care facility where the services are rendered, and where the Blue Plan has not entered into a different agreement with such hospital or mental health care facility, in the event of an emergency, the Blue Plan will pay for Medically Necessary emergency care mental health Covered Services provided by such Physician in accordance with applicable prudent layperson standards, the definition of Medical Necessity in § 7.16(a), and the terms and conditions of the Plan Member's Plan, and the Blue Plan will pay for Medically Necessary mental health Covered Services provided by Physicians resulting from the admission in accordance with the definition of Medical Necessity in § 7.16(a) and the terms and conditions of the Plan Member's Plan.
- (e) Each Blue Plan will post on its Provider Website an authorization form that Physicians providing mental health services to the Blue Plan's Plan Members may print or download to obtain Plan Member consent for release of Clinical Information to the Blue Plan.

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7.35 Use of Third Party Intellectual Property

If and to the extent that any activity of a Blue Party in compliance with one or more provisions of this Agreement has subjected or, in a Blue Party's reasonable judgment, may subject it to an Intellectual Property Claim, including but not limited to a claim by the AMA, the Blue Party's obligation to comply with that provision or those provisions is suspended. Within ten (10) days of determining that compliance with one or more provisions may subject it to an Intellectual Property Claim, the Blue Party

will notify the Class Compliance Dispute Facilitator and Class Counsel and offer to meet and confer to resolve the issue including developing one or more alternative business practices that achieve comparable results to the affected provisions at no significant increase in cost to the Blue Plan. If the parties do not resolve the issue, and Class Counsel and the Class Compliance Dispute Facilitator believe there is an alternative business practice that achieves comparable results, without a significant increase in cost and without creating an Intellectual Property Claim, Class Counsel and the Class Compliance Dispute Facilitator may bring a Compliance Dispute under § 12.

7.36 Competitive Flexibility

(a) “Negotiated Purchaser”

- (i) A “Negotiated Purchaser “ is an entity that meets all of the following requirements: (x) the entity is an employer (including any governmental unit acting in the capacity of an employer, other than the federal government under the FEHBP), union, trust, association or other entity that sponsors a Self-Insured Plan or Fully-Insured Plan covering a group of active and/or retired employees; (y) the entity has negotiated, intends to negotiate (or otherwise has issued a request for proposals), or is negotiating a service agreement or insurance contract with the Blue Plan; and (z) as a result of the entity’s size, covered lives, or strategic significance, changes made by the Blue Plan to its standard operating policies and procedures are both required by such entity and reasonably necessary in order to obtain or maintain an agreement with such entity. There will be a limited number of such entities for each Blue Plan during the Effective Period of this Agreement.
- (ii) Each Blue Plan will make reasonable good faith efforts to satisfy Negotiated Purchasers without any terms or conditions that differ from those contained in § 7. A Blue Plan’s agreement with a Negotiated Purchaser may have terms or conditions that differ from those contained in § 7 if reasonably necessary in order for the Blue Plan to obtain or maintain a service agreement or insurance contract with the entity. All other terms and conditions of this Agreement shall remain in full force and effect. The Blue Plan will promptly notify the Class Compliance Dispute Facilitator of any agreement containing any such term or condition and promptly thereafter post on its Provider Website any material differences from the provisions of § 7 that relate to the terms and conditions of payment to Participating Physicians, Participating Physician Groups or

Participating Physician Organizations. The Class Compliance Dispute Facilitator, *sua sponte* or upon receiving a complaint from a Class Member, may challenge any such term or condition through the Compliance Dispute process described in § 12.10. Such challenge shall be brought within five (5) business days following the date on which the Blue Plan provides notice to the Class Compliance Dispute Facilitator of any agreement containing any such term or condition. If the Class Compliance Dispute Facilitator fails within the period set forth herein to challenge the proposed term or condition of any such agreement, such failure shall be deemed a waiver to challenge any such term or condition in such agreement. A final decision of such a challenge shall preclude further challenges to the same term or condition.

(b) Ability of Blue Parties to Substitute Business Practices

- (i) Each Blue Party 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 the Blue Party reasonably believes, expects and intends that the newly-adopted means or method of disclosure or transmission is as effective as or more effective than the means or method set forth in this Agreement.
- (ii) Each Blue Party may substitute for any of the business practices required of it by § 7 of this Agreement an alternative business practice so long as the alternative business practice is reasonably designed to achieve comparable results consistent with this Agreement. Prior to implementing any such alternative business practice, a Blue Party shall give notice to the Class Compliance Dispute Facilitator of such alternative business practice, and meet and confer with the Class Compliance Dispute Facilitator, if requested, within fifteen (15) business days following the date of the notice with respect thereto. If the matter is not resolved, and the Blue Party proceeds with implementation, then the Class Compliance Dispute Facilitator may bring a compliance dispute with respect to the alternative business practice within ten (10) business days following notice from the Blue Party of its implementation of such alternative business practice. Alternatively, the Blue Party may defer implementation and seek a review of the matter by the Compliance Dispute Officer. The Class Compliance Dispute Facilitator may confer with and seek the assistance of Class Counsel in connection with any such dispute. The Blue Party shall cease implementing any alternative

business practice, to the extent it has done so, within sixty (60) days following the written notice to the Blue Party from the Compliance Dispute Officer that such alternative business practice is not reasonably designed to achieve comparable results consistent with this Agreement. If the Class Compliance Dispute Facilitator fails within the period set forth herein to request to meet and confer with the Blue Party, such failure shall be deemed a waiver to challenge any such alternative business practice in the future. The Compliance Dispute Officer shall hold in confidence all information supplied by the Blue Party regarding such alternative business practice.

(c) Modification for Specific Circumstances

Notwithstanding the provisions of § 7.36(a), a Blue Plan may modify any undertaking if either (i) the modification is reasonably necessary to compete in a particular geographic marketplace, or (ii) performance of one or more provisions of this Agreement would be impractical. For this purpose, performance would be “impractical” if it would place the Blue Plan at a demonstrable operational disadvantage, would be unduly burdensome, or would, on account of new technology, be inefficient or less cost-effective relative to use of the new technology. Each Blue Plan shall have an obligation to use good faith efforts to address any issue that arises under this subsection by taking action consistent with the terms of § 7 if it is reasonably practical to do so. In the event a Blue Plan intends to implement a modification under this § 7.36(c), the Blue Plan shall give notice to Class Compliance Dispute Facilitator of the terms of such modification, which notice shall be in advance of implementing the modification unless competitive circumstances prevent advance notice in which case the notice shall be as soon as practicable. Class Compliance Dispute Facilitator shall have fourteen (14) days in which to provide written notice to the Blue Plan of any objections to such modification. Failure to provide such notice shall constitute a waiver of the right to object or assert a Compliance Dispute with regard to such modification, as otherwise permitted under subsection (c) of this § 7.36. Within ten (10) business days after the Blue Plan’s receipt of any notice of objections, the Blue Plan, if requested in the notice of objections, shall meet and confer with Class Compliance Dispute Facilitator with respect to the objections. If the Blue Plan and Class Compliance Dispute Facilitator are unable to resolve the matter, the Blue Plan shall promptly notify the Class Compliance Dispute Facilitator whether

it intends to implement or continue to implement the modification. If the Blue Plan gives notice that it intends to implement or continue to implement the modification, then within ten (10) business days of the notice, the Class Compliance Dispute Facilitator may initiate a Compliance Dispute. If the Compliance Dispute Officer rules in favor of the Blue Plan, such final decision of such a challenge shall preclude further challenges to the modification. If the Compliance Dispute Officer rules against the Blue Plan, any remedy shall be limited to directing the Blue Plan to submit and implement an adequate corrective action plan, and imposing on the Blue Plan the obligation to pay actual damages including interest suffered by a Class Member as a result of the implementation of any modification. Any activity conducted by a Blue Plan under a corrective action plan shall be subject to the provisions of § 13.3(a)(iii). The Class Compliance Dispute Facilitator may confer with and seek the assistance of Class Counsel in connection with any such dispute.

8. Other Settlement Consideration

In addition to the business initiatives set forth in § 7 of this Agreement, the settlement consideration shall include a settlement fund (the “**Settlement Fund**”) for payment of claims to Class Members, which will be established and operated in accordance with the provisions of §§ 8.2 through 8.4.

8.1 Intentionally omitted

8.2 Settlement Fund

- (a) Each Blue Plan shall pay the amount specified for it in Exhibit K to an account (the “**Settlement Administration Account**”) (each such payment constituting a “**Settlement Fund Payment**”), as hereinafter provided in this § 8.2 and § 8.5. Subject to the provisions of § 8.2(e), the sum of all Settlement Fund Payments shall equal \$131,209,507 (the “Settlement Fund Amount”) plus interest as provided in § 8.5. Each Settlement Fund Payment shall be treated as a payment to a Qualified or Designated Settlement Fund under I.R.C. § 468B and the regulations or proposed regulations promulgated thereunder (including without limitation Treasury Reg. § 1.468B-1-5 or any successor regulation).
- (b) By no later than ten (10) days following the Preliminary Approval Date, the Blue Parties shall cause to be established the Settlement Administration Account. The Blue Parties shall select and retain a settlement administrator (the “**Settlement Administrator**”). Under the joint supervision of the Blue Parties and Class Counsel or their designees, and subject to the supervision, direction and approval of the Court, the Settlement Administrator shall be responsible for the administration of the Settlement Administration Account.

- (c) Each Blue Plan shall pay its Settlement Fund Payment by wire transfer of immediately available funds, not later than ten (10) days after the Effective Date
- (d) The Settlement Fund shall consist of the total of all Settlement Fund Payments and all interest, dividends, and other income earned on funds in the Settlement Administration Account, less any reserve for taxes.
- (e) The settlement consideration identified in §§ 7.31, 8.2(a), and 9.1 of this Agreement is premised on the participation in this Agreement by all Blue Plans. If any Blue Plan terminates its participation in this Agreement pursuant to § 14.2, (i) the Settlement Fund Amount defined in this § 8.2 shall be reduced by the amount specified in Exhibit K for the Terminating Blue Plan, as defined in § 14.2, and (ii) the Estimated Value defined in § 7.31, and the Unopposed Amount, defined in § 9.1, shall be reduced by the percentage specified in Exhibit K for the Terminating Blue Plan.

8.3 Responsibilities of the Settlement Administrator

In addition to the responsibilities set forth in § 8.2(b), the responsibilities of the Settlement Administrator shall expressly include without limitation: (i) the determination of the eligibility of any Class Member to receive payment from the Settlement Fund and the amount of payment to be made to each Class Member from the Settlement Administration Account, in accordance with the provisions of § 8.3 of this Agreement; (ii) the determination as to whether the election of any Class Member to contribute a settlement payment has been authorized by such Class Member, in accordance with the provisions of § 8.3(g) of this Agreement; (iii) the administration of an appropriate procedure for the adjudication of disputes that may arise with respect to the eligibility of a Class Member to receive a payment from the Settlement Fund or the amount of the payment authorized to be made to any Class Member under the provisions of this Agreement; (iv) the filing of any tax returns necessary to report any income earned by the Settlement Fund and the payment from the Settlement Administration Account, as and when legally required, of any tax payments (including interest and penalties) due on income earned by the Settlement Fund and to request refunds, when and if appropriate, with any such tax refunds that are issued to become part of the Settlement Fund; (v) the compliance with any other applicable law; and (vi) any other duties the Blue Parties and Class Counsel agree in writing to assign to the Settlement Administrator. The fees and expenses of the Settlement Administrator shall be paid by the Blue Parties; provided that neither the Blue Parties nor Class Counsel shall be responsible for any other costs, expenses or liabilities of the Settlement Fund.

- (a) The portion of the Settlement Fund that will be available in the aggregate to satisfy claims by Retired Physicians (the “Retired Physician Amount”) shall be equal to the Settlement Fund multiplied by two times the quotient derived by dividing the number of Retired Physicians who file valid Claim Forms within ninety (90) days of the Notice Date by the total number of Class Members, as determined by the Settlement Administrator. Each Retired Physician who files a valid Claim Form shall be entitled to receive a payment equal to the Retired Physician Amount divided by the total number of Retired Physician valid Claim Forms. A Retired Physician who retired after January 1, 2003 shall have the option of filing either as a Retired Physician or as an Active Physician pursuant to the provisions of §8.3(c). If the claim of a Physician is unclear as to whether it is brought by a Retired Physician or as an Active Physician, the Settlement Administrator will treat the claim in the manner that will result in the largest payment to the Physician.
- (b) The amount remaining in the Settlement Fund after subtracting the Retired Physician Amount will be available to satisfy claims by Class Members other than Retired Physicians (the “Active Physician Amount”).
- (c) Each Active Physician who files a valid Claim Form within ninety (90) days of the Notice Date shall be entitled to receive payment from the Settlement Fund in an amount to be determined according to whether the Active Physician’s gross receipts for providing Covered Services to Plan Members during the three calendar year period of 2004, 2005 and 2006 were (x) less than \$5,000 or the Active Physician was a member of the settlement class in John R. Gregg, MD, et al v. Independence Blue Cross, et al, Robert P. Good MD v. Independence Blue Cross, et al, and Pennsylvania Orthopedic Society v. Independence Blue Cross, et al (“IBC Class Action Settlement”), who did not opt out of the IBC Class Action Settlement and who is relying solely on gross receipts for providing Covered Services to IBC Members to recover from the Settlement Fund, (y) at least \$5,000 but less than \$50,000, or (z) \$50,000 or greater. For purposes of this determination, gross receipts include amounts paid by Blue Plans or by Delegated Entities for providing Covered Services to Plan Members. The Settlement Administrator shall determine the category for each Active Physician based upon the certification in the Claim Form and/or such independent verification, if any, that the Settlement Administrator may undertake in its sole discretion.
- (d) The Settlement Administrator shall determine the total number of Active Physicians who fall within each of the three categories set forth in § 8.3(c) and determine the total number of distribution

shares (each a “Base Amount”) necessary to make distributions according to the following formula: The Active Physician Amount shall be allocated among all Active Physicians who file valid Claim Forms such that each Active Physician who falls within § 8.3(c)(x) shall be entitled to receive a single Base Amount; each Active Physician whose Claim Form establishes that he or she falls within § 8.3(c)(y) shall be entitled to receive five times the Base Amount; and each such Active Physician whose Claim Form establishes that he or she falls within § 8.3(c)(z) shall be entitled to receive ten times the Base Amount. A Class Member who files an otherwise valid Claim Form but does not specify a category of gross receipts for Covered Services to Plan Members, shall be deemed to be entitled to a single Base Amount, and the Settlement Administrator has no obligation to pursue additional information about the Class Member’s status or amount of receipts.

- (e) The Settlement Administrator shall establish procedures to permit an Active Physician to establish, through the submission of billing records or similar information, that he or she should fall into a category entitled to a higher payment from the Settlement Fund based on aggregate payments received for providing Covered Services to Plan Members over any other consecutive three-year period from January 1, 1997 through December 31, 2006.
- (f) If a Class Member submits a Claim Form requesting compensation under the wrong compensation category (e.g., a request under the Retired Physician Amount which should have been submitted as a request under the Active Physician Amount), the Settlement Administrator may at its sole discretion review the Claim Form under the provisions set forth herein for the correct settlement category unless the documentation submitted with said Claim Form is insufficient under those provisions.
- (g) Each Class Member who files a valid Claim Form may elect either to receive the payment from the Settlement Fund or to direct that such amount be contributed on his, her or its behalf to the Physicians’ Foundation for Health Systems Innovations, Inc. (“Foundation”) or to a charitable organization set forth on Exhibit L. The Foundation and the charitable organizations set forth on Exhibit L shall be identified on a list attached to the Claim Form.
- (h) An eligible Class Member must submit a timely claim form (the “Claim Form”) to the Settlement Administrator using the Claim Form attached as Exhibit A hereto and in accordance with the Claim Form Instructions attached as Exhibit B and included in the Notice and in the Claim Form in order for such Class Member to have a valid right to receive payment from the Settlement Fund. Promptly after receipt of all timely Claim Forms, the Settlement Administrator shall calculate the amount that is payable to, or on

behalf of, each Class Member pursuant to the provisions of § 8.3. Reasonably promptly upon completion by the Settlement Administrator of the calculations of the amounts that are payable and after all Settlement Fund Payments have been made, reserved for tax liabilities or as otherwise agreed by the Parties, the Settlement Administrator shall cause the Settlement Administration Account to disburse payment to Class Members in each category who or which submitted valid Claim Forms in accordance with § 8.3 or to the Foundation or to a charitable organization set forth on Exhibit L as directed by such Class Members. Any Class Member submitting a Claim Form shall, through the act of submitting that Claim Form, be subject to the jurisdiction of the Court for any related proceedings. Physician Groups and Physician Organizations shall be allowed to file Claim Forms on behalf of Physicians employed by or otherwise working with them at the time that the claims are made, without the necessity of individual signatures from the individual Physicians, but only if the Physician does not submit an individual claim on his/her own behalf. Notwithstanding the provisions in this § 8.3, an Active Physician Class Member against whom a Blue Plan has obtained a final finding of “fraud and/or abuse” from a judicial, arbitral, or governmental administrative proceeding and against whom that Blue Plan has obtained a corresponding final judgment for damages arising from a claim (or claims) for payment, during the same period for which claims may be asserted under § 8, shall not be entitled to receive payment from the Settlement Fund. For purposes of this § 8.3(h) only, the phrase “fraud and/or abuse” shall mean that the Active Physician Class Member engaged in any activities which are prohibited under 42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b, 1395nn, 1396b, 31 U.S.C. §§ 3729-3733, the federal CHAMPUS/TRICARE statute or other federal, state or local statutes or regulations related to the filing of false or fraudulent claims for payment for Covered Services or the making of false statements regarding the provision or payment of Covered Services. The prohibitions contained in these statutes or regulations include, but are not limited to, the following: (a) knowingly and willfully making or causing to be made a false statement or representation of a fact in any application for any benefit or payment; (b) knowingly and willfully making or causing to be made any false statement or representation of a fact for use in determining rights to any benefit or payment; (c) failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment on its own behalf or on behalf of another, with intent to fraudulently secure such benefit or payment; and (d) knowingly and willfully soliciting or receiving any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind or offering to pay or receive such remuneration, including, but not

limited to holding any financial interest in a provider of medical services that is prohibited under the federal law commonly referred to as the “Stark Law” (i) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare or Medicaid, or (ii) in return for purchasing, leasing, or ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part by Medicare or Medicaid. Each Blue Plan shall provide to the Settlement Administrator within ninety (90) days of the Notice Date the (i) name and tax identification number for each Class Member against whom the Blue Plan has obtained a finding of fraud and/or abuse from a judicial or administrative proceeding and (ii) the amount of the corresponding judgment for damages. A Blue Plan’s failure to provide such information to the Settlement Administrator may be deemed a waiver of its right to object to the payment from the Settlement Fund for those Class Member(s) for whom the Blue Plan failed to timely provide the requisite information. The foregoing limitation shall not act to reduce the aggregate amount of the Settlement Fund.

8.4 Reversion to Charitable Organizations of Unclaimed Amounts

At a reasonable time determined by the Settlement Administrator, but not less than 120 days after all payments have been disbursed to Class Members or contributed at the direction of Class Members, in each case pursuant to § 8.3 of this Agreement, the Settlement Administrator shall determine, with respect to Class Members within each state, the amount of unclaimed funds remaining in the Settlement Fund including un-cashed checks and interest earned on such funds, but excluding taxes owed on such earnings (the “Reversion Amounts”). The Settlement Administrator shall provide written notice of the Reversion Amounts to the Blue Parties and Class Counsel and, no later than twenty (20) business days after providing such written notice, the Settlement Administrator shall cause the Settlement Fund to remit the Reversion Amounts to one or more of the charitable organizations listed on Exhibit L within the applicable state or if there is none to the Foundation. Following the Settlement Administrator’s determination of the Reversion Amounts, stop payment orders may be placed on all unclaimed funds, and no Class Member shall have any claim on the Settlement Fund.

8.5 Payments of Interest

Each Settlement Fund Payment shall include interest at the Interest Rate accruing from the thirtieth (30th) day after the Preliminary Approval Date to the Effective Date, with no compounding.

8.6 Other Settlement Administration Provisions

- (a) The Parties and their respective counsel shall not have any responsibility for, interest in, or liability whatsoever with respect to: (i) the investment of or distribution of the Settlement Fund, (ii) the determination, administration, calculation, or payment of Claim Forms from the Settlement Fund, or (iii) any losses incurred in connection therewith.
- (b) No Person shall have any cause of action against the Representative Plaintiffs, Class Counsel, the Settlement Administrator, the Blue Parties, the Released Parties, or the Blue Parties' counsel, based on the administration or implementation of the Agreement or orders of the Court or based on the distribution of monies under the Agreement, and the Person's sole remedy (other than those provided pursuant to the terms of the Agreement), shall be by an application to the Court for enforcement of the Agreement pursuant to § 12.
- (c) The Settlement Administrator shall make appropriate reports on Internal Revenue Code Form 1099 with respect to all payments it makes to Class Members under this Agreement. The Settlement Administrator shall file any tax returns necessary with respect to any income earned by the Settlement Fund and shall pay, as and when legally required to do so, any tax payments (including interest and penalties) due on income earned by such Fund, and shall request refunds, when and if appropriate, and shall apply any such refunds that are issued to the Settlement Fund to become a part thereof (or, if refunds are received after distribution, to the Foundation).
- (d) If the Final Order and Judgment is set aside or reversed, in whole or in part, for any reason, then at such time as the time for any appeal from the final order of set aside or reversal has elapsed (including without limitation any extension of time for the filing of any appeal that may result by operation of law or order of the Court) with no notice of appeal having been filed, all funds in the Settlement Administration Account, including interest accrued thereon, shall be released forthwith to the Blue Plans in proportion to their respective payments.

9. Attorneys' Fees, Representative Plaintiffs' Fees and Fees for Representative Plaintiffs in Other Actions

9.1 The Blue Plans Shall Pay Attorneys' Fees

Class Counsel intend to apply to the Court for an award of Attorneys' Fees in an amount not to exceed \$50,168,365, (the "**Unopposed Amount**") which application the Blue Plans agree not to oppose. Each Blue Plan

shall pay a portion of the amount of the Attorneys' Fees awarded by the Court ("Attorneys' Fees") in proportion to the percentage assigned to the Blue Plan in Exhibit K. The Blue Plans' total payments of Attorneys' Fees shall not exceed the Unopposed Amount and shall be made in accordance with § 9.3 of this Agreement. If any Blue Plan terminates its participation in this Agreement pursuant to §14.2, the Unopposed Amount shall be reduced by the percentage assigned to the Blue Plan in Exhibit K. If the Court awards Attorneys' Fees in excess of the Unopposed Amount, Class Counsel, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The Attorneys' Fees agreed to be paid pursuant to this provision are in addition to and separate from all other consideration and remedies paid to and available to the Class Members. The Blue Plans shall not be obligated to pay any attorneys' fees or expenses incurred by or on behalf of any Releasing Party in connection with the Action, other than the payment of Attorneys' Fees in accordance with this § 9.1.

9.2 The Blue Parties Shall Pay Representative Plaintiffs' Fees

In addition to Attorney's Fees, Class Counsel intends to apply to the Court for an award of fees for each Representative Plaintiff in the amount of \$7,500, which application the Blue Parties agree not to oppose. The Blue Parties shall pay such fees, not later than ten (10) days after the Effective Date to Representative Plaintiffs in the amount awarded by the Court up to but not exceeding such unopposed amount. If the Court awards fees to Representative Plaintiffs in excess of \$7,500 each, Representative Plaintiffs, on behalf of themselves and the Class, hereby covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The fees to Representative Plaintiffs agreed to be paid pursuant to this § 9.2 are in addition to the other consideration afforded the Class Members. The Blue Parties shall support the award of fees to Representative Plaintiffs up to \$7,500 as reasonable and appropriate and shall not object to such request nor appeal an award up to that amount. The fees set forth in §§ 9.1 and 9.2 are the only consideration that Released Parties shall be obligated to give Class Counsel and the Representative Plaintiffs as a result of prosecuting and settling this Action, other than the additional express agreements made herein.

9.3 Timing of Fee Payments

Each Blue Plan shall wire transfer its portion of Attorneys' Fees to the trust account of Archie Lamb, PC, not later than ten (10) days after the Effective Date, with interest at the Interest Rate accruing from the thirtieth (30th) day following the Final Order Date to the Effective Date, with no compounding.

9.4 Fees to Representative Plaintiffs in Other Actions.

In addition to Attorney's Fees, Class Counsel intends to apply to the Court for an award of fees for each of the Representative Plaintiffs in Other Actions in the amount of \$7,500, which application the Blue Parties agree not to oppose. Those Blue Parties listed on Exhibit M shall pay such fees to the Representative Plaintiffs in Other Actions as designated on Exhibit M, not later than ten (10) days after the Effective Date in the amount awarded by the Court up to but not exceeding such unopposed amount. If the Court awards fees to Representative Plaintiffs in Other Actions in excess of \$7,500 each, Representative Plaintiffs in Other Actions, on behalf of themselves and the Class, shall covenant and agree to waive, release and forever discharge the amount of any such excess award and to make no effort of any kind or description ever to collect same. The fees to Representative Plaintiffs in Other Actions agreed to be paid pursuant to this § 9.4 are in addition to the other consideration afforded the Class Members. The Blue Parties shall support the award of fees to Representative Plaintiffs in Other Actions up to \$7,500 as reasonable and appropriate and shall not object to such request nor appeal an award up to that amount. Such fees are the only consideration that Released Parties shall be obligated to give Representative Plaintiffs in Other Actions, other than the additional express agreements made herein.

10. Application to Fully-Insured Plans and Self-Insured Plans

Section 7 of this Agreement applies to each Blue Plan's conduct with respect to both Fully-Insured Plans and Self-Insured Plans, except: (i) as otherwise specified in this Agreement, or (ii) as provided by applicable law, including, without limitation, fulfillment of a Blue Plan's obligations as a plan fiduciary in connection with any Plan subject to the requirements of ERISA.

11. Limited Liability

11.1 Settlement Implementation

The Billing Dispute External Reviewer, the Independent Review Organization or Organizations (and members and agents, if any), the Class Compliance Dispute Facilitator (and agents, if any), the Blue Compliance Dispute Facilitators (and agents, if any), and the Compliance Dispute Officer (and agents, if any) (including, in the case of individual Compliance Dispute Facilitators and/or Compliance Dispute Officers, selected in accordance with § 12.7) do not owe a fiduciary duty to the Parties, and the Parties shall ask the Court to grant such persons limited immunity from liability for their actions under this Agreement, except for any willful misconduct or gross negligence.

11.2 Blue Parties

The liability of each Blue Party under this Agreement shall be several. No breach of a several obligation by a Blue Party shall result in any liability to any other Blue Party or provide any basis for any compliance action or other remedy against any other Blue Party.

12. Compliance Disputes Arising Under This Agreement

12.1 Jurisdiction, Coordination and Costs

(a) Compliance Dispute Facilitators

Class Counsel shall appoint a Class Compliance Dispute Facilitator (the “**Class Compliance Dispute Facilitator**”) to facilitate any disputes initiated by a Class Member within sixty (60) days after the Final Order Date. The Blue Parties shall appoint a Blue Compliance Dispute Facilitator (the “**Blue Compliance Dispute Facilitator**”) to facilitate the resolution of any disputes within sixty (60) days after the Final Order Date; provided, however, that the Parties agree to hold any Compliance Dispute in abeyance until such time as each of the Parties’ respective Compliance Dispute Facilitator and/or Compliance Dispute Officer has/have been appointed. All compliance dispute resolutions without full review under § 12.5 below shall be addressed by the Class Compliance Dispute Facilitator and the Blue Compliance Dispute Facilitator.

(b) Compliance Dispute Officer.

Class Counsel and the Blue Parties shall agree upon a Compliance Dispute Officer (the “**Compliance Dispute Officer**”) within sixty (60) days after the Final Order Date.

All Compliance Dispute resolutions with full review under § 12.6 below shall be directed to the Compliance Dispute Officer. Compliance Disputes shall not be directed to the Court nor to any other state court, federal court, arbitration panel or any other binding or non-binding dispute resolution mechanism, except as provided in this Agreement.

One year after any Compliance Dispute Officer is appointed, either of Class Counsel or the Blue Parties may request the appointment of a new Compliance Dispute Officer. Class Counsel and the Blue Parties will agree upon a new Compliance Dispute Officer within thirty (30) days of any such request.

(c) Program Title

The compliance dispute program set forth in § 12.1 through § 12.6 shall be referred to as the “Joint Compliance Dispute Program”.

(d) Fees and Costs

The Blue Parties shall pay the reasonable fees and expenses of the Compliance Dispute Officer, the Class Compliance Dispute Facilitator and the Blue Compliance Dispute Facilitator.

12.2 Who May Petition the Compliance Dispute Officer

Class Compliance Dispute Facilitator may petition the Compliance Dispute Officer on behalf of any Class Member or Signatory Medical Society.

12.3 Procedure for Initiating Compliance Disputes

To initiate a Compliance Dispute, a Class Member or Signatory Medical Society shall submit a completed Compliance Dispute Claim Form, attached hereto as Exhibit C, to the Class Compliance Dispute Facilitator. The Class Compliance Dispute Facilitator shall provide a copy of the completed Compliance Dispute Claim Form to the Blue Party's Compliance Dispute Facilitator.

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12.5 Dispute Resolution Without Full Review

- (a)** If the Class Compliance Dispute Facilitator, in its sole judgment, determines that a dispute initiated by a Class Member or Signatory Medical Society is frivolous or the actual harm suffered is de minimis, it shall notify the Class Member or Signatory Medical Society and notify the affected Blue Compliance Dispute Facilitator that there will be no further proceedings on such dispute.
- (b)** If the Class Compliance Dispute Facilitator, in its sole judgment, determines a dispute initiated by a Class Member or Signatory Medical Society requires full review (without any other attempt at resolution), it shall immediately refer the dispute to the Compliance Dispute Officer for full review and shall notify the Class Member or Signatory Medical Society and the Blue Compliance Dispute Facilitator of this referral.
- (c)** If the Class Compliance Dispute Facilitator, in its sole judgment, determines a dispute initiated by a Class Member or Signatory Medical Society may be resolved without full review, the Class Compliance Dispute Facilitator and the Blue Compliance Dispute Facilitator shall assist in an attempt to achieve a resolution of the dispute agreed to by the Class Member or Signatory Medical Society and the affected Blue Party. All parties to such dispute agree to assist the Class Compliance Dispute Facilitator and the

Blue Compliance Dispute Facilitator in such efforts. If such efforts do not achieve resolution of the dispute within sixty (60) days after submission of the Compliance Dispute Claim Form, the Class Compliance Dispute Facilitator shall refer the dispute to the Compliance Dispute Officer for full review and shall notify the Class Member or Signatory Medical Society and the Blue Compliance Dispute Facilitator of this referral.

12.6 Dispute Resolution With Full Review

(a) Requirements for a Compliance Dispute With Full Review.

Following the procedure set forth in § 12.5, to receive full review, a Compliance Dispute must meet the following requirements:

- (i) A Class Member or Signatory Medical Society submitted a properly completed Compliance Dispute Claim Form to the applicable Compliance Dispute Facilitator not later than ninety (90) days after such Compliance Dispute arose or reasonably could be known, whichever is later; and
- (ii) The Compliance Dispute Officer, in its sole judgment, determines that the Compliance Dispute:
 - (1) alleges a failure by a Blue Party to comply with an obligation under Section 7 of this Agreement; and
 - (2) is not properly the subject of a proceeding under §§ 7.10 or 7.11 of this Agreement;

(b) Memoranda to Compliance Dispute Officer.

- (i) The Compliance Dispute Officer shall in writing request memoranda from the parties to the Compliance Dispute regarding the merits of the dispute and appropriate remedies. The complaining Class Member or Signatory Medical Society shall have fifteen (15) days from the date of such request to submit its memorandum, and the other party shall submit its memorandum in response within fifteen (15) days after receipt of the complaining Class Member's or Signatory Medical Society's memorandum.
- (ii) In the event that the Compliance Dispute relates to the Blue Plan's compliance with § 7.8(d)(ii) of this Agreement, the Blue Plan may present directly to the Compliance Dispute Officer *ex parte* and *in camera* the Blue Plan's arguments in support of the Clinical Information submission request, including, where applicable, arguments that the Blue Plan

is invoking its right to obtain Clinical Information pursuant to § 7.8(d)(ii) because the Blue Plan has a reasonable basis for believing that an investigation of fraudulent or abusive (whether intentional or unintentional) billing practices is warranted. The Compliance Dispute Officer shall not disclose any information designated as “Confidential” by the Blue Plan.

(c) Oral Argument of Compliance Dispute.

The Compliance Dispute Officer, at its sole option, may request the parties to the Compliance Dispute to present oral argument of the Compliance Dispute at a time and place agreed to by the parties to the Compliance Dispute and the Compliance Dispute Officer.

(d) Decisions by the Compliance Dispute Officer.

- (i) In resolving a Compliance Dispute, the Compliance Dispute Officer shall provide a written decision, made in its sole judgment and based only on the Compliance Dispute Claim Form with supporting documents and testimony by affidavit, memoranda, and any oral argument, determining whether the affected Blue Party has failed to comply with its obligations under § 7 of this Agreement, and if so, directing what actions are to be taken by the affected Blue Party to fulfill its obligations under § 7 of this Agreement.
- (ii) In the event that the Compliance Dispute relates to the Blue Plan’s compliance with § 7.8(d)(ii), the Compliance Dispute Officer’s written decision to the parties to the Compliance Dispute shall state only that (a) the Blue Plan has complied with § 7.8(d)(ii) and the matter is thus closed, or (b) that the Blue Plan has not complied with § 7.8(d)(ii) and the requirement for submission of Clinical Information is to cease, as to that dispute. This limitation on the content of the Compliance Dispute’s written opinion applies to all Compliance Disputes relating to the Blue Plan’s compliance with § 7.8(d)(ii), regardless of whether the Compliance Dispute involves a Clinical Information submission request in connection with a Blue Plan’s investigation of fraudulent or abusive billing practices. In the event that the Blue Plan has invoked its right to obtain Clinical Information, pursuant to § 7.8(d)(ii), because the Blue Plan has a reasonable basis for believing that an investigation of fraudulent or abusive (whether intentional or unintentional) billing practices is warranted, the Compliance Dispute Officer’s sole responsibility in these

circumstances shall be to make a determination as to whether the Blue Plan has a reasonable basis for its belief.

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(f) Systemic Remedy

If the Compliance Dispute Officer determines, after adequate notice and a reasonable opportunity to respond consistent with this § 12, that the affected Blue Party has not fulfilled its obligations under § 7 of this Agreement with respect to other Class Members beyond the complaining Class Member or Signatory Medical Society in the Compliance Dispute, the Compliance Dispute Officer may order appropriate remedies only as necessary and designed to obtain compliance with the terms of this Agreement.

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

The Parties agree that the decision of the Compliance Dispute Officer shall be final unless appealed to the Court. The Parties further agree that the scope of review by the Court shall be limited to whether the Compliance Dispute Officer's final decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," as defined by 5 U.S.C. § 706(2)(A). If the Court finds such final decision was "arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law", the Court may remand the Compliance Dispute to the Compliance Dispute Officer for further proceedings.

(h) Enforcement by the Court.

If the Compliance Dispute Officer determines that the affected Blue Party has not complied with its final decision, it shall provide written notice of such noncompliance to the affected Blue Party. If the affected Blue Party does not comply within thirty (30) days from the date of such notice, the Compliance Dispute Officer shall provide written notice to the Class Member or Signatory Medical Society in the Compliance Dispute, and the Class Member or Signatory Medical Society may petition the Court for enforcement.

12.7 Individual Plan Compliance Dispute Program

The Blue Parties listed on Exhibit P will use an individual plan compliance dispute program that follows the requirements set out in §§12.1 through 12.6 above, except each listed Blue Party and Class Counsel shall agree upon an individual Compliance Dispute Officer and each will select an individual Compliance Dispute Facilitator in accordance with the requirements in section 12.1.

The Blue Parties that use an individual plan compliance dispute program may not use the Joint Compliance Dispute Program, unless agreed to in writing by Class Counsel.

12.8 Compliance Reporting.

- (a) During the Effective Period, each Blue Party shall provide to a designated Blue Compliance Reporting Officer at BCBSA information regarding its compliance with the obligations set forth in § 7 of this Agreement. Each Blue Plan will take steps reasonably necessary to monitor and certify its compliance with this Agreement and will designate an appropriate representative to be responsible for this activity. Within thirty (30) days after the end of each calendar year beginning in 2008, during the applicable Effective Period, the Blue Compliance Reporting Officer shall provide a written summary report of such information to the Compliance Dispute Officer. A copy of this report shall be provided by the Compliance Dispute Officer to any Party upon request. The summary report will contain the following information from each Blue Plan:

7.5	Blue Plan’s standard Precertification lists
7.6	Blue Plan’s list of material adverse changes
7.8(b)	Blue Plan’s list of efforts to cause its claims payment systems to be consistent within each state in which the Blue Plan operates
7.8(d)	Blue Plan’s list of Significant Edits
7.8(d)(i)	Blue Plan’s list of customized Edits added to any standard claims editing software product at Blue Plan’s request
7.8(d)(ii)	Blue Plan’s list of categories of claims for which there is routine review of Clinical Information
7.8(d)(iii)	Blue Plan’s list of any circumstances where particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers
7.9(b)	Blue Plan’s list of the dates of meetings of the Physician Advisory Committee and the members of the Physician Advisory Committee

7.10(f)	Blue Plan's list of decisions issued by the Billing Dispute External Reviewer which required payment by the Blue Plan
7.16(a)	Blue Plan's list of the number of Adverse Determinations sent to External Review for final determination for the preceding calendar year and the percentage of such Adverse Determinations that are reversed.
7.23	Blue Plan's list of actions to improve accuracy of information about eligibility of Plan Members
7.31	Blue Parties' approximate aggregate amount spent as provided in § 7.31 to be filed no later than thirty (30) days prior to the Termination Date.

- (b) A Blue Party may elect not to participate in the joint compliance reporting program set out in § 12.8(a) above, and instead establish its own individual plan compliance reporting program, except for the reporting of information relating to compliance with § 7.31, which shall be included in the report filed under § 12.8(a). All Blue Parties electing to have an individual plan compliance reporting program are on the list attached as Exhibit Q. Each Blue Party electing to use an individual plan compliance reporting program will designate a local compliance reporting officer who will follow the requirements and procedures as set out for the joint compliance reporting program in § 12.8(a) above.

12.9 Compliance Monitoring

For purposes of monitoring compliance with this Agreement, each Blue Plan shall allow the Compliance Dispute Officer and the Class Compliance Dispute Facilitator access to its Provider Website; provided, however, that such access shall not include access to Physician fee schedules and protected health information as defined by HIPAA.

12.10 Compliance Dispute/Negotiated Purchaser Designation

- (a) In the event that a Compliance Dispute is brought by the Class Compliance Dispute Facilitator, regarding a term or condition subject to § 7.36(a), the matter shall be submitted directly to the Compliance Dispute Officer. The Blue Plan may present directly to the Compliance Dispute Officer with a copy to the Class Compliance Dispute Facilitator, on a confidential basis, the Blue Plan's reasons for its action, including that the purchaser qualifies

as a Negotiated Purchaser as defined in § 7.36(a)(i) and that the term or condition was reasonably necessary to obtain or maintain the service agreement or insurance contract. The Class Compliance Dispute Facilitator may respond to the submission of the Blue Plan within five (5) business days of receipt of a copy of the submission. The Compliance Dispute Officer's decision shall be limited to whether the purchaser is a Negotiated Purchaser, whether the term or condition was reasonably necessary, and, as a result, whether the term or condition is permitted under § 7.36. The Compliance Dispute Officer and the Class Compliance Dispute Facilitator shall not disclose any information that the Blue Plan has submitted as confidential. The Class Compliance Dispute Facilitator may confer with one or more of Class Counsel in connection with the dispute if the Class Compliance Dispute Facilitator does not disclose any confidential information, or if the Class Counsel involved agrees to keep the information confidential.

- (b) The Compliance Dispute Officer shall render a final decision within ten (10) days following submission of information required by the Blue Plan under § 7.36(a). If the Compliance Dispute Officer rules against the Blue Plan, any remedy shall be limited to directing the Blue Plan to submit and implement an adequate corrective action plan, and imposing on the Blue Plan the obligation to pay actual damages including interest suffered by a Class Member as a result of the implementation of any modification. Any activity conducted by a Blue Plan under a corrective action plan shall be subject to the provisions of §13.3(a)(iii). The Class Compliance Dispute Facilitator may confer with and seek the assistance of Class Counsel in connection with any such dispute.

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

13.1 Discharge of All Released Claims

- (a) Upon the Effective Date, the “**Released Parties**,” which shall include the Blue Parties and each of their present and former parents, divisions and Affiliates and each of their respective current or former officers, directors, employees, agents, insurers and attorneys (and the predecessors, heirs, executors, administrators, legal representatives, successors and assigns of each of the foregoing), and all Persons who provided claims processing services, software, proprietary guidelines or technology to the Blue Parties, their subsidiaries or Affiliates, and those contracted agents processing claims on their behalf (including, without limitation, NASCO), together with each such Person’s predecessors or successors (but only to the extent of such Person’s services and work was done pursuant to contract with the Blue

Parties or their subsidiaries or Affiliates), but excluding all Delegated Entities, shall be released and forever discharged by the Signatory Medical Societies and all Class Members, and by their respective current and former officers, directors, employees, attorneys, heirs, executors, administrators, agents, legal representatives, professional corporations, partnerships, assigns and successors, but only to the extent claims are derived by contract or operation of law from the claims of Class Members, (collectively, the “**Releasing Parties**”) from any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys’ fees, losses, claims, liabilities and demands of whatever kind, source or character whether arising under any federal or state law, which (consistent with the Parties’ understanding of the settlements in Shane) includes, but is not limited to, the Racketeer Influenced and Corrupt Organizations Act, antitrust and other statutory and common law claims, intentional or non-intentional, (each a “**Claim**”), arising on or before the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, business practices, representations, omissions, circumstances or other matters referenced in the Action, or addressed in this Agreement, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons, or to the business practices that are the subject of § 7. This includes, without limitation and as to Released Parties only, any aspect of any fee for service claim submitted by any Class Member to a Blue Plan, and any claims of any Class Member related to or based upon any Capitation agreement between a Blue Plan and any Class Member or other Person or entity, or the delay, nonpayment or amount of any Capitation payments by a Blue Plan, and any allegation that any Blue Party has conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, Delegated Entities and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, business practices, representations, omissions, circumstances or other matters related to the Action, or with regard to any Blue Party’s liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, Delegated Entities and/or other third parties.

- (b) Except for Claims for damages against defendants in the Action that are not Parties relating to providing Covered Services to Blue Plans’ Plan Members in connection with the BlueCard Program and other similar national account delivery programs governed by BCBSA (including but not limited to NASCO-to-NASCO

arrangements), the Releasing Parties further agree to forever abandon and discharge any and all Claims that exist now or that might arise in the future against any other Persons which Claims arise from, or are based on, conduct by any of the Released Parties that occurred on or before the Effective Date and are, or could have been, alleged in the Complaint, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons. Nothing in this Agreement is intended to relieve any Person or entity that is not a Released Party from responsibility for its own conduct or conduct of other Persons who are not Released Parties, or to preclude any Representative Plaintiff from introducing any competent and admissible evidence to the extent consistent with §§ 14 and 16.

- (c) Any Claims released or discharged pursuant to §§ 13.1(a) or 13.1(b), subject to the exception regarding Retained Claims contained in § 13.6, shall be referred to as “**Released Claims.**”

13.2 Covenant Not to Sue

- (a) The Releasing Parties and each of them agree and covenant not to sue or prosecute, institute or cooperate in the institution, commencement, filing, or prosecution of any suit or proceeding in any forum based upon or related to any Released Claims against any Released Party.
- (b) Notwithstanding any other provision of this Agreement (including, without limitation, this § 13.2), nothing in this Agreement shall be deemed to in any way impair, limit, or preclude the Releasing Parties’ rights to enforce any provision of this Agreement, or any court order implementing this Agreement, in a manner consistent with the terms of the Agreement.

13.3 Bar Order

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

- (a) The Releasing Parties are permanently enjoined from: (i) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on any or all Released Claims against one or

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

- (b) All Persons who are, have been, could be, or could have been alleged to be joint tortfeasors, co-tortfeasors, co-conspirators, or co-obligors with the Released Parties or any of them respecting the Released Claims or any of them, are hereby, to the maximum extent permitted by law, barred and permanently enjoined from making, instituting, commencing, prosecuting, participating in or continuing any Claim, claim-over, cross-claim, action, or proceeding, however denominated, regardless of the allegations, facts, law, theories or principles on which they are based, in this Court or in any other court or tribunal, against the Released Parties or any of them with respect to the Released Claims, including without limitation equitable, partial, comparative, or complete contribution, set-off, indemnity, or otherwise, whether by contract, common law or statute, arising out of or relating in any way to the Released Claims. All such claims are hereby fully and finally barred, released, extinguished, discharged, satisfied and made unenforceable to the maximum extent permitted by law, and no such claim may be commenced, maintained, or prosecuted against any Released Party. Any judgment or award obtained by a Class Member against any such Person shall be reduced by the amount or percentage, if any, necessary under applicable law to relieve any Released Party of all liability to such Person on such barred claims. Such judgment reduction, partial or complete release, settlement credit, relief, or setoff, if any, shall be in an amount or percentage sufficient under applicable law as determined by the Court to compensate such Person for the loss of any such barred claims against any Released Party. Where the claims of a Person who is, has been, could be, or could have been alleged to be a joint tortfeasor, co-tortfeasor, co-conspirator or co-obligor with a Released Party respecting the Released Claims have been barred and permanently enjoined by this § 13.3, the claims of Released Parties against that Person respecting those Released Claims are similarly fully and finally barred, released, extinguished,

discharged, satisfied and made unenforceable to the maximum extent permitted by law.

13.4 Dismissal With Prejudice

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

13.5 Waiver of California Civil Code § 1542 and Similar Provisions

With respect to all Released Claims, the Releasing Parties and each of them agree that they are expressly and unconditionally waiving and relinquishing to the fullest extent permitted by law:

- (a) the provisions, rights and benefits conferred by § 1542 of the California Civil Code, which provides:

“A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR”, and

- (b) any law of any state or territory of the United States, federal law or principle of common law, or of international or foreign law, which is similar, comparable or equivalent to § 1542 of the California Civil Code. Each Class Member and each Signatory Medical Society may hereafter discover facts other than or different from those which he, she or it knows or believes to be true with respect to the Claims which are the subject matter of the provisions of § 13, but each such Class Member and each Signatory Medical Society hereby expressly and unconditionally waives and fully, finally and forever settles and releases, upon the entry of Final Order and Judgment, any known or unknown, suspected or unsuspected, contingent or non contingent Claim, with respect to the subject matter of the provisions of § 13, whether or not concealed or hidden, without regard to the discovery or existence of such different or additional facts.

13.6 Retained Claims

Notwithstanding the foregoing, the Releasing Parties are not releasing claims for payment (each a “**Retained Claim**” and, collectively, the “**Retained Claims**”) for Covered Services provided to Plan Members

prior to or on the Effective Date as to which, as of the Effective Date: (i) no claim with respect to such Covered Services has been submitted to a Blue Plan, provided that the applicable period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with a Blue Plan but such claim has not been finally adjudicated by the Blue Plan. For purposes of clause (ii), above, final adjudication shall mean completion of the Blue Plan's internal appeals process. In the event that a claim referred to in clause (ii) is finally adjudicated less than thirty (30) days prior to the Effective Date, such claim shall constitute a Retained Claim if a Physician seeks relief under § 7.10 not later than ninety (90) days after notice of such final adjudication, but otherwise such claim shall constitute a Released Claim. Disputes relating to Retained Claims shall be resolved exclusively pursuant to the appropriate remedial provisions of this Agreement.

13.7 Covenant Not to Sue on Retained Claims and Compliance Disputes

Upon the Effective Date and through the Termination Date, the Releasing Parties and each of them agree and covenant not to sue or prosecute, institute or cooperate in the institution, commencement, filing, or prosecution of any suit or proceeding against any Released Party, in any forum (i) any Retained Claim or (ii) any Compliance Dispute (whether or not asserted), which respectively shall be asserted and pursued only pursuant to Sections 12 and 13.6 of this Agreement. This § 13.7 shall not apply to: (i) any claims that arise within twenty (20) days before the Termination Date that could not reasonably be presented or resolved pursuant to the procedures set forth in this Agreement; provided that any such claim shall be prosecuted on an individual basis only and not otherwise; or (ii) any remedy under a state or federal law or applicable regulation elected by a Physician pursuant to § 7.29(m).

13.8 Non-Released Persons and Non-Released Claims

- (a) Nothing in this Agreement is intended to relieve any Person that is not a Released Party from responsibility for its own conduct or conduct of other Persons who are not Released Parties for claims that are not Released Claims. Nothing in this Agreement is intended to preclude any Representative Plaintiffs from introducing any competent and admissible evidence to the extent consistent with §§ 14 and 16.
- (b) Except as provided in § 13.1, nothing in this Agreement prevents the Representative Plaintiffs and the Class from pursuing claims to hold any Person that is not a Released Party liable for damages caused by that Person's conduct in a conspiracy involving any Released Party.

13.9 Irreparable Harm

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

13.10 Legislative Changes

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

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

14.1 Suspension of Discovery and Other Proceedings

- (a) Except as set forth in Exhibit O with respect to BCBSA, upon execution of this Agreement, the Releasing Parties and Class Counsel shall discontinue all discovery activity or related proceedings in the Action against the Released Parties, provided that if this Agreement is terminated pursuant to § 14.2 as to a Blue Party, the Releasing Parties and Class Counsel may pursue discovery or related proceedings solely against the Blue Party as to which the Agreement is terminated and any defendant in this Action that has not settled. Where a Blue Plan provides or has provided claims processing services for a non-settling defendant or a Terminating Blue Plan, and such Blue Plan is in the possession of that non-settling defendant's or Terminating Blue Plan's claims data pursuant to the provision of those services, the foregoing sentence shall not prevent the Releasing Parties or Class Counsel from obtaining discovery of those claims data pursuant to a discovery request issued to the non-settling defendant or Terminating Blue Plan. Notwithstanding the foregoing, nothing herein shall require a Blue Plan to provide any data concerning any of its claims, including, but not limited to, claims under the BlueCard Program or any similar national account delivery program governed by BCBSA (including but not limited to NASCO-to-NASCO arrangements).
- (b) Upon entry of the Preliminary Approval Order, the Releasing Parties and Class Counsel agree to suspend and stay all proceedings in the Action against the Released Parties, other than proceedings as may be necessary to carry out the terms and conditions of the Agreement. The Preliminary Approval Order shall also bar and enjoin all Class Members from commencing or prosecuting any action asserting any Released Claims, and stay any other actions or proceedings brought by any Class Members

asserting any Released Claims. If, and only to the extent that, this Agreement terminates pursuant to § 14.2 of this Agreement, the Parties shall not be deemed to have waived any rights as a result of such suspension or stay of proceedings.

- (c) Upon the Effective Date, and notwithstanding any of the other provisions in this Agreement, the Released Parties shall have no obligation to preserve documents and evidence with respect to Released Claims, including any obligations under the Agreed Order for Preservation of Records, and the Releasing Parties and Class Counsel shall not pursue any spoliation claims or other actions or sanctions against a Released Person with respect to documents or evidence related to the Released Claims.

14.2 Right to Terminate this Agreement

- (a) If, at the Preliminary Approval Hearing or within thirty (30) days thereafter, the Court does not enter the Preliminary Approval Order and approve the Claim Form, Claim Form Instructions, Mailed Notice, and the Published Notice submitted to the Court pursuant to § 4 of this Agreement, in each case in substantially the same form as Exhibits A, B, E, and G, any Party shall have the right, in the sole and absolute discretion of such Party, to terminate its participation in this Agreement by delivering a notice of termination to the other Parties within forty-five (45) days following the Preliminary Approval Hearing.
- (b) If the Court does not grant the stay and injunctions as provided in § 14.1(b) and the interim injunction with respect to the Tag Along Actions, as provided in § 15.1, each in the form contained in the Preliminary Approval Order (Exhibit F), each Blue Party may in its sole and absolute discretion terminate its participation in this Agreement by delivering a notice of termination to the other Parties within forty-five (45) days following the Preliminary Approval Hearing.
- (c) If the number of putative Class Members submitting Opt-Out requests exceeds five percent (5%) of the total number of putative Class Members in the United States, each Blue Party may in its sole and absolute discretion terminate its participation in this Agreement by delivering a notice of termination to the other Parties within thirty (30) days of receipt of the complete list of Opt-Out requests from the Notice Administrator referred to in § 6.
- (d) If the number of putative Class Members in any Blue Plan's service area within a state submitting Opt-Out requests exceeds five percent (5%) of the total number of putative Class Members in that Blue Plan's service area within that state, except as provided

in Exhibit H, the affected Blue Plan may in its sole and absolute discretion terminate its participation in this Agreement by delivering a notice of termination to the other Parties within thirty (30) days of receipt of the complete list of Opt-Out requests from the Notice Administrator referred to in § 6.

- (e) If the putative Class Members in any Blue Plan's service area submitting Opt-Out requests received, in the aggregate, at least five percent (5%) of the total dollar payments that such Blue Plan made to putative Class Members in calendar year 2006, the affected Blue Plan may in its sole and absolute discretion terminate its participation in this Agreement by delivering a notice of termination to the other Parties within thirty (30) days of receipt of the complete list of Opt-Out requests from the Notice Administrator referred to in § 6.
- (f) If the Court has not entered the Final Order and Judgment substantially in the forms attached hereto as Exhibit D by the date that is 180 days after the Preliminary Approval Date, any Party may, in its sole and absolute discretion, terminate its participation in this Agreement by delivering a notice of termination to the other Parties within 200 days after the Preliminary Approval Date.
- (g) If more than twenty-five percent (25%) of the total number of Blue Parties validly terminate their participation in this Agreement pursuant to this § 14.2, Class Counsel and each of the remaining Blue Parties may in its sole and absolute discretion terminate its participation in this Agreement by delivering a notice of termination to the other Parties, within thirty (30) days following the last date on which a termination notice may be provided under §§ 14.2(a)-(f) of this Agreement.
- (h) In the event of any termination of the Agreement in its entirety by Class Counsel or all Blue Parties collectively pursuant to the terms of this § 14.2, the Parties shall be restored to their original positions, except as expressly provided herein. In the event of any termination of individual participation in the Agreement by any Blue Plan (a "**Terminating Blue Plan**"), the Terminating Blue Plan, the Releasing Parties and Class Counsel shall be restored to their original positions, except as expressly provided herein.

14.3 Intentionally Left Blank

14.4 Effective Date

If the Final Order and Judgment is entered by the Court and the time for appeal from all of such orders and judgment has elapsed (including without limitation any extension of time for the filing of any appeal that

may result by operation of law or order of the Court) with no notice of appeal having been filed, the “**Effective Date**” shall be the next business day after the last date on which notice of appeal could have been timely filed. If the Final Order and Judgment is entered and an appeal is filed as to any of them, the “**Effective Date**” shall be the next business day after the Final Order and Judgment is affirmed, all appeals are dismissed, and no further appeal to, or discretionary review in, any court remains. Notwithstanding the foregoing, at any time after the Final Order and Judgment is entered by the Court but before the Effective Date would otherwise occur, any Blue Party may in its sole and absolute discretion elect to declare that the Effective Date for its participation in this Agreement has occurred by providing notice to the Parties, and thereafter that electing Blue Party, Class Counsel and the Releasing Parties shall 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.

14.5 Intentionally Left Blank

14.6 Termination Date of Agreement

- (a) This Agreement shall terminate (the “**Termination Date**”) upon the earliest to occur of (i) as to a Party, that Party’s termination of this Agreement pursuant to § 14.2, above, (ii) the date on which the appellate court rejects, in whole or in part, the Final Order and Judgment, upon any appeal or discretionary review thereof, and no further appeal to, or discretionary review in, any court remains, or (iii) the four year anniversary of the Preliminary Approval Date. As of the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability under this Agreement on the part of any of the Parties, except for willful or knowing breaches of this Agreement prior to the Termination Date; provided that in the event of a termination of this Agreement under clause (iii) of this § 14.6(a), (x) the provisions of §§ 13.1, 13.2, 13.3, 13.4, 13.5, 13.7, 13.8, 14.1, 15 and 16, shall survive such termination indefinitely, (y) the provisions of § 7.10 and § 7.11 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing Disputes that are in the process of being resolved as of the Termination Date and any disputes described in § 7.11 as of the Termination Date, and (z) the provisions of §§ 12.1 through 12.6 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Compliance Disputes involving a Blue Plan that are in the process of being resolved by the Compliance Dispute Officer as of the Termination Date.

- (b) On the Termination Date, all of a Blue Party's obligations under this Agreement shall be deemed satisfied except as and only to the extent that a term of § 7 of this Agreement has been extended by the Blue Party as provided in this § 14.6(b) as to that Blue Party only. No decision or ruling of the Compliance Dispute Officer shall have any force on the Parties after the Termination Date, and the Blue Parties shall be under no obligation to continue performance of any kind under this Agreement. A Blue Party may, in its sole and absolute discretion, elect to continue after the Termination Date, the implementation of various business practices described in this Agreement. A Blue Party also may, where it has a good faith basis, and notwithstanding any Implementation Date in § 7 of this Agreement or in Exhibit I hereto, delay the implementation, in whole or in part, of any provision of this Agreement upon notice to Class Counsel. Whether or not the foregoing notice is provided, in the event that implementation is delayed other than as provided in § 7, the term of the Agreement shall be extended solely with respect to the delayed provision for a period of time equal to the length of the delay.

15. Related Actions

15.1 Ordered Stays and Dismissals in Tag-Along Actions

As to any action brought by or on behalf of Class Members that asserts any claim that as of the Effective Date would constitute a Released Claim against any Blue Parties, other than the Action, that has been, or will in the future, be designated as a tag-along action or consolidated with the Provider Track actions under MDL Docket No. 1334 (the “**Tag-Along Actions**” (a list of such pending Tag-Along Actions is attached hereto as Exhibit N to this Agreement)), Class Counsel and relevant Parties shall cooperate to obtain an order of the Court, to be included in the Preliminary Approval Order, providing for the interim stay of all proceedings as to any Blue Parties in each such action pending entry of the Final Order and Judgment. In addition, no later than ten (10) business days after the Effective Date, Class Counsel and relevant Parties will submit an order of dismissal with prejudice as to any Blue Parties for each such pending Tag-Along Action on Exhibit N; provided that no such dismissal order shall be sought with respect to any Tag-Along Action with respect to any named plaintiff that has submitted a valid and timely Opt-Out request.

15.2 Certain Related State Court Actions

As to any action that is now pending in, or hereafter may be filed in or remanded to, any state court that asserts any Released Claim against any Blue Party on behalf of any Releasing Party, Class Counsel and the relevant Parties agree that they will cooperate with the Blue Party and file all documents necessary (a) to obtain an interim stay of all proceedings

against the Blue Party and (b) on or promptly after the Effective Date, to obtain the dismissal with prejudice of any such action, other than with respect to any named plaintiff in such action that has submitted a valid and timely Opt-Out request.

15.3 Other Related Actions

As to any action not referred to in §§ 15.1 or 15.2 that is now pending or hereafter may be filed in any court that asserts any of the Released Claims against any Blue Parties on behalf of any Releasing Party, Class Counsel and the relevant Parties agree that they will cooperate with the Blue Party, to the extent reasonably practicable, in the Blue Party's efforts to seek relief from the Court or the forum court to obtain the interim stay and dismissal with prejudice of such action as to any Blue Parties to the extent necessary to effectuate the other provisions of this Agreement.

16. Not Evidence; No Admission of Liability

In no event shall this Agreement, in whole or in part, whether effective, terminated, or otherwise, or any of its provisions or any negotiations, statements, or proceedings relating to it in any way be construed as, offered as, received as, used as or deemed to be evidence of any kind in the Action, in any other action, or in any judicial, administrative, regulatory or other proceeding, except the Agreement may be used 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 Blue Parties, the Representative Plaintiffs, or the Signatory Medical Societies, or as a waiver by the Blue Parties, the Representative Plaintiffs or the Signatory Medical Societies of any applicable defense, including without limitation any applicable statute of limitations. None of the Parties waives or intends to waive any applicable attorney-client privilege or work product protection or other privilege for any negotiations, statements or proceedings relating to this Agreement. This provision shall indefinitely survive the termination of this Agreement.

17. Entire Agreement; Amendment

17.1 Entire Agreement

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

or this Agreement. This Agreement shall not be modified in any respect except by a writing executed by Class Counsel and each of the Blue Parties, except as provided in § 17.2.

17.2 Modification Generally

This Agreement may be amended or modified with respect to a particular Blue Party only as provided in a written instrument signed by or on behalf of that Blue Party and Class Counsel (or their successors in interest), or as set forth in § 7.36.

17.3 Intentionally Left Blank

18. No Presumption Against Drafter

None of the Parties shall be considered to be the drafter of this Agreement or any provision hereof for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Agreement was drafted with substantial input by all Parties and their counsel, and no reliance was placed on any representations other than those contained herein. The Parties agree that this fully integrated Agreement shall be construed by its own terms and not by referring to, or considering, the terms of any other settlement agreement between plaintiffs and another defendant in the Action or Shane.

19. Captions and Headings

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

20. Continuing Jurisdiction and Exclusive Venue

20.1 Continuing Jurisdiction

Except as otherwise provided in this Agreement, it is expressly agreed and stipulated that the United States District Court for the Southern District of Florida shall have exclusive jurisdiction and authority to consider, rule upon, and issue a final order with respect to proceedings, 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, each of the Blue Parties, each Signatory Medical Society and each Class Member hereby irrevocably submits to the exclusive jurisdiction and venue of the United States District Court for the Southern District of Florida for any suit, action, proceeding, case, controversy, or

dispute relating to this Agreement and/or Exhibits hereto and negotiation, performance or breach of same.

20.2 Parties Shall Not Contest Jurisdiction

In the event of any case, controversy, or dispute arising out of the negotiation of, approval of, performance of, or breach of this Agreement, and solely for purposes of such case, controversy, or dispute, to the fullest extent that they may effectively do so under applicable law, the Parties irrevocably agree that they are and shall be subject to the jurisdiction of the Court, and that the Court is a proper venue and convenient forum. Furthermore, the parties shall jointly urge the Court to include the provisions of this § 20 in its Final Order and Judgment approving this Agreement.

21. Cooperation

Representative Plaintiffs, the Signatory Medical Societies, Class Counsel and the Blue Parties 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.

22. Counterparts

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

23. Additional Signatory Medical Societies

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

24. Successors and Assigns

The provisions of this Agreement shall be binding upon and inure to the benefit of each Blue Party and its respective successors and assigns; provided that no Blue Party may assign, delegate or otherwise transfer any of its rights or obligations under this Agreement to a third party that is not a successor or affiliate without the consent of Class Counsel. The provisions of this Agreement shall not apply with respect to any corporation, business, or other entity acquired by a Blue Party after the Preliminary Approval Date, and a Blue Party shall have no obligations

under this Agreement with respect to such corporation, business, or entity or the business operations of such corporation, business or entity after the Preliminary Approval Date. The provisions of this Agreement shall not apply with respect to any activities related to FEHBA.

25. Governing Law

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

26. Contacts for Communications Between Class Counsel and The Blue Parties

At all times during the term of this Agreement, Class Counsel, on the one hand, and the Blue Parties, on the other, shall each designate a representative to facilitate communications between or among the Parties, and provide written notification to the other of the person so designated.

27. Severable Agreement

The provisions of this Agreement are intended to be severable. Should any of the provisions be found illegal, invalid or unenforceable by any court of competent jurisdiction for any reason, it shall be severable from the remainder of this Agreement, and the remainder of this Agreement shall be unchanged and shall be read as if it did not contain the illegal or invalid provision.

28. Effect of Other Settlements

The Representative Plaintiffs and the Signatory Medical Societies will not reach a settlement with any defendant in this Action which is not a Party which settlement includes a provision containing relief to the Class Members which is also relief to the Class Members set forth in this Agreement if: (i) such relief to the Class Members is applicable to Self-Insured Plans under this Agreement, but is not made applicable to Self-Insured Plans in the proposed settlement agreement; (ii) such relief is made applicable to Class Members who are Non-Participating Physicians under this Agreement, but is not made applicable to Non-Participating Physicians in the proposed settlement agreement, or (iii) such relief to Class Members is applicable to programs offered or sponsored by any state or federal governmental entity other than in its capacity as an employer under this Agreement, but is not made applicable to programs offered or sponsored by any state or federal governmental entity other than in its capacity as an employer in the proposed settlement. The Representative Plaintiffs and Signatory Medical Societies further agree that they will not reach a settlement with any defendant in this Action which is not a Party (or which does not become a Party in the future to this Agreement) which settlement imposes a less burdensome obligation on such other defendant regarding the obligations set forth in any of § 7.18, § 7.19 or § 7.20, unless such less burdensome obligation is a result of good faith negotiation between such defendant and the Medical Society in the state where it does business and is an exception similar to those exceptions set forth in

Exhibit H. A settlement agreement involving only a financial payment obligation and no prospective relief shall be construed as a less burdensome obligation under this provision.

DELIVERED on April 27, 2007.