HMO SETTLEMENT

ENFORCEMENT TOOLKIT

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*** waiting for designation of Compliance or External Billing Dispute Review Company**

RICO SETTLEMENTS AT-A-GLANCE: HEALTH PLAN FINANCIAL COSTS

(As of August 30, 2005)

	Physician Cash Recovery	**Physicians' Foundation Funds**	**Ensuring Continued Health Plan Accountability**	**Prospective Relief**	**SubTotal**	**Attorneys Fees**	**Final Approval Dates**
AETNA	$100 Million	$20 Million	0	>$300 Million	>$420 Million	$50 Million	11/6/2003
CIGNA	>$70 Million	$15 Million	0	>$400 Million	>$485 Million	$55 Million	4/22/2004
Health Net	$39 Million	0	$1 Million	>$80 Million	>$120 Million	$20 Million	Hearing Scheduled 9/19/2005
Prudential	0	0	$22 Million	0		$5 Million	Hearing Scheduled 9/19/2005
Anthem/WellPoint	$135 Million	$5 Million	0	>$250 Million	>$390 Million	$58 Million	Hearing Scheduled 12/2/2005
TOTALS	**$>344 Million**	**$40 Million***	**$23 Million**	**>$1.3 Billion**	**>$1.7 Billion**	**$188 Million****	

*Physicians' Foundations for Health Systems Excellence and Health Systems Innovations have more than $100 Million as a result of physician charitable contributions of their cash recoveries.

**The attorneys fees reflect approximately 10% of the value of the Settlements.

RICO SETTLEMENTS AT A GLANCE -- PROSPECTIVE RELIEF

PROSPECTIVE RELIEF AVAILABLE TO PHYSICIANS	**Aetna**	**CIGNA**	**Anthem/ WellPoint**	**Health Net**
Better Medical Necessity Definition. Patients will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, and cheaper alternatives are permissible only when they are "at least as likely to produce equivalent therapeutic or diagnostic results."	7.16	7.16	7.16	7.16
Payment of Vaccines and Vaccine Administration. Recommended vaccines and injectibles and the administration of such vaccines and injectibles, will be reimbursed.	7.14	7.14	7.14	7.14
Reduced Downcoding. Evaluation and management CPT codes will not be automatically downcoded or reassigned.	7.19	7.19	7.19	7.19
Fewer Contract Changes. No material adverse change to a contract may be made on less than 90 days written notice.	7.6	7.6	7.6	7.6
Fairer Payment Rules. CPT coding edits will comply with most of the guidelines contained in the AMA CPT Manual.	7.20	7.20	7.20	7.20
Most Favored Nation Clauses Prohibited. Health Plan will not include any "most favored nation clause" in its contracts with physicians.	_____	_____	_____	7.29
Disclosure of Fee Schedules. Physician Fee Schedules will be available on the internet.	7.3, 7.14	7.3, 7.14	7.3, 714	7.3, 7.14
Consistency and Disclosure of Payment Rules. Payment rules will become consistent across all of Health Plan's products. Moreover, most reimbursement edits and claims adjudication logic will be disclosed.	7.8	7.2, 7.8	7.8	7.8
Capitation from Date of Enrollment. Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to date of enrollment.	7.28	7.28	7.28	7.28
Assignment of Benefits Accepted. Health plan will recognize an assignment of benefits.	7.15	7.15	_____	7.15
All products clauses limited. Health Plan generally will not require physicians to participate in products they do not want to participate in.	7.13	7.13	7.13	7.13

Stop-loss Insurance May be Purchased Elsewhere. Health Plan will not restrict physicians from purchasing stop-loss coverage from other insurers.	7.29	7.29	7.29	7.29
Faster Credentialing. New physician group members will be generally credentialed within 90 days of application, which physician groups can submit prior to their employment, and little or no additional credentialing will be required when already credentialed physicians change employment or location.	7.13	7.13	7.13	7.13
Arbitration Fees Capped. For solo and small group physicians arbitration fees will be capped at $1000.	7.29	7.29	_____	7.29
Arbitration Reform. Health Plan's participation contracts will not require overreaching arbitration provisions as specified.	_____	_____	7.29	7.29
Prompt, external dispute resolution mechanism for physician disputes. A streamlined, external review system will be established enabling physicians to dispute Health Plan's decisions on billing or medical records requests (Billing Dispute External Review Board) and on medical necessity (Medical Necessity External Review Process).	7.10, 7.11	7.10, 7.11 7.12	7.10, 7.11	7.10, 7.11
Gag clauses prohibited. "Gag" clauses will be prohibited.	7.29	7.29	7.29	7.29
Non-participating physicians protected. Disparaging language will be removed from EOBs, and the Agreement will not change or alter the rights of non-participating physicians to balance bill patients or to avoid dealing with Health Plan. Moreover, Health Plan (not Aetna) will disclose information concerning its "UCR" calculations.	7.21, 7.29	7.14, 7.21, 7.29	7.14, 7.21, 7.29	7.14, 7.21, 7.29
Limitation on Rental Networks. Health Plan will disclose on each EOB or remittance advice the identity of any PPO discount it is claiming, and within 30 days of a physician's request, will provide the physician with a copy of the signed agreement between the physician and that PPO, or else Health Plan will not be entitled to that discount.	_____	_____	_____	7.29
No HIPAA Mandate. Non-participating physicians will not be forced to use electronic transactions or otherwise become HIPAA compliant, and Health Plan agrees to continue to accept paper claims.	7.17	7.17	7.17	7.17
Restrictive Endorsements Limited. When the check is a partial payment of allowable charges, physicians may cash a check with "Payment in Full" on it without waiving the right to pursue a remedy under the Settlement.	_____	7.29	7.29	7.29

Better Mental Health Coverage. Health Plan will generally apply the §7.16 definition of medical necessity described above to mental health care, including treatment for psychiatric illness and substance abuse, it will treat its participating psychiatrists like its other participating physicians with respect to its provider directories and referrals, and it will adhere to the "prudent lay person standard" for emergency services, including admission, or physical or chemical restraints.	_____	7.33	7.33	7.33
Better state and federal law supercedes the Agreement.	7.29	7.29	7.29	7.29

More Information:

www.hmosettlements.com - complete copies of all settlement agreements and forms, and place to e-mail questions

Any Signatory Medical Society

American Medical Association - Private Sector Advocacy

Compliance Dispute Facilitators

Julia Stewart - **Phone: (205) 323-1888**
Fax: (205) 323-8907
jstewart@waadlaw.com

Cam Staples - **Telephone: 203-821-2000**
Fax: 203-821-2000
Email: ccs@npmlaw.com

RICO SETTLEMENTS AT-A-GLANCE FAIRER PAYMENT RULES
Coding Edits More Consistent with CPT Codes, Guidelines and Conventions

The Aetna, CIGNA, Health Net and Anthem/WellPoint Settlements include the following provisions specific to claims edits:

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
Reduced Downcoding of Evaluation and Management Codes	As of the Implementation Date, Company shall not automatically reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"). Notwithstanding the foregoing sentence, Company shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of the information in the written medical record at the time the service was rendered for particular claims, a review of information derived from Company's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of evaluation and management services; provided that the decision to reduce is based at least in part on a review of the clinical record.	CIGNA HealthCare shall not automatically reduce the code level of CPT® Evaluation and Management Codes billed for Covered Services. Notwithstanding the foregoing sentence, CIGNA HealthCare shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by a selected Class Member) based on a review of Clinical Information at the time the service was rendered for particular claims, a review of information derived from CIGNA HealthCare's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of Evaluation and Management services; provided that the decision to reduce is based at least in part on a review of the Clinical Information.	As of the Implementation Date, Company shall not automatically reduce the code level or reassign the category (e.g., a change of consult to office visit) of evaluation and management codes billed for Covered Services (**"Downcoding"**). Notwithstanding the foregoing sentence, Company shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level or reassign the category for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of Clinical Information, a review of information derived from Company**'**s fraud and abuse detection programs or other programs that create reasonable cause to believe there may be fraudulent, abusive or other billing practices which would be inappropriate according to CPT codes, guidelines and conventions; provided that the decision to reduce is based on a review of the Clinical Information for that patient encounter. Company may also reassign a CPT code to correct coding errors based on objective non-diagnostic patient information on the face of the claim (such as new to established patient, correcting age inconsistencies, or similar objective	As of the Final Order Date, Company shall not automatically reassign or reduce the code level of evaluation and management codes billed for Covered Services ("**Downcoding**"), except that Company may reassign a new patient visit code to an established patient visit code based solely on CPT® Codes, guidelines and conventions. Notwithstanding the foregoing sentence, Company 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 Company'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.

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
			changes).	
Add On and Modifier 51 Exempt	No modifier 51-exempt codes shall be subject to Multiple Procedure Logic. §7.20(b)(i). "Add-on" codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic. §7.20(b)(ii).	CIGNA HealthCare will process and separately reimburse add-on billing codes and modifier 51 exempt billing codes without reducing payment under CIGNA HealthCare's Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to the guidelines and protocols set forth in CPT®. §7.20(d).	Company will process and separately reimburse modifier 51 exempt codes without reducing payment under Company's Multiple Procedure Logic, except that Company may apply specific reimbursement policies for CPT modifier 51 exempt codes that are consistent with CPT codes, guidelines and conventions. "Add-on" codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to CPT® codes, guidelines and conventions.	Company will process and separately reimburse modifier 51 exempt codes without reducing payment under Company**'**s Multiple Procedure Logic, except that Company may apply specific reimbursement policies for CPT modifier 51 exempt codes that are consistent with CPT codes, guidelines and conventions. **"** Add-on**"** codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to CPT® codes, guidelines and conventions.

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
Modifier 25	If a bill contains a CPT® code for performance of an evaluation and management CPT® code appended with a modifier 25 and a CPT code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and eligible for payment, unless the clinical information indicates that use of the modifier 25 was inappropriate or Aetna has disclosed that such services are not appropriately reported together. §7.20(b)(iii).	CIGNA HealthCare shall not require Class Members to submit Clinical Information of their patient encounters in order to receive payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service. CIGNA HealthCare shall pay for both CPT® Evaluation and Management Codes and surgical codes or other procedure codes when submitted for the same patient on the same date of service with appropriate modifiers (*e.g.*, modifiers 25 and 57), unless a Claim Coding and Bundling Edit (which edit will be disclosed on the Website and shall be consistent with this section 7.20) precludes payment of the specific combination of billing codes involved. Additionally, CIGNA HealthCare will remove from its claim review and payment systems those Claim Coding and Bundling Edits that generally deny payment for CPT® Evaluation and Management Codes when submitted with surgical or other procedure codes for the same patient on the same date of service except for a discrete number of exceptions which will be disclosed on CIGNA HealthCare's Website. Nothing in this Agreement shall prohibit CIGNA HealthCare from requiring use of the appropriate CPT® Code modifiers for Evaluation and Management billing codes (*e.g.*, modifiers 25 and 57) on their original claim forms.	(i) Company shall not require a Physician to submit Clinical Information of their patient encounters solely because the Physician seeks payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service, provided that the correct CPT Evaluation and Management code, surgical code and modifier (e.g., CPT modifiers 25 or 57) are included on the initial claim submission. (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 Company has disclosed pursuant to § 7.8(c)(iii) the limited [and reasonable number of finite] code combinations that are not appropriately reported together. Payment shall only be made for one Evaluation and Management service for any single day unless payment for more than one is appropriate pursuant to CPT codes, guidelines and conventions.	(1) Company shall not require a Physician to submit Clinical Information of their patient encounters solely because the Physician seeks payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service, provided that the correct CPT Evaluation and Management code, surgical code and modifier (e.g., CPT modifiers 25 or 57) are included on the initial claim submission. (2) If a bill contains a CPT® code for an Evaluation and Management service appended with a CPT® modifier 25 and a CPT® code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and separately eligible for payment, unless the Clinical Information indicates that use of the CPT® modifier 25 was inappropriate or Company has disclosed pursuant to § 7.8(c)(iii) the limited and reasonable number of finite code combinations that are not appropriately reported together. Payment shall only be made for one Evaluation and Management service for any single day unless payment for more than one is appropriate pursuant to CPT codes, guidelines and conventions.

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
		Moreover, nothing in this Agreement shall preclude CIGNA HealthCare from requiring Participating Physicians and Non-Participating Physicians (to the extent the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to produce copies of their Clinical Information in connection with such an audit. §7.20(a).	iii) Company will remove from its claim review and payment systems those Claim Coding and Bundling Edits that automatically 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 Company's Website. (iv) Nothing in this Agreement shall (i) prohibit Company from requiring use of the appropriate CPT® Code modifiers, according to CPT codes, guidelines and conventions, for Evaluation and Management billing codes (e.g., CPT® modifiers 25 or 57) on their original claim forms, or (ii) preclude Company from requiring Participating Physicians and Non-Participating Physicians (to the extent the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to allow access to their Clinical Information in connection with such an audit.	3) Company will remove from its claim review and payment systems those Claim Coding and Bundling Edits that result in denial of payment for CPT® Evaluation and Management Codes with a CPT® modifier 25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service except for a limited number of exceptions, consistent with 7.20(c)(ii) above, which will be disclosed on Company's Website. (4) Nothing in this Agreement shall (i) prohibit Company from requiring use of the appropriate CPT® Code modifiers, according to CPT codes, guidelines and conventions, for Evaluation and Management billing codes (e.g., CPT® modifiers 25 or 57) on their original claim forms, or (ii) preclude Company from requiring Participating Physicians and Non-Participating Physicians (to the extent the Non-Participating Physician has elected to continue to assert a claim for payment pursuant to an assignment of benefits after a request for Clinical Information, and the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to allow access to their Clinical Information in connection with such an audit.

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
Supervision and Interpretation	A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that for each such procedure (e.g., review of x-ray or biopsy analysis) Aetna shall not be required to pay for supervision or interpretation by more than one physician. §7.20(b)(iv).	A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided, that for each such procedure (*e.g.*, review of x- ray or biopsy analysis), CIGNA HealthCare shall not be required to pay for supervision or interpretation by more than one physician; and provided further that, consistent with Section 7.8.(c)of this Agreement, nothing in this Section 7.20(e) shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements of the billed CPT® Code have been satisfied. §7.20(e).	A five-digit CPT® code for supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that (i) the supervision and interpretation service is not included in another CPT code submitted therewith according to CPT codes, guidelines and conventions, and (ii) for each such procedure (e.g., review of x-ray or biopsy analysis), Company shall not be required to pay for supervision or interpretation by more than one Physician.	A five-digit CPT® code for supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that (i) the supervision and interpretation service is not included in another CPT code submitted therewith according to CPT codes, guidelines and conventions, and (ii) for each such 35 procedure (e.g., review of x-ray or biopsy analysis), Company shall not be required to pay for supervision or interpretation by more than one Physician.
Indented Codes	Other than codes specifically identified as modifier 51-exempt or "add-on", a CPT® code that is considered an "indented code" within the CPT® code book shall not be reassigned into another CPT® code unless more than one indented code under the same indentation is also submitted with respect to the same service, in which case only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently (e.g., cardiac catheterization series), all such codes properly billed shall be recognized and eligible for payment. §7.20(b)(v)	Other than codes specifically identified as modifier 51-exempt or "add-on," a CPT® Code that is considered an indented code within CPT® shall not be reassigned into the primary (*i.e.*, non-indented) code, from the same CPT® Code series, unless more than one indented code under the same indentation is submitted with respect to the same service, in which event only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently, all such codes properly billed shall be recognized and eligible for payment. §7.20(f).	Company shall not reassign any CPT code into any other CPT code or deem a code ineligible for payment based solely on the format of the published CPT descriptions (i.e., indented codes).	Company shall not reassign any CPT code into any other CPT code or deem a code ineligible for payment based solely on the format of the published CPT descriptions (i.e., indented codes).

	AETNA SETTLEMENT	CIGNA SETTLEMENT	HEALTH NET	ANTHEM/WELLPOINT
Modifier 59	A CPT® code appended with a modifier 59 shall be recognized and separately eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) such procedures or services are not normally reported together but are appropriately reported together under the particular circumstances and (2) it would not be more appropriate to append any other CPT®-modifier to such code or codes. §7.20(b)(vi).	CPT® Codes submitted with a modifier 59 attached will be recognized and eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; (2) it would not be more appropriate to append any other CPT® recognized modifier to such codes; and (3) to the extent that the CPT® Code submitted for payment with a modifier 59 attached is otherwise subject to a Claim Coding and Bundling edit, substantiating Clinical Information indicates that the use of Modifier 59 was appropriate (which requirement shall be posted on the Website consistent with Section7.8.(c) of this Agreement) §7.20(g).	A CPT® code submitted with a CPT® modifier 59 shall be recognized and separately eligible for payment to the extent it designates a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances and (2) it would not be more appropriate to append any other CPT® modifier to such code or codes.	A CPT® code submitted with a CPT® modifier 59 shall be recognized and separately eligible for payment to the extent it designates a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that (1) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances and (2) it would not be more appropriate to append any other CPT® modifier to such code or codes.
Global Periods	No global periods for surgical procedures shall be longer than any period then designated on a national basis by the Centers for Medicare and Medicaid Services (CMS) for such surgical procedures. §7.20(b)(vii).	No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict CIGNA HealthCare 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). §7.20(h).	No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict Company from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).	No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict Company from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).

Automatic Downcoding of Service Intensity	Aetna shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® code is one among a series that differentiates among simple, intermediate and complex. §7.20(b)(viii).	CIGNA HealthCare shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® Code is one among a series that differentiates among simple, intermediate and complex; provided that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.i shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements for intermediate and complex versions of the service have been satisfied. §7.20(i).	Company shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® code is one among or across a series that includes without limitation codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.	Company shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® code is one among or across a series that includes without limitation codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.
Annual Update of Modifier 51 exempt Codes	By May 6, 2004, or as soon thereafter as is reasonably practicable, Aetna 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 Aetna shall not be obligated to take any action prior to the effective date of the additions or reclassifications. §7.20(b)(ix).	CIGNA HealthCare 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, CIGNA HealthCare shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require CIGNA HealthCare 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 complete once each year. §7.20(d).	Commencing six (6) months after the Implementation Date, or as soon thereafter as is reasonably practicable, Company shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as to modifier 51 exempt status since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, Company shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require Company to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.	Commencing six (6) months after the Implementation Date, or as soon thereafter as is reasonably practicable, Company shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as to modifier 51 exempt status since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, Company shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require Company to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

`Non-exclusive Listing of Modifiers	Nothing contained in this section shall be construed to limit Aetna's recognition of modifiers to those modifiers specifically addressed in this Section. §7.20(x).	Nothing contained in this Section shall be construed to limit CIGNA HealthCare's recognition of modifiers to those modifiers specifically addressed in this Section. §7.20(j).	Nothing contained in this § 7.20 shall be construed to limit Company's recognition of CPT® modifiers to those CPT® modifiers specifically addressed in this § 7.20. Company agrees to recognize and consider for reimbursement all CPT® modifiers appropriately coded pursuant to CPT®.	Nothing contained in this § 7.20 shall be construed to limit Company's recognition of CPT® modifiers to those CPT® modifiers specifically addressed in this § 7.20. Company agrees to recognize and consider for reimbursement all CPT® modifiers appropriately coded pursuant to CPT®.

COMPLIANCE DISPUTES

Aetna and CIGNA Settlement Step-by-Step Compliance Dispute Procedure

Listed below are the steps to take to challenge a violation of the terms of Section 7 of the Aetna and CIGNA Settlement Agreements. Section 7 lists the business practice changes to which Aetna and CIGNA have committed.

1. Any physician who has not opted out of the Settlement may file a compliance dispute with the Compliance Dispute Facilitator (the "Facilitator"), Julia Stewart. Compliance disputes must be filed within 30 calendar days of the date the dispute arose.

2. The Medical Society of the State of New York is an official Signatory Medical Society to these Settlements. MSSNY will assist MSSNY members with this process, and will file on their behalf on request. Call a MSSNY Office of General Counsel at (516) 488-6100, Ext. 352.

3. The compliance dispute form and Section 7 of each health plan Settlement Agreement are also available on www.hmosettlements.com.

4. The form must be completed by the physician or his or her office staff, and must include the **physician's signature**. The physician should describe, using specific facts, the health plan's conduct which he or she believes constitutes a material breach of the health plan's obligation under Section 7 of the Agreement. The physician should also specify which provision of Section 7 has been breached, and describe how he or she has been harmed by the breach.

5. The physician should attach to the form any supporting documentation, including any correspondence between the physician and the health plan, and any records which the physician believes are relevant for the Facilitator to determine the merits of the complaint.

6. The completed form and attachments should be mailed to the Compliance Dispute Facilitator at the address below. **No fee is required**.

7. After the Facilitator receives the compliance dispute form, the Facilitator will contact the physician to advise whether the form is properly completed, and whether, in the Facilitator's opinion, the alleged wrongful conduct is a compliance dispute.

8. The Facilitator will prosecute the dispute on the physician's behalf **without charge**, and keep the physician informed as the compliance dispute process takes its course.

9. The address for the Facilitator is:

   Julia S. Stewart
   White, Arnold, Andrews & Dowd
   2025 Third Avenue North, Suite 600
   Birmingham, Alabama 35203
   Telephone: 1-877-760-0157
   Fax: 205-323-8907
   jstewart@waadlaw.com

UNITED STATE DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

MDL NO.: 1334
MASTER FILE NO.: 00-1334-MD-MORENO

IN RE:
MANAGED CARE LITIGATION

THIS DOCUMENT RELATES TO
PROVIDER TRACK CASES ONLY

Aetna Compliance Dispute Claim Form

The undersigned hereby declares that he or she is a Class Member who did not Opt-Out of the settlement Agreement.

_____
Name of Class Member

_____

_____
Address

_____

_____
City, State, and Zip Code

_____
Signature

_____
Tax Identification Number under which covered
physician services were provided, if applicable

_____
E-mail address

Check one of the following:

____ I am bringing this Compliance Dispute on my own behalf.

____ I hereby authorize the following Signatory Medical Society to bring this Compliance Dispute on my behalf: _____.

Please set forth in detail below, using particularized facts, Company's conduct which you allege constitutes a material breach of Company's Obligations under § 7 of the settlement Agreement. Please note the specific provision of § 7 allegedly breached, and please describe how the undersigned has been harmed by the alleged breach. Please also set forth the relief that you request. You may attach any supporting materials you wish.

In Order to allege a valid Compliance Dispute you must complete and return this form by First Class mail **no later than 30 days** after the Compliance Dispute first arose to:

Julia Smeds Stewart
Aetna Compliance Dispute Facilitator
WHITE ARNOLD ANDREWS & DOWD P.C.
2025 Third Avenue North, Suite 600
Birmingham, AL 35203
Phone: (205)323-1888
Fax: (205) 323-8907
jstewart@waadlaw.com

UNITED STATE DISTRICT COURT
FORT THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334
MASTER FILE NO.: 00-1334-MD-MORENO

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

CIGNA HEALTHCARE PHYSICIAN SETTLEMENT
COMPLIANCE DISPUTE CLAIM FORM

The undersigned hereby declares that he, she or it is a Class Member and did not Opt-Out of the CIGNA HealthCare Physicians Settlement Agreement.

Name_____

Address_____

_____

_____

Tax Identification Number_____

CIGNA HealthCare Provider Number
(if applicable)_____

Email Address_ _____

Telephone Number_____

Physician's Name (print)_____

Physician's Signature_____

Date_____

Check one of the following:

☐ I am bringing this Compliance Dispute on my own behalf.

☐ I hereby authorize the following Signatory Medical Society to bring this Compliance Dispute on my behalf: _____.

Please set forth in detail below, using particularized facts, Company's conduct which you allege constitutes a material breach of Company's Obligations under §7 of the settlement Agreement. Please note the specific provision of §7 allegedly breached, and please describe how the undersigned has been harmed by the alleged breach. Please also set forth the relief that you request. You may attach any supporting materials you wish.

In Order to allege a valid Compliance Dispute you must complete and return this form by First Class mail **no later than 30 days** after the Compliance Dispute first arose to:

Julia Smeds Stewart
Aetna Compliance Dispute Facilitator
WHITE ARNOLD ANDREWS & DOWD P.C.
2025 Third Avenue North, Suite 600
Birmingham, AL 35203
Phone: (205) 323-1888
Fax: (205) 323-8907
jstewart@waadlaw.com

Health Net Settlement Step-by-Step Compliance Dispute Procedure

Listed below are the steps to take to challenge a violation of the terms of Section 7 of the Settlement Agreement. Section 7 lists the business practice changes to which Health Net has committed.

1. Any physician who has not opted out of the Settlement may file a compliance dispute with the Compliance Dispute Facilitator (the "Facilitator"), Cameron C. Staples. Compliance disputes must be filed within 90 calendar days of the date the dispute arose or was reasonably discovered.

2. The California Medical Association is an official Signatory Medical Society to this Settlement. CMA will assist CMA members with this process, and will file on their behalf on request. Call a CMA Health Law Information Specialist at (415) 882-5144.

3. The compliance dispute form and Section 7 of each health plan Settlement Agreement are also available on at the *RICO Resource Center* at www.cmanet.org, or at www.hmosettlements.com.

4. The form must be completed by the physician or his or her office staff, and must include the **physician's signature**. The physician should describe, using specific facts, the health plan's conduct which he or she believes constitutes a material breach of the health plan's obligation under Section 7 of the Agreement. The physician should also specify which provision of Section 7 has been breached, and describe how he or she has been harmed by the breach.

5. The physician should attach to the form any supporting documentation, including any correspondence between the physician and the health plan, and any records which the physician believes are relevant for the Facilitator to determine the merits of the complaint.

6. The completed form and attachments should be mailed to the Compliance Dispute Facilitator at the address below, or if you prefer that CMA file on your behalf, to RICO Compliance Disputes, 221 Main Street, Suite 580, San Francisco, CA 94105. **No fee is required**.

7. After the Facilitator receives the compliance dispute form, the Facilitator will contact the physician to advise whether the form is properly completed, and whether, in the Facilitator's opinion, the alleged wrongful conduct is a compliance dispute.

8. The Facilitator will prosecute the dispute on the physician's behalf **without charge**, and keep the physician informed as the compliance dispute process takes its course.

9. The address for the Facilitator is:

    Cameron C. Staples
    Neubert Pepe & Monteith, PC
    195 Church Street
    New Haven, CT 06510
    Telephone: 203-821-2000
    Fax: 203-821-2000
    Email: ccs@npmlaw.com

UNITED STATE DISTRICT COURT
FORT THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

HEALTHNET PHYSICIAN GROUP AND PHYSICIAN ORGANIZATION SETTLEMENT COMPLIANCE DISPUTE CLAIM FORM

The undersigned hereby declares that he or she is a Class Member and did not Opt-Out of the Health Net Physician, Physician Group and Physician Organization Settlement Agreement.

Name_____

Address_____

_____

Tax Identification Number_____

_____

Health Net Provider Number
(if applicable)_____

Email Address_ _____

Telephone Number_____

Signature_____

Date_____

Check one of the following:

☐ I am bringing this Compliance Dispute on my own behalf.

☐ I hereby authorize the following Signatory Medical Society to bring this Compliance Dispute on my behalf: _____.

Set forth in detail below, using particularized facts, the specific obligation(s) of Health Net to you under Section 7 of the Settlement Agreement which you allege Health Net has materially failed to perform. Describe how you have been adversely affected by Health Net's alleged failure to comply with those specific obligation(s). You may attach supporting materials or affidavid testimony.

You must complete and submit this petition no later than ninety (90) days after the Compliance Dispute first arose or after you first became aware of the Compliance Dispute to:

Compliance Dispute Facilitator
Cameron C. Staples
Neubert Pepe & Monteith, PC
195 Church Street
New Haven, Ct 06510
Telephone: 203-821-2000
Fax: 203-821-2000
Email: ccs@npmlaw.com

BILLING DISPUTES

RICO Settlement Step-By-Step External Billing Dispute Procedure

Aetna and CIGNA Settlements

Listed below are the steps to take to challenge a payment by Aetna or CIGNA which you believe violates your contract or that Settlement Agreement in connection with health plan's application of coding and payment rules or methodologies to patient–specific factual situations. This process does not apply to disputes over medical records submission requirements or Medical Necessity Denials. For these types of disputes, obtain the relevant dispute form and follow the instructions. Also, if your dispute involves a violation of Section 7.19 or 7.20 or other systemic issue, you may pursue your complaint as a Compliance Dispute.

How do I file a billing dispute?

- You must complete an External Billing Dispute Resolution Form ("Form") and submit the Form to:

  HAYES Plus, Inc.
  157 S. Broad Street, Suite 400
  Lansdale, PA 19446
  Phone: (215) 855-0615, Fax: (215) 855-5318
  www.hayesplus.com

- Copies of the forms applicable to each Settlement and each dispute resolution process are also available at **www.hmosettlements.com.**

What are the prerequisites to filing?

- **Completion of Internal Appeals Process.** Physicians or physician groups must either complete the health plan's internal appeals process or have waited at least **45 calendar day**s from the health plan's receipt of all documentation necessary to complete the internal appeal ("implied exhaustion"). To the extent that there is a disagreement about whether the internal appeals process has been exhausted, the matter will be decided by the BDERB.

  - For a description of Aetna's internal appeals process, please visit "Health Care Professional ToolKit" on Aetna's website at: **https://www.aetna.com/provweb/subPageAction.do?resource=dbaHealthToolkit.xml**.

  - For a description of CIGNA's internal appeals process, please visit **http://www.cigna.com/health/provider/medical/procedural/claim_appeals/index.html**

- **Filing Deadline.** Billing disputes, with all supporting documentation, must be submitted no more than **90 calendar days** after the internal appeals process is exhausted (**30 calendar days** with respect to "**Retained Claims**").

  - **Filing Fee.** If the difference between the amount that the physician received and the amount the physician believes that the health plan should have paid ("amount in dispute") is $1,000 dollars or less, the filing fee is $50. If the amount in dispute exceeds $1,000, the filing fee is $50 plus 5% of the amount in dispute. The filing fee will never exceed 50% of the cost of the review. In the event that a dispute is withdrawn, the fee will be refunded.

- **Minimum $500 in Dispute. The amount in dispute must be greater than $500 before it will be resolved.** If the amount in dispute is less than $500, you should still submit the External Billing Dispute Resolution Request Form and request the BDERB to defer consideration of the dispute until the

physician or physician group accumulates documentation of similar disputed claims totaling an amount greater than $500. The physician or physician group will have **1 year** from the date of deferment to supply additional disputes. In the event that the physician or physician group does not reach the $500 threshold during that year, the filing fee will be refunded.

When will the decision be made?

- Dispute decisions must be rendered by the BDERB within **30 calendar days** of receipt of all necessary documentation, which should generally be no later than **60 calendar days** from the physician's original submission of claims satisfying the $500 threshold.

What happens when the BDERB issues a decision?

- The decision of the BDERB is binding upon both the health plan and the physician.
- If the BDERB decides against the health plan, the physician or physician group **must be paid within 15 calendar days** of the decision.
- The health plan will record, in writing, a summary of the results of the proceedings conducted by the BDERB.
- If the same issue is the subject of 20 proceedings or more, and the health plan's position is overturned 50% of the time, the issue will be brought to the attention of the Physician Advisory Committee[1].

Why should I consider using this process?

- The dispute will be decided by certified coders and, as necessary, professionals in the clinical specialty or area at issue.
- The BDERB will apply the Settlement terms, applicable contract terms that are consistent with the Settlement and "generally accepted medical billing standards" where these are silent. The Settlement incorporates state laws that are more protective of physicians' rights, so physicians retain the benefits of those laws.
- The process is cheaper and faster than arbitration or litigation.

[1]The purpose of the Physician Advisory Committee is to provide input to the health plan on issues of common concern to physicians nationwide. The Committee includes nine (9) physician members who have authority to recommend changes to the health plan's business practices. A listing of the Physician Advisory Committee members for each Settlement is available at **www.hmosettlements.com**.

Do I have to use this process?

- This process is optional, except with respect to "**Retained Claims**," claims that were in the pipeline when the applicable Settlement was finalized.

What is a "Retained Claim"?

- **Aetna** "***Retained Claims***" include all physician claims for services rendered before November 6, 2003 that, on November 6, were either in the process of being adjudicated by Aetna, or had not yet been filed but the claim filing period (120 days unless extended for extraordinary circumstances) had not elapsed. All other claims for services rendered before November 6, 2003 were released by the Settlement and are thus no longer subject to challenge.

  - For internal appeals completed on or after January 5, 2004 for services rendered before November 6, 2003, your dispute must be received by Hayes Plus no later than 30 calendar days after Aetna's internal appeals process is completed.

- ***CIGNA*** "***Retained Claims***" include all physician claims for services rendered on or before April 22, 2004 that, as of April 22, were in the process of being adjudicated by CIGNA, or had been finally adjudicated by CIGNA on or after March 24, 2004, or had not yet been filed but the claim filing period (180 days unless extended for extraordinary circumstances) had not elapsed. All other claims for services rendered before April 23, 2004 were released by the Settlement and are thus no longer subject to challenge, except by filing a claim to the Category A or Claim Distribution Fund in the formal CIGNA damages process.

  - For internal appeals completed on or after July 3, 2004 for services rendered before April 23, 2004, your dispute must be received by Hayes Plus no later than 90 calendar days after CIGNA's internal appeals process is completed.

  - Retained claims must be filed on a special Retained Claim Form.

PROSPECTIVE RELIEF OVERVIEWS

AETNA SETTLEMENT OVERVIEW

(Agreement dated May 21, 2003 – Final Approval by Judge Moreno October 24, 2003)

The following is a general overview of the major provisions of the Aetna Settlement likely to be of interest to California physicians. It is not intended to be comprehensive. The prospective relief noted below generally extends for four (4) years from the date of preliminary approval, unless terminated earlier as specified in the Agreement. All provisions set forth below are currently effective. Because of Aetna's recent agreement to extend the Settlement for one year (with the exception of the External billing dispute resolution process and the provision requiring acceptance of assignments), these will remain effective until June 2, 2008. Physicians interested in the specifics should read the language of the actual Settlement Agreement.

Retrospective Relief:

- $100,000,000 to class members, without any requirement for the submission of medical records. (§8)
- $20,000,000 to a Foundation controlled by the Medical Societies that initiated the litigation to create interactions to improve the quality of health care in the country. (§8)
- All retrospective relief has been fully distributed.

Prospective Relief: $300 million

- ***Better Medical Necessity Definition*** - Patients will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, and cheaper alternatives are permissible only when they are "at least as likely to produce equivalent therapeutic or diagnostic results." (§7.16)
- ***Payment of Vaccines and Vaccine Administration*** - Recommended vaccines and injectibles and the administration of such vaccines and injectibles, will be reimbursed. (§7.14)
- ***Reduced Downcoding*** - Evaluation and management codes will not be automatically downcoded. (§7.19)
- ***Fairer Payment Rules*** - CPT reimbursement coding edits will comply with almost all of the guidelines contained in the AMA CPT Manual. (§7.20)
- ***Disclosure of Fee Schedules*** - Physician fee schedules will be available on the Internet by December 31, 2004. (§7.3)
    - Fee schedules can be changed once a year only. (§7.14)
- ***Disclosure of Payment Rules*** - Payment rules will be consistent across all company products by December 31, 2004. (§7.8(a))
    - A Web-based pre-adjudication tool will be available on the Aetna Website so that physicians can determine what they will be paid. (§7.8)
    - Reimbursement edits and claims adjudication logic will be disclosed. (§7.8)
- ***Capitation from Date of Enrollment*** - Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to date of enrollment. (§7.28)
- ***Participation in Pharmacy Risk Pools Optional –*** Aetna's contracting policies will not require the use of pharmacy risk pools. (§7.29)

- ***Stop-loss Insurance May be Purchased Elsewhere –*** Aetna will not restrict physicians from purchasing stop-loss coverage from other insurers. (§7.29)

- ***Faster Credentialing –*** New physician group members will be credentialed within 90 days of application, which physician groups can submit prior to their employment. (§7.13)

- ***Arbitration Fees Capped -*** Arbitration fees for solo and small group physicians will be capped at $ 1000. (§7.29)

- ***Prompt, external dispute resolution mechanism for physician disputes –*** A streamlined, external review system will be established enabling physicians to dispute Aetna's decisions on billing or medical records requests (Billing Dispute External Review Board) and on medical necessity (Medical Necessity External Review Process). (§§7.10, 7.11)

- ***Gag clauses prohibited -*** "Gag" clauses will be prohibited. (§7.29)

- ***Non-participating physicians protected –*** Disparaging language will be removed from EOBs, and the Agreement will not change or alter the rights of non-participating physicians to balance bill patients or to avoid dealing with Aetna. (§§7.21 and 7.29)

- ***No HIPAA Mandate –*** Non-participating physicians will not be forced to use electronic transactions or otherwise become HIPAA compliant, and Aetna agrees to continue to accept paper claims. (§7.17)

- ***Better state law supercedes the Agreement***. (§7.29)

Enforcement of Settlement Agreement

- A Physicians' Advisory Committee will be created to address issues of nationwide scope. (§7.9)

- Physicians and signatory state medical societies will enforce the Agreement, including Aetna's agreement to abide by those laws that are more protective of physicians than the provisions otherwise contained in the Agreement, exclusively through an efficient dispute resolution process. The United States District Court Judge handling the litigation will have ultimate enforcement power. (§12)

- Physicians and signatory state medical societies retain the right to seek the enactment of better state laws and regulations, and to enforce those better protections in the courts. (§13(h))

Coverage:

- The settlement covers all physicians (over 700,000 physicians, physician groups and physician organizations) who have provided covered services to any person enrolled in or covered by a plan offered or administered by any of the defendants named in the complaint (including Aetna, CIGNA, Prudential, Humana, Wellpoint, Pacificare, Healthnet, Anthem, United and Coventry).

- The settlement also includes the following 19 Signatory Medical Societies: Alaska, California, Connecticut, Denton County (Tx), El Paso County (Co), Florida, Georgia, Hawaii, Louisiana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Northern Virginia, South Carolina, Tennessee, Texas and Washington.

CIGNA SETTLEMENT OVERVIEW

(Agreement Preliminarily Approved September 5, 2003—Finally Approved April 22, 2004)

The following is a general overview of the major provisions of the CIGNA Settlement likely to be of interest to California physicians. It is not intended to be comprehensive. The prospective relief noted below generally extends for four (4) years from the date of preliminary approval, unless terminated earlier as specified in the Agreement. All provisions set forth below are currently effective. Physicians interested in the specifics should read the language of the actual Settlement Agreement.

Retrospective Relief:

- $70,000,000 minimum, unlimited maximum depending on extent class members prove CIGNA improperly downloaded, bundled or denied specific claims based on erroneous medical necessity determinations.

- $15,000,000 to a Foundation controlled by the Medical Societies that initiated the litigation to create interactions to improve the quality of health care in the country. (§8)

- The time period for filing damage claims has passed; the final distribution of all damages had not occurred as of August 30, and a dispute over that distribution is pending in Court, before Judge Moreno.

Prospective Relief: over $400 million

- ***Better Medical Necessity Definition*** - Patients will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, and cheaper alternatives are permissible only when they are "at least as likely to produce equivalent therapeutic or diagnostic results." (§7.16)

- ***Payment of Vaccines and Vaccine Administration*** - Recommended vaccines and injectibles and the administration of such vaccines and injectibles, will be reimbursed. (§7.14)

- ***Reduced Downcoding*** - Evaluation and management codes will not be automatically downcoded. (§7.19)

- ***Fairer Payment Rules*** - CPT reimbursement coding edits will comply with almost all of the guidelines contained in the AMA CPT Manual. (§7.20)

- ***Disclosure of Fee Schedules*** – Complete physician fee schedules will be available on request without charge. (§7.3)

    - Fee schedules can be changed once a year only. (§7.14)

- ***Disclosure of Payment Rules*** - Payment rules will be consistent across all company products. (§7.8(a))

    - If one becomes available in commercially reasonable terms, a Web-based pre-adjudication tool will be available on the CIGNA Website so that physicians can determine what they will be paid. (§7.8)

    - CIGNA's Computer claims processing software will be identified by name and version, and each claim coding and bundling edit that results in a substantial number of (at least 500) denials or reductions will be "described with particularity." (§7.2)

- ***Capitation from Date of Enrollment*** - Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to date of enrollment. (§7.28)

- ***All products and all affiliates clauses prohibited –*** CIGNA will not require physicians to participate in products they do not want to participate in, except that, generally speaking, psychiatrists who provide covered services to patients covered by CIGNA Behavioral Health, Inc., are expected to provide those services to all patients whose care is managed by CIGNA Behavioral Health to the extent they have room in their practice. (§7.13)

- ***Participation in Pharmacy Risk Pools Optional –*** CIGNA's contracting policies will not require the use of pharmacy risk pools. (§7.29)

- ***Stop-loss Insurance May be Purchased Elsewhere –***CIGNA will not restrict physicians from purchasing stop-loss coverage from other insurers. (§7.29)

- ***Faster Credentialing –*** New physician group members will be credentialed within 90 days of application, which physician groups can submit prior to their employment, and little or no additional credentialing will be required when already credentialed physicians change employment or location. (§7.13)

- ***Arbitration Fees Capped*** - Arbitration fees for solo and small group physicians will be capped at $1000. (§7.29)

- ***Prompt, external dispute resolution mechanism for physician disputes –*** A streamlined, external review system will be established enabling physicians to dispute CIGNA's decisions on billing (Billing Dispute External Review Process), on medical necessity (Medical Necessity External Review Process), and on medical records requests (Clinical Information Officers). (§§7.10, 7.11, 7.12)

- ***Gag clauses prohibited*** - "Gag" clauses will be prohibited. (§7.29)

- ***Non-participating physicians protected –*** Disparaging language will be removed from EOBs, and the Agreement will not change or alter the rights of non-participating physicians to balance bill patients or to avoid dealing with CIGNA. (§§7.21 and 7.29) Moreover, CIGNA will identify any databases it licenses from other parties to determine "reasonable and customary billed charges," and will disclose the data it used to make any specific determination that is challenged.

- ***No HIPAA Mandate –*** Non-participating physicians will not be forced to use electronic transactions or otherwise become HIPAA compliant, and CIGNA agrees to continue to accept paper claims. (§§7.17 and 7.29)

- ***Restrictive Endorsements Limited*** – When the check is a partial payment of allowable charges, physicians may cash a check with "Payment in Full" on it without waiving the right to pursue a remedy under the Settlement. (§7.29)

- ***Better Mental Health Coverage*** – CIGNA will generally apply the §7.16 definition of medical necessity described above to mental health care, including treatment for psychiatric illness and substance abuse, it will treat its participating psychiatrists like its other participating physicians with respect to its provider directories and referrals, and it will adhere to the "prudent lay person standard" for emergency services, including admission, or physical or chemical restraints. (§7.33)

- ***Better state law supercedes the Agreement***. (§7.29)

Enforcement of Settlement Agreement

- A Physicians' Advisory Committee will be created to address issues of nationwide scope. (§7.9)

- Physicians and signatory state medical societies will enforce the Agreement, including CIGNA's agreement to abide by those laws that are more protective of physicians than the provisions otherwise contained in the Agreement, exclusively through an efficient dispute resolution process. The United States District Court Judge handling the litigation will have ultimate enforcement power. (§15)

- Physicians and signatory state medical societies retain the right to seek the enactment of better state laws and regulations, and to enforce those better protections in the courts. (§13)

Coverage:

- The settlement covers all physicians (over 700,000 physicians, physician groups and physician organizations) who have provided covered services to any person enrolled in or covered by a plan offered or administered by any of the defendants named in the complaint (including CIGNA, Aetna, Prudential, Humana, Wellpoint, Pacificare, Healthnet, Anthem, United and Coventry).

- The settlement also includes the following 19 Signatory Medical Societies: Alaska, California, Connecticut, Denton County (Tx), El Paso County (Co), Florida, Georgia, Hawaii, Louisiana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Northern Virginia, South Carolina, Tennessee, Texas and Washington.

Health Net Settlement Overview

(Agreement dated May 2, 2005; Preliminarily Approved by Judge Moreno May 10, 2005)

The following is a general overview of the major provisions of the Health Net Settlement likely to be of interest to California physicians. It is not intended to be comprehensive. The prospective relief noted below generally extends for four (4) years from the date it is implemented, unless terminated earlier as specified in the Agreement. *See* Attachment A for the relevant start dates. Physicians interested in the specifics should read the language of the actual Settlement Agreement, which is posted in CMA's *RICO Resource Center* at **www.cmanet.org**.

Retrospective Relief:

- $39,000,000 to class members, without any requirement for the submission of medical records. (§8)
- $1,000,000 to the Compliance Fund to be used for monitoring and enforcing compliance with the Settlements. (§8)
- The deadline for claims filing is September 21. 2005.

Prospective Relief: Over $80 million

- ***Better Medical Necessity Definition*** - Patients will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, and cheaper alternatives are permissible only when they are "at least as likely to produce equivalent therapeutic or diagnostic results." (§7.16)
- ***Payment of Vaccines and Vaccine Administration*** - Recommended vaccines and injectibles and the administration of such vaccines and injectibles, will be reimbursed. (§7.14)
- ***Reduced Downcoding*** - Evaluation and management CPT codes will not be automatically downcoded or reassigned. (§7.19)
- ***Fewer Contract Changes*** – No material adverse change to a contract may be made on less than 90 days written notice. (§7.6)
- ***Fairer Payment Rules*** - CPT coding edits will comply with most of the guidelines contained in the AMA CPT Manual. (§7.20)
- ***Most Favored Nation Clauses Prohibited*** – Health Net will not include any "most favored nation clause" in its contracts with physicians. (§7.29)
- ***Consistency and Disclosure of Payment Rules*** - Payment rules will be consistent across all of Health Net's commercial products within each separately licensed health plan by December 31, 2005. Moreover, most reimbursement edits and claims adjudication logic will be disclosed. (§7.8)
- ***Capitation from Date of Enrollment*** - Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to date of enrollment. (§7.28)
- ***All products and "other payor" clauses prohibited*** – Health Net will not require physicians to participate in products they do not want to participate in, including but not limited to products the Company offers to workers' compensation payors. (§7.13) Moreover, Health Net will not require physicians to be "leased" to entities other than Health Net, its affiliates, or their self-funded plans' customers. (§7.29)
- ***Stop-loss Insurance May be Purchased Elsewhere*** – Health Net will not restrict physicians from purchasing stop-loss coverage from other insurers. (§7.29)

- ***Faster Credentialing –*** New physician group members will be credentialed within 90 days of application, which physician groups can submit prior to their employment, and little or no additional credentialing will be required when already credentialed physicians change employment or location. (§7.13)

- ***Arbitration Fees Capped -*** For solo and small group physicians arbitration fees will be capped at $1000 and Health Net's participation contracts will not require that arbitrations take place more than 100 miles from the physicians' office, or that there be multiple arbitrators for disputes of less than $500,000. (§7.29)

- ***Prompt, external dispute resolution mechanism for physician disputes –*** A streamlined, external review system will be established enabling physicians to dispute Health Net's decisions on billing or medical records requests (Billing Dispute External Review Board) and on medical necessity (Medical Necessity External Review Process). (§§7.10, 7.11)

- ***Gag clauses prohibited -*** "Gag" clauses will be prohibited. (§7.29)

- ***Non-participating physicians protected –*** Disparaging language will be removed from EOBs, and the Agreement will not change or alter the rights of non-participating physicians to balance bill patients or to avoid dealing with Health Net. (§§7.21 and 7.29) Moreover, Health Net will identify "the data used … to determine the "reasonable and customary" charge" whenever any specific determination is challenged. (§7.14)

- ***Limitation on Rental Networks –*** Health Net will disclose on each EOB or remittance advice the identity of any PPO discount it is claiming, and within 30 days of a physician's request, will provide the physician with a copy of the signed agreement between the physician and that PPO, or else Health Net will not be entitled to that discount. (§7.29)

- ***No HIPAA Mandate –*** Non-participating physicians will not be forced to use electronic transactions or otherwise become HIPAA compliant, and Health Net agrees to continue to accept paper claims. (§7.17)

- ***Restrictive Endorsements Limited*** – When the check is a partial payment of allowable charges, physicians may cash a check with "Payment in Full" on it without waiving the right to pursue a remedy under the Settlement. (§7.29)

- ***Better Mental Health Coverage*** – Health Net will generally apply the §7.16 definition of medical necessity described above to mental health care, including treatment for psychiatric illness and substance abuse, it will treat its participating psychiatrists like its other participating physicians with respect to its provider directories and referrals, and it will adhere to the "prudent lay person standard" for emergency services, including admission, or physical or chemical restraints. (§7.33)

- ***Better state and federal law supercedes the Agreement***. (§7.29)

Enforcement of Settlement Agreement

- A Physicians' Advisory Committee will be created to address issues of statewide or greater scope. (§7.9)

- Physicians and signatory state medical societies will enforce the Agreement, including Health Net's agreement to abide by those laws that are more protective of physicians than the provisions otherwise contained in the Agreement, exclusively through an efficient "compliance dispute" resolution process. The United States District Court Judge handling the litigation will have ultimate enforcement power. (§12)

- Physicians and signatory state medical societies retain the right to seek the enactment of better state laws and regulations, and to enforce those better protections. (§13.9)

Coverage:

- The Settlement covers all physicians (over 700,000 physicians, physician groups and physician organizations) who have provided covered services to any person enrolled in or covered by a plan offered or administered by any of the defendants named in the complaint (including Aetna, CIGNA, Prudential, Humana, Wellpoint, Pacificare, Health Net, Anthem, United and Coventry).

- The Settlement also includes the following 15 Signatory Medical Societies: California, Connecticut, El Paso County (Co), Florida, Georgia, Hawaii, Louisiana, Nebraska, New Jersey, North Carolina, Northern Virginia, South Carolina, Tennessee, Texas and Washington.

Distribution of Monetary Relief

- Retired Physicians who file valid claims will receive their pro rata share of the Retired Physician Amount, which will he calculated based on the number of retired physicians who file valid proofs of claim (they receive more than Active Physicians because they will not directly benefit from the prospective relief).

- Active Physicians will be entitled to receive the portion of the Settlement Fund that is available after subtracting the Retired Physician Amount.

- Each Active Physician who files a valid Proof of Claim will receive an amount based on the physician's gross receipts for providing covered services to Health Net Members during a three-year calendar period, depending on whether those receipts were less than $5,000 (entitling the physician to a single base amount) at least $5,000 but less than $50,000 (entitling the physician to five times the base amount), or $50,000 or greater (entitling the physician to ten times the base amount), regardless of whether these amounts were paid by Health Net or one of its delegated entities. The calculations will be based on Health Net's records for the period 2002-2004, unless the Physician wishes to submit his or her own proof of payment. ***Physicians who received payment for services to Health Net members from an IPA or other delegated entity or who had larger gross receipts in an earlier three-year period should elect this option, and submit 1099s or other documentation reflecting payments from those organizations, supplemented with a letter certifying what percentage of that payment was from Health Net and/or its subsidiaries.***

- In determining the amount of gross receipts, Physicians may only count payments from Health Net and its subsidiaries and affiliates which include: Health Net of California, Inc., Health Net of Arizona, Inc., Health Net of Oregon, Inc., Health Net of the Northwest, Inc., Health Net of Connecticut, Inc., Health Net of New York, Inc., Health Net of New Jersey, Inc., Health Net of Pennsylvania, Inc., plans that were formerly associated with Foundation Health Corporation, Inc., such as Intergroup Prepaid Health Services of Arizona, Inc., Intergroup of Utah, Inc., CareFlorida Health Systems, Inc., Community Medical Plan, Inc., S. Colorado Health Plan, Foundation Health, A California Health Plan, Inc., Foundation Health, A Florida Health Plan, Inc., Foundation Health, A Colorado Health Plan, Inc., Foundation Health, A Louisiana Health Plan, Inc., Foundation Health, A Texas Health Plan, Inc., and Foundation Health, A Oklahoma Health Plan, Inc., plans that were formerly associated with QualMed, Inc., such as QualMed Plans for Health, Inc., QualMed Plans for Health of Ohio and W. Virginia, Inc., QualMed Plans for Health of Pennsylvania, Inc., QualMed Colorado Health Plan, Inc., QualMed Oregon Health Plan, Inc., QualMed Plans for Health New Mexico, QualMed Washington Health Plan, and Preferred Health Network, Inc., plans that were formerly associated with Health Systems International, Inc., such as MD Health Plan, Greater Atlantic Health Services, Inc., Advantage Health, and Pennsylvania Health Care Plan, Inc., plans that were formerly associated with Foundation Health Systems, Inc. such as First Option Health Plan of New Jersey, Inc., First Option Health Plan of Pennsylvania, Inc., PACC HMO/PACC Health Plans, Physicians Health Services ("PHS"), Inc., PHS of New York, Inc., PHS of New Jersey, Inc., and PHS of Connecticut, Inc., and others (collectively "Health Net").

- Even if you never treated a Health Net enrollee, you are entitled to damages if between January 1990 and May 10, 2005 you treated any enrollee of any of the ten defendant health plans: Aetna, Anthem, Coventry, CIGNA, Humana, Health Net, United, PacifiCare, Prudential and/or WellPoint; and you have not opted out of the Health Net Settlement. Class Members who never treated a Health Net enrollee are entitled to claim the Base Amount (check the 1st box in Section II) or, if retired, to claim as a retired physician, pursuant to Section I.

- Physicians who do not specify a category of gross receipts will be deemed entitled to a single base amount.

- Each Retired Physician and Active Physician has the option of receiving payments or directing his or her amount to the California Medical Association Foundation, or the Foundation created by the CIGNA Settlement, the Physicians' Foundation for Health Systems Innovations.

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

- It is suggested that Physicians send claim forms via certified mail so they have proof the documents were sent out on time.

Enclosure: Attachment A

ATTACHMENT A

IMPLEMENTATION DATES FOR SECTION 7 COMMITMENTS

Section	Description	Implementation Date*
7.1	Automated Adjudication of Claims	5/10/05
7.2	Increased Intranet and Clearinghouse Functionality	
a	Investments/Requirements	Effective Date + 90 days
b	Electronic Transactions	Effective Date + 90 days
c	Website Access—Facilitator/Medical Societies	9/7/05
7.3	Availability of Fee Schedule/CPT Code Inquiries	Effective Date + 120 days
7.4	Provider Relations Investment	5/10/05
7.5	Reduced Pre-certification Requirements/Disclosure	
a	Reduced Pre-certification Requirements	11/6/05
b	Disclosure of Pre-certification Requirements	11/6/05
c	Disclosure of Customized Pre-certification List	11/6/05
7.6	Material Adverse Charge Notice	7/9/05
7.7	Initiatives to Reduced Claims Resubmissions	11/6/05
7.8	Disclosure of Commitments Concerning Claims Payment Practices	
a	Consistency of Claim Payment Practices	The later of the Effective Date or 12/31/05
b	Certain Claims Bundling Logic	Effective Date + 90 days
c	Request for Clinical Information	Effective Date + 90 days
d	Claims with Modifiers 25 and 59	The later of the Effective Date or 12/31/05
e	Updates	The later of the Effective Date or 12/31/05
7.9	Physicians Advisory Committee	Effective Date
7.10	New Dispute Resolution Process for Physician Billing Disputes	Effective Date
7.11	Medical Necessity/Experimental-Investigational Determinations	Effective Date
7.12	ERA/EFT	12/31/05
7.13	Participation in Company's Network	
a	Credentialing	Effective Date + 90 days
b	"All Products" Clauses	7/9/05
c	Termination Without Cause	7/9/05
d	Rights of Class Members to Refuse to Accept New Patients	Effective Date

* Company may at its option give noticed to Class Counsel that it is implementing a commitment earlier than the date for such commitment on this Exhibit A, in which case the Implementation Date, Effective Period and Conclusion Date for such commitment(s) shall be advanced in accordance with the date set forth in such notice.

7.14	Fee Schedule Changes	
a	Notice	Effective Date
b	Payment Rules for Injectibles, DME, etc.	Effective Date
c	Appeals of R&C Determinations	Effective Date
7.15	Recognition of Assignments of Benefits	9/7/05
7.16	Application of Clinical Judgment	
a(1)	Medical Necessity Definition	7/9/05
a(2)	External Review Statistics	Effective Date
b	Policy Issues Involving Clinical Judgment	7/9/05
c	Consideration of Administrative Exemption Program	Effective Date
7.17	Billing and Payment	
a	Timing of Claim Submissions 120-day requirement	12/31/05
b	Claims Submissions (acceptance of certain forms and submissions of Clinical Information)	12/31/05
7.18	Timelines for Processing and Payment of Complete Claims	
a	Logging of Receipt Date and Attempt to Require 24-Hour Transmission by Clearinghouses	The later of the Effective Date + 6 months or 10/1/06
b	Payment of Simple Interest	The later of the Effective Date + 6 months or 10/1/06
7.19	No Automatic Downcoding of Evaluation and Management Claims	5/10/05
7.20.a.i	Modifications to Payment Policies	The later of the Effective Date + 6 months or 10/1/06
7.21	Modification of Language in EOBs and Remittance Forms	Effective Date + 120 days
7.22	Overpayment Recovery Procedures	Effective Date + 90 days
7.23	Efforts to Improve Accuracy of Eligibility Information	5/10/05
7.24	Response to Physicians Inquiries	5/10/05
7.25	Confirmation of Medical Necessity	7/9/05
7.26	Electronic Connectivity	Effective Date + 90 days
7.27	Physician Information on Website	Effective Date + 90 days
7.28	Capitation and Physician Organization Issues	
a	Capitation Reporting	Effective Date
b	PCP Assignment	Effective Date
7.29	Miscellaneous	
a	No “Gag Clauses”	7/9/05
b	Ownership of Medical Records	7/9/05
c	Arbitration Fee Limits	Effective Date + 60 days
d	Impact on Physician Agreements	Obligations and commitments to be incorporated into physician contracts (where required) as they commence pursuant to this Exhibit A
e	Impact of this Agreement on Covered Services	5/10/05
f	Privacy of Records	5/10/05

g	Physician Risk Pools	5/10/05
h	"Stop Loss"	5/10/05
i	Pharmacy Provisions—Disclosures re: Formulary; Maintenance of Exception Process; Coverage for Off-Label Uses	5/10/05
j	Restrictive Endorsements	5/10/05
k	Scope of Responsibilities	Obligations and commitments to be incorporated into physician contracts (where required) as they commence pursuant to this Exhibit A
l	Provision of Contract Copies	7/9/05
m	State and Federal Laws	5/10/05
n	Modification of Means of Disclosure	5/10/05
o	Participating Physicians Status and Limits on Obligations on Non-Participating Physicians	Effective Date
p	Limitation on Rental Networks	Effective Date + 60 days
q	Most Favored Nations Clauses	7/9/05
7.30	Compliance with Applicable law and Government Contracts	Obligations and commitments to be incorporated into physician contracts (where required) as they commence pursuant to this Exhibit A
7.31	Value of Section 7 Initiatives	5/10/05
7.32	Force Majeure	5/10/05
7.33	Mental Health Provisions	Effective Date + 120 days

ANTHEM/WELLPOINT SETTLEMENT OVERVIEW

(Agreement Dated July 11, 2005; Preliminarily Approved by Judge Moreno, July 14,2005)

The following is a general overview of the major provisions of the Anthem/Wellpoint Settlement likely to be of interest to California physicians. It is not intended to be comprehensive. The prospective relief noted below generally extends for four (4) years from the date Judge Moreno preliminarily approves it, with specific aspects commencing as specified in the Agreement. *See* Attachment A. Physicians interested in the specifics should read the language of the actual Settlement Agreement, which is posted in the CMA's RICO Resource Center at **www.cmanet.org**.

Retrospective Relief:

- $135,000,000 to class members, without any requirement for the submission of medical records. (§8)
- $5,000,000 to a Foundation devoted to improving medical practice. (§8)
- the deadline for filing claims is November 17, 2005.

Prospective Relief: Over $250 million

- ***Better Medical Necessity Definition*** - Patients will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, and cheaper alternatives are permissible only when they are "at least as likely to produce equivalent therapeutic or diagnostic results." (§7.16)
- ***Payment of Vaccines and Vaccine Administration*** - Recommended vaccines and injectibles and the administration of such vaccines and injectibles, will be reimbursed. (§7.14)
- ***Reduced Downcoding*** - Evaluation and management CPT codes will not be automatically downcoded or reassigned. (§7.19)
- ***Fewer Contract Changes*** – No material adverse change to a contract may be made on less than 90 days written notice. (§7.6)
- ***Fairer Payment Rules*** - CPT coding edits will comply with most of the guidelines contained in the AMA CPT Manual. (§7.20)
- ***Consistency and Disclosure of Payment Rules*** - Payment rules will generally be consistent across all Blue Cross products except Medi-Cal, Healthy Families, MRMIB and FEHBP. Moreover, most reimbursement edits and claims adjudication logic will be disclosed. (§7.8)
- ***Capitation from Date of Enrollment*** - Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to date of enrollment. (§7.28)
- ***All products clauses limited*** – Wellpoint will not require physicians to participate in products they do not want to participate in its Medicare Advantage or Medi-Cal networks in order to participate in its Prudent Buyer Network. Wellpoint also agrees that it will not require physicians who otherwise do not provide Worker's Compensation services to provide those services as a condition of participation in the Prudent Buyer Network. (7.13)
- ***Stop-loss Insurance May be Purchased Elsewhere*** – Wellpoint will not restrict physicians from purchasing stop-loss coverage from other insurers. (§7.29)

- ***Faster Credentialing –*** New physician group members will be credentialed within 90 days of application, which physician groups can submit prior to their employment, and little or no additional credentialing will be required when already credentialed physicians change employment or location. (§7.13)

- ***Arbitration Reform –*** Arbitration fees will be refunded to those physicians who prevail. Moreover, Wellpoint's participation contracts will not (1) require that arbitrations take place more than 50 miles from the physicians' office, (2) require that there be multiple arbitrators, (3) prevent the recovery of any statutory or otherwise legally available damages or other relief, (4) restrict the statutory or otherwise legally available scope or standard of review, (5) completely prohibit discovery, or (6) shorten the statute of limitations. (§7.29)

- ***Prompt, external dispute resolution mechanism for physician disputes –*** A streamlined, external review system will be established enabling physicians to dispute Wellpoint's decisions on billing or medical records requests (Billing Dispute External Review Board). (§7.10)

- ***Gag clauses prohibited –-*** "Gag" clauses will be prohibited. (§7.29)

- ***Non-participating physicians protected –*** Disparaging language will be removed from EOBs, and the Agreement will not change or alter the rights of non-participating physicians to balance bill patients or to avoid dealing with Wellpoint. (§§7.21 and 7.29) Moreover, Wellpoint will disclose "the general methodology, including the percentile of the included charge data on which the maximum allowable amount is based, and source data used by Company to determine the usual, reasonable and customary amount for the service or supply" whenever any specific determination is challenged. (§7.14)

- ***No HIPAA Mandate –*** Non-participating physicians will not be forced to use electronic transactions or otherwise become HIPAA compliant, and Wellpoint agrees to continue to accept paper claims. (§7.17)

- ***HIPAA Compliance –*** For those physicians who want to take advantage of the enormous potential savings made possible by electronic transactions, including electronic remittance advice and verification of eligibility, Wellpoint agrees, at the physician's election, to make those transactions available. (§7.2)

- ***Restrictive Endorsements Limited*** – When the check is a partial payment of allowable charges, physicians may cash a check with "Payment in Full" on it without waiving the right to pursue a remedy under the Settlement. (§7.29)

- ***Better Mental Health Coverage*** – Wellpoint will generally apply the §7.16 definition of medical necessity described above to mental health care, including treatment for psychiatric illness and substance abuse, it will treat its participating psychiatrists like its other participating physicians with respect to its provider directories and referrals, and it will adhere to the "prudent lay person standard" for emergency services, including admission, or physical or chemical restraints. (§7.33)

- ***Better state and federal law supercedes the Agreement***. (§7.29)

Enforcement of Settlement Agreement

- A Physicians' Advisory Committee will be created to address issues of regional or nationwide scope. (§7.9)

- Physicians and signatory state medical societies will enforce the Agreement, including Wellpoint's agreement to abide by those laws that are more protective of physicians than the provisions otherwise contained in the Agreement, exclusively through an efficient "compliance dispute" resolution process. The United States District Court Judge handling the litigation will have ultimate enforcement power. (§12)

- Physicians and signatory state medical societies retain the right to seek the enactment of better state laws and regulations, and to enforce those better protections. (§13.10)

Coverage:

- The Settlement covers all physicians (over 700,000 physicians, physician groups and physician organizations) who have provided covered services to any person enrolled in or covered by a plan offered or administered by any of the defendants named in the complaint (including Aetna, CIGNA, Prudential, Humana, HealthNet, Pacificare, Wellpoint, Anthem, United and Coventry).

- The Settlement also includes the following 11 Signatory Medical Societies: California, Connecticut, El Paso County (Co), Florida, Georgia, Louisiana, Northern Virginia, Rhode Island, South Carolina, Texas and Puerto Rico.

Distribution of Monetary Relief

- Retired Physicians who file valid claims will receive their pro rata share of the Retired Physician Amount, which will he calculated based on the number of retired physicians who file valid proofs of claim (they receive more than Active Physicians because they will not directly benefit from the prospective relief).

- Active Physicians will be entitled to receive the portion of the Settlement Fund that is available after subtracting the Retired Physician Amount.

- Each Active Physician who files a valid Proof of Claim will receive an amount based on the physician's gross receipts for providing covered services to Wellpoint Members during a three-year calendar period between January 1, 1996 and December 31, 2004, depending on whether those receipts were less than $5,000 (entitling the physician to a single base amount) at least $5,000 but less than $50,000 (entitling the physician to five times the base amount), or $50,000 or greater (entitling the physician to ten times the base amount), regardless of whether these amounts were paid by Wellpoint or one of its delegated entities. The calculations will be based on Wellpoint's records for the period 2002-2004, unless the Physician wishes to submit his or her own proof of payment. ***Physicians who received payment for services to Wellpoint members from an IPA or other delegated entity or who had larger gross receipts in an earlier three-year period should elect this option, and submit 1099s or other documentation reflecting payments from those organizations, supplemented with a letter certifying what percentage of that payment was from Wellpoint and/or its subsidiaries.***

- Physicians who do not specify a category of gross receipts will be deemed entitled to a single base amount.

- Each Physician has the option of receiving payments or directing his or her amount to the California Medical Association Foundation, or the Foundation created initially by the CIGNA Settlement, the Physicians' Foundation for Health Systems Innovations, Inc.

- Physician Groups may submit claims on behalf of Physicians employed or otherwise working with them at the time the claims are submitted, but only to the extent these Physicians do not submit individual claims. Physician Groups should file the claim form using the group's tax ID number and address, and attach a list of the names and Social Security Numbers of the individual physicians on whose behalf the group is claiming, and the category of gross receipts applicable to each physicians, as discussed above. The claim form should be signed by the Medical Group's President or by another individual who has authority to represent the listed physicians.

- It is suggested that Physicians send their claim forms via certified mail so they have proof their documents were sent out before the deadline.

ATTACHMENT A

Start Dates of Anthem/WellPoint's Obligations Under Section 7 of the Agreement

Section	Obligation	Start Date
§ 7.1	Automated Adjudication	7/15/05
§ 7.2	Increased Internet and Clearinghouse Functionality	7/15/05
§ 7.3	Availability of Fee Schedules and Scheduled Payment Dates – Complete Fee Information	Final Order Date + 12 months
§ 7.3	Availability of Fee Schedules and Scheduled Payment Dates – Up To 100 CPT Codes	Final Order Date
§ 7.4	Investments in Initiatives to Improve Provider Relations	7/15/05
§ 7.5	Reduced Precertification Requirements – Posting on Provider Website	Final Order Date + 3 months
§ 7.5	Reduced Precertification Requirements - Proposals to Self-Insured Plans	Contracts Issued or Renewed After Final Order Date
§ 7.6	Greater Notice of Policy and Procedure Changes	Final Order Date
§ 7.7	Initiatives to Reduce Claim Resubmissions	7/15/05
§ 7.8,	Disclosure of and Commitments Concerning Claims Payment Practices	---
§ 7.8(b)	Consistency of Claim Payment Practices	Final Order Date + 12 months
§ 7.8(d)	Disclosure of Significant Edits on Provider Website	Final Order Date + 6 months (or as soon thereafter as practicable)
§ 7.8(d)(i)	Publish Customized Edits on Provider Website	Final Order Date + 6 months (or as soon thereafter as practicable)
§ 7.8(d)(ii)	Commitments regarding Submission of Clinical Information	Final Order Date
§ 7.8(d)(iii)	Disclosures regarding Modifiers 25 and 59	Final Order Date + 6 months
§ 7.9	Physician Advisory Committee	---
§ 7.9(a)	Establishment of Physician Advisory Committee	The later of the Final Order Date + 3 months or the selection of the members of the Physician Advisory Committee in accordance with § 7.9(b)
§ 7.9(b)	Selection of Members by Company	9/13/05
§ 7.9(b)	Selection of Members by Representative Plaintiffs	9/13/05
§ 7.9(b)	Selection of Remaining Members	11/12/05
§ 7.10	New Dispute Resolution Process for Physician Billing Disputes	---
§ 7.10(a)	Establishment of Billing Dispute External Review Board	Final Order Date + 4 months
§ 7.10(d)	Selection of the BDERB Members	11/12/05
§ 7.11	Determinations Related to Medical Necessity and Experimental or Investigational Nature of Proposed Services	---
§ 7.11(a)	Procedures regarding Initial Determinations	Final Order Date
§ 7.11(b)(ii)	Establishment of Internal and External Review Processes	Final Order Date + 12 months
§ 7.12	[Intentionally Left Blank]	---
§ 7.13	Participation in Company's Network	---

§ 7.13(a)	Credentialing of Physicians	Final Order Date + 6 months
§ 7.13(b)	General Commitments regarding All Products Clauses	Final Order Date
§ 7.13(b)	Notice to Participating Physicians in Standard Prudent Buyer Plan of Right to Opt Out	Effective Date + 60
§ 7.13(c)	Termination Without Cause	Final Order Date
§ 7.13(d)	Class Member Refusal to Accept New Patients	Final Order Date
§ 7.14	Fee Schedule Changes	---
§ 7.14(a)	Establishing Standard Fee Schedules	Final Order Date
§ 7.14(a)	Limitations regarding Reduction of Fee Schedules	January 1 of the Year Following the Effective Date
§ 7.14(b)	Payment Rules for Injectibles, DME, and Review of New Technology	Final Order Date
§ 7.14(c)	Usual, Reasonable, and Customary Appeals	Final Order Date + 3 months
§ 7.14(d)	Usual, Reasonable, and Customary Determinations	Final Order Date + 3 months
§ 7.15	[Intentionally Left Blank]	---
§ 7.16	Application of Clinical Judgment	---
§ 7.16(a)	Medical Necessity Definition – Current Agreements	Final Order Date
§ 7.16(a)	Medical Necessity Definition – Future Agreements	Agreements Issued After Final Order Date
§ 7.16(a)	Adverse Determination Denial Rate	For the calendar year beginning after the Final Order Date
§ 7.16(b)	Policy Issues Involving Clinical Judgment	Final Order Date
§ 7.16(c)	Consideration of Administrative Exemption Program	Final Order Date + 6 months
§ 7.17	Billing and Payment	---
§ 7.17(a)	Time for Submission of Claims	Final Order Date
§ 7.17(b)	Claims Submission (re: acceptance of certain forms and submissions of Clinical Information)	Final Order Date
§ 7.18	Timelines for Processing and Payment of Complete Claims	---
§ 7.18(a)	30 Day Period for Processing and Payment of Complete Claims	Final Order Date + 9 months
§ 7.18(a)	15 Day Period for Processing and Payment of Electronically Submitted Complete Claims	Effective Date + 1 year
§ 7.18(b)-(d)	Timing of Payment for Complete Claims and Payment of Interest	Final Order Date + 9 months
§ 7.18(e)	Commitments regarding Claim Handling	Final Order Date + 9 months
§ 7.19	No Automatic Downcoding of Evaluation and Management Claims	Final Order Date
§ 7.20	Bundling and Other Computerized Claim Editing	---
§ 7.20(a)-(h)	Modifications to Payment Policies	Final Order Date + 9 months
§ 7.20(i)	Updating Claims Editing Software	Final Order Date + 6 Months (or as soon thereafter as practicable)
§ 7.21	EOB and Remittance Advice Content	---
§ 7.21(a)	Content of EOB Forms	Final Order Date + 6 months (or as soon thereafter as practicable)
§ 7.21(a)	Content of Remittance or Similar Forms	Final Order Date + 6 months (or as soon

		thereafter as practicable)
§ 7.22	Overpayment Recovery Procedures	Final Order Date
§ 7.23	Improve Accuracy of Eligibility Information	Final Order Date
§ 7.24	Responses to Physician Inquiries	7/15/05
§ 7.25	Confirmation of Medical Necessity	Final Order Date
§ 7.26	Electronic Connectivity	7/15/05
§ 7.27	Information about Physicians Provided by Company	Final Order Date
§ 7.28	Capitation and Physician Organization Specific Issues	---
§ 7.28(a)	Capitation Reporting	Final Order Date + 120 days
§ 7.28(b)	Payments for Plan Members under Capitation Who Do Not Select PCP at Time of Enrollment	Final Order Date + 120 days
§ 7.29	Miscellaneous	---
§ 7.29(a)	No "Gag Clauses"	Final Order Date
§ 7.29(b)	Ownership of and Access to Clinical Information	7/15/05
§ 7.29(c)	Arbitration	Final Order Date
§ 7.29(d)	Impact on Standard Form Agreements and Individually Negotiated Contracts	---
§ 7.29(d)(i)	Standard Form Agreements	Final Order Date
§ 7.29(d)(ii)	Current Individually Negotiated Contracts	7/15/05
§ 7.29(d)(iii)	Future Individually Negotiated Contracts	7/15/05
§ 7.29(e)	Impact on Covered Services	Final Order Date
§ 7.29(e)	Recommendation to Self-Insured Plans	Contracts Issued or Renewed After Final Order Date
§ 7.29(f)	Privacy of Records	7/15/05
§ 7.29(g)	Pharmacy Risk Pools	Final Order Date
§ 7.29(h)	"Stop Loss" Coverage	Final Order Date
§ 7.29(i)	Pharmacy Provisions	Final Order Date
§ 7.29(j)	Restrictive Endorsements	7/15/05
§ 7.29(k)	Scope of Company's Responsibilities	---
§ 7.29(k)(i)	Future Contracts with Delegated Entities	Final Order Date
§ 7.29(k)(ii)	Application to Health Link	Final Order Date
§ 7.29(k)(iii)	Application to Blue Card Program	Final Order Date
§ 7.29(k)(iv)	BCBSA Rules and Regulations	Preliminary Approval Date
§ 7.29(k)(v)	Impact of Settlement(s) in Thomas	Final Order Date
§ 7.29(l)	Copies of Contracts	Final Order Date
§ 7.29(m)	State and Federal Laws and Regulations	7/15/05
§ 7.29(n)	Modification of Means of Disclosure	7/15/05
§ 7.29(o)	Limitations on Obligations of Non-Participating Physicians	7/15/05
§ 7.29(p)(i)	Limitation on Rental Networks – Disclosures on Provider Websites	Final Order Date + 3 months
§ 7.29(p)(ii)	Limitation on Rental Networks – Commitments Regarding Use of Rental Networks or Discounted Fee Schedules	Final Order Date + 3 months
§ 7.29(q)	Effect of Assignment of Benefits	7/15/05
§ 7.31	Estimated Value of Section 7 Initiatives	---
§ 7.32	Force Majeure	7/15/05
§ 7.33	Mental Health and Substance Abuse Provisions	---

§ 7.33(a)	Medical Necessity Definition – Current Agreements	Final Order Date
§ 7.33(a)	Medical Necessity Definitions – Future Agreements	Agreements Issued After Final Order Date
§ 7.33(b)	Listing of Participating Psychiatrists; Referrals	Final Order Date
§ 7.33(c)	Payment for Medically Necessary Covered Services	Final Order Date
§ 7.33(d)	"Prudent Lay Person" Laws	Final Order Date
§ 7.33(e)	Posting of Authorization Form	Final Order Date
§ 7.34	Annual Compliance Reporting	Final Order Date