SETTLEMENT AGREEMENT

dated as of

May 23, 2005

by and among

DEFENDANTS,

THE REPRESENTATIVE PLAINTIFFS,

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AND CLASS COUNSEL

SETTLEMENT AGREEMENT

This Settlement Agreement (the "Agreement") is made and entered into as of the date set forth on the signature pages hereto by and among the Medical Society of the State of New York (hereinafter "MSSNY") and the Representative Plaintiffs (on behalf of themselves and each of the Class Members who have not validly and timely requested to Opt-Out of this Agreement), by and through their counsel of record in Medical Society of the State of New York v. Excellus, Inc., et al. and Dolan, et al. v. Excellus, Inc., et al. Civ. Nos. 9769-01, 9768-01 the "Actions") (hereinafter collectively, "Plaintiffs") and Excellus, Inc. Excellus Health Plan, Inc., and Excellus Benefits Services, Inc., (hereinafter collectively "Defendant"). MSSNY, the Representative Plaintiffs, the Class Members who have not validly and timely requested to Opt-Out of this Agreement, and the Defendant are herein collectively referred to as the "**Parties**". The Parties intend this Agreement to resolve, discharge and settle the Released Claims, fully, finally and forever according to the terms and conditions set forth below.

WITNESSETH:

WHEREAS, on August 15, 2001 an action was filed in the Supreme Court, State of New York, County of Monroe (the "Court"), entitled Dolan, et al.v. Excellus, Inc., et al. and whereas an action was filed on August 15, 2001 in the Supreme Court, State of New York, County of Monroe, entitled Medical Society of the State of New York v. Excellus, Inc., et al.

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

WHEREAS, Defendant denies the material factual allegations and legal claims asserted in the Actions, including without limitation any and all charges of wrongdoing or liability arising out of any of the conduct, statements, acts or omissions alleged, or that could have been alleged, in the Actions including without limitation the allegations that the Representative Plaintiffs and/or other Class Members have suffered damages; that Defendant improperly manipulated claim procedures or fraudulently misrepresented the criteria for insurance coverage determination, treatment decisions, and payments; that Defendant conspired with or aided and abetted wrongful conduct of any other person; and that the Representative Plaintiffs and/or other Class Members were harmed by the conduct alleged in the Actions;

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

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

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

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

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

WHEREAS, Plaintiffs have determined that it is in their best interests to obtain the benefits afforded by the applicable provisions of this Agreement, and, in exchange therefor, to make the commitments and agreements contained herein, including without limitation those contained in § 7;

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

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

1. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

1.13. **"Complete Claim"** means a claim for Covered Services that (a) is timely received by Company (b) has a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (c) (i) when submitted via paper has all the elements of the UB-92 or Form 1500 (or successor standard) forms as specified in the New York State Insurance Regulation defining "clean claims" (II NYCRR Section 217) or (ii) when submitted via an electronic transaction, uses only permitted standard code sets (e.g., CPT®-4, ICD-9, HCPCS) and has all the elements of the standard electronic formats, as required by applicable Federal authority and state regulatory authority, and (d) is a claim for which Company is a responsible payor.

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

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

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

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

1.18. **"Compliance Dispute"** means (i) any claim with respect to which Company has failed in any manner to carry out any of its obligations under § 7 of this Agreement and (ii) any claim of the type described in § 1.71 and § 13.2 of this Agreement that is not also any of the following: (A) a Released Claim, (B) a Billing Dispute; or (C) a claim for which the Medical Necessity External Review Process is available.

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

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

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

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

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

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

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

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

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

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

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

1.29. **Provision Deleted**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.51. "**Overpayment**" means, with respect to a claim submitted by or on behalf of a Physician (or Physician Group or Physician Organization), any erroneous or excess payment that Company makes because of payment of an incorrect rate, (e.g., inconsistent with the fee schedule), duplicate payment for the same Physician Service, payment with respect to an individual who was not a Plan Member as of the date the Physician provides the Physician Service(s) that are the subject of such payment, or payment for any non-Covered Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.66. "**Provider Website**" means the secure (password protected) online resource for Participating Physicians to obtain information about Company, its products and policies and other information described in more detail in this Agreement, and which is currently located at https://www.excellusbcbs.com/providers/index.shtml

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

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

1.69. **Provision Deleted**

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

1.71. **"Released Rights"** or **"Released Claims"** means any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities, and demands of whatever kind or character that relate, arise from, or pertain to billing or payment for Covered Services and includes any and all claims that have been or could have been asserted by or on behalf of MSSNY and any or all Class Members against the Released Persons, or any of them, and which arise prior to Final Approval by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in any of the Actions, except as otherwise provided for by this Agreement. This includes, without limitation and as to Released Persons only, any aspect of any Fee for Service Claim submitted by any Class Member to Company, and claims based upon a capitation agreement with Company, and any allegation that Company has conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions or with regard to Company's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, and/or other third parties. Notwithstanding this definition Released Claims do not include any claims that are alleged in the action Rochester Community Individual Practice Association, Inc. v. Finger Lake Health Insurance Company (State of New York, County of Monroe) Index No. 2975/98.

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

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

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

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

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

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

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

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

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

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

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

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

1.83. "**Termination Date**" shall have the meaning assigned to that term in §24.2 of this Agreement.

2. The Action and Class Covered by This Agreement.

This Agreement sets forth the terms of an agreement with respect to the Actions between Company and MSSNY and all Class Members who have not validly and timely requested to Opt-Out of this Agreement.

a. Commitment to Support and Communicate with Class Members

The Settling Parties agree that it is in their best interests to consummate this Agreement and to implement all the terms and conditions contained herein

and to cooperate with each other and to take all actions reasonably necessary to obtain Court approval of this Agreement and entry of the orders of the Court that are required to implement its provisions. They also agree to endorse and support this Agreement in accordance with and subject to the provisions of this Agreement.

Class Counsel and Plaintiffs shall make every reasonable effort to encourage putative Class Members to participate and not to Opt Out. In addition, Class Counsel shall make all reasonable efforts to enforce the Compliance Dispute resolution provisions of this Agreement set forth in § 11.

Plaintiffs, Class Counsel and Company agree that Company may communicate with putative Class Members regarding the provisions of this Agreement, so long as such communications are not inconsistent with the Initial Notice, the Notice of Commencement of the Claims Period or other agreed upon communications concerning the Agreement.

3. Preliminary Approval of Settlement.

Pursuant to New York Civil Practice Law and Rules Article 9, the Settling Parties shall submit this Agreement, together with the exhibits attached hereto, to the Court at a hearing (the "Preliminary Approval Hearing") for, among other things, its conditional certification of a settlement class, preliminary approval of the Agreement and Plan of Notice and scheduling of a Fairness Hearing, and shall apply to the Court for an Order of Preliminary Approval and Conditional Class Certification, substantially in the form of Exhibit F ("Preliminary Approval Order").

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

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

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

Company shall pay the reasonable cost of notice to Class Members, including without limitation first class mail costs for the mailing of the Mailed Notice, substantially in the same form as Exhibit E. Payment by Company of the cost of the Mailed Notice shall be non-refundable and shall be in addition to the other agreements made herein. Company shall pay for the cost to publish the Published Notice no more than three times in the legal notices section in the daily newspapers published in the regions the Company serves. If publication in one or more of said publications on the foregoing schedule is determined not to be practicable, then either Class Counsel or Company may apply to the Court for alternative notice by publication. Company shall also publish the Published Notice on the Public Website, and, to the extent feasible, shall also publish notice in MSSNY's publication. Company shall maintain the Public Website notices at Company's cost through at least the Objection Date.

All notices to any Party (including without limitation any designations made by Class Counsel pursuant to this Agreement) required under this Agreement shall be sent by first class U.S. Mail, by hand delivery, or by facsimile, to the recipients designated in this Agreement. Timeliness of all submissions and notices shall be measured by the date of receipt, unless the addressee refuses or delays receipt. The Persons designated to receive notices under this Agreement are as follows, unless notification of any change to such designation is given to each other Party hereto pursuant to this § 4:

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

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

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

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

such notice within 20 days of receipt thereof, such receiving Party shall be deemed to have accepted any proposal made by the notifying Party in such notice and shall be deemed to have waived any rights under this Agreement with respect to the matter that is the subject of such notice.

5. Procedure for Final Approval; Limited Waiver.

Following the dissemination of Notice as described in § 4, Representative Plaintiffs, Class Counsel and Company shall seek the Court's final approval of this Agreement. Class Members shall have until the Objection Date to file, in the manner specified in the Mailed Notice, any objection or other response to this Agreement. The Parties agree to urge the Court to set the Objection Date for the date that is 60 days after the Notice Date (the "**Objection Date**").

5.1. Notice and Opt-Out Timing and Rights.

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

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

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

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

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

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

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

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

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

6.1. Limited Waiver.

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

7. Settlement Consideration: Business Practice Initiatives.

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

and began to implement certain of the business practice initiatives described in this § 7 while the Parties were engaged in discussions to resolve the Action. Such initial and partial implementation, which shows the Company's good faith desire to resolve the Actions, were undertaken to form part of the consideration of the settlement. Company shall have the unilateral and unrestricted right to block access to and/or not apply any or all of the business practice initiatives set forth below to such Class Members, if any, who Opt Out. Without in any way qualifying or limiting the foregoing, Company is informed that it is not uncommon for some members of a class action to opt out for a variety of reasons independent of, among other things, the substantive allegations in the Complaint or the terms of a proposed settlement.

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

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

7.1. Automated Adjudication of Claims.

Company, recognizing the desirability of making investments to improve its business relationships with Physicians providing health care services and supplies to Company's Members through, among other things, efficiency in the processing of claims, has made substantial investments and will continue to make investments in target claims platforms to which the Company will be migrating substantially all the claims handling now being performed on its existing claims platforms; and by the use of its common claims platforms, and through streamlining processing on these platforms, will increase the percentage of claims that are auto-adjudicated, in an effort to shorten the period for payment of claims, and to improve the overall efficiency of the claim adjudication process.

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

7.2. Increased Internet and Clearinghouse Functionality.

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

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

7.3. Availability of Fee Schedules and Scheduled Payment Dates.

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

7.4. Investments in Initiatives to Improve Provider Relations

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

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

7.5. Reduced Pre-Certification Requirements.

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

7.6. Greater Notice of Policy and Procedure Changes.

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

7.7. Initiatives to Reduce Claims Resubmissions.

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