

SETTLEMENT AGREEMENT

dated as of

May 23, 2005

by and among

DEFENDANTS,

THE REPRESENTATIVE PLAINTIFFS,

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AND CLASS COUNSEL

## SETTLEMENT AGREEMENT

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

### WITNESSETH:

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

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

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

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

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

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

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

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

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

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

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

1. Definitions.

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

- 1.1. **“Actions”** means Dolan, et al. v. Excellus, Inc., et al. and Medical Society of the State of New York v. Excellus, Inc., et al., Nos. 9768-01 and 9769-01, Supreme Court, State of New York, County of Monroe.
- 1.2. **“Active Physician”** means a Class Member who is a Physician and who is not a Retired Physician.
- 1.3. **“Active Physician Benefit”** shall have the meaning assigned to that term in § 8 of this Agreement.
- 1.4. **“Affiliate”** means with respect to any Person, any other Person controlling, controlled by or under common control with such first Person. The term “control” (including without limitation, with correlative meaning, the terms “controlled by” “under common control with”), as used with respect to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management policies of such Person, whether through the ownership of voting securities or otherwise.
- 1.5. **“Agreement”** shall have the meaning assigned to that term in the preamble of this Agreement.
- 1.6. **“Attorneys’ Fees”** means the funds for attorneys’ fees and expenses that may be awarded by the Court to Class Counsel.
- 1.7. **“Billing Dispute”** shall have the meaning assigned to that term in § 7.10 of this Agreement.
- 1.8. **“Billing Dispute External Review Administrator”** shall have the meaning assigned to that term in § 7.10 of this Agreement.
- 1.9. **“Business Day”** means any day on which commercial banks are open for business in New York City.
- 1.10. **“Class”** means any and all Participating and Non-Participating Physicians, Physicians Groups and Physician Organizations who provided Covered Services in the State of New York to any Plan Member or any individual enrolled in or covered by an insured plan in the State of New York offered or administered by any Person named as a defendant in the Actions or by any of their respective current or former subsidiaries or affiliates, in each case from August 15, 1996 through the Preliminary Approval Date.
- 1.11. **“Class Counsel”** means those Persons set forth on Exhibit A attached hereto.
- 1.12. **“Class Member”** means any Person who is a member of the Class.

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

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

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

1.16. **“Company”** means Excellus Health Plan, Inc.

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

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

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

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

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

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

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

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

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

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

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

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

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

1.29. **Provision Deleted**

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

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

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

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

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

- 1.35. **“Final Order and Judgment”** means the order and form of judgment approving this Agreement and dismissing the Actions against Company with prejudice, in each case in the form attached hereto as Exhibit C.
- 1.36. **“Fully Insured Plan”** means a Plan as to which Company assumes all or a majority of healthcare cost and/or utilization risk.
- 1.37. **“Implementation Date”** means the 41<sup>st</sup> day after the entry of the Final Order and Judgment approving this Agreement, unless a notice of appeal is filed therefrom. In such event, at the option of the Defendant, the Implementation Date shall be eleven calendar days after the Final Order and Judgment is affirmed, all appeals are dismissed, and no further appeal or review in any court remains.
- 1.38. **“Independent Practice Association”** means those IPAs and IPA-like entities with which Excellus has contracts as set forth in Exhibit D attached hereto.
- 1.39. **“Individually Negotiated Contract”** means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the terms of Company’s standard form agreement to individually suit the needs of a particular Participating Physician, Physician Group or Physician Organization.
- 1.40. **“Mailed Notice”** means the form of notice attached hereto as Exhibit E.
- 1.41. **“Material Adverse Change”** means any change in the Company’s policies that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by Company to a significant number of Participating Physicians for Covered Services (ii) a significant number of Participating Physicians’ administration of their practices, or (iii) Physicians in any specialty or subspecialty.
- 1.42. **“Medical Necessity”** or **“Medically Necessary”** shall have the meaning assigned to that term in § 7.16.a. of this Agreement.
- 1.43. **“Medical Necessity External Review Process”** shall have the meaning assigned to that term in § 7.11 of this Agreement.
- 1.44. **“Medical Necessity Independent Review Organization”** means an organization that provides independent medical reviews of Company’s denials of coverage which are based on the lack of medical necessity or the experimental/investigational nature of the proposed or rendered service or supply for self-funded groups.
- 1.45. **“Multiple Procedure Logic”** means the adjustment(s) to payment(s) for one or more procedures or other services, in each case constituting Covered

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

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

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

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

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

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

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

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

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

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

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

- 1.56. **“Physician”** means an individual duly licensed by the New York State licensing board as a Medical Doctor or as a Doctor of Osteopathy and shall include both Participating Physicians and Non-Participating Physicians.
- 1.57. **“Physician Group”** means two or more Physicians who practice medicine under a single taxpayer identification number.
- 1.58. **“Physician Advisory Committee”** shall have the meaning assigned to that term in § 7.9 of this Agreement.
- 1.59. **“Physician Organization”** means any association, partnership, corporation or other form of organization (including without limitation independent practice associations and physician hospital organizations) that arranges for care to be provided by Physicians organized under multiple taxpayer ID numbers, to Plan Members.
- 1.60. **“Physician Services”** means Covered Services that a Physician provides to a Plan Member, as specified in applicable agreements with Company, or otherwise.
- 1.61. **“Physician Specialty Society”** means a United States medical specialty society recognized by the American Medical Association as a national medical specialty society or that represents physicians certified by a board recognized by the American Board of Medical Specialties.
- 1.62. **“Plan”** means a Plan Member’s health care benefits as set forth in the Plan Member’s Summary Plan Description, Certificate of Coverage or other applicable coverage document.
- 1.63. **“Plan Member”** means an individual enrolled in or covered by a Plan offered or administered by Company. Plan Member does not include participants of the FEP program for Federal employees.
- 1.64. **“Preliminary Approval Date”** means the date the Preliminary Approval Order is entered by the Court.
- 1.65. **“Preliminary Approval Order”** means the preliminary approval order, in the form attached hereto as Exhibit F.
- 1.66. **“Provider Website”** means the secure (password protected) online resource for Participating Physicians to obtain information about Company, its products and policies and other information described in more detail in this Agreement, and which is currently located at <https://www.excellusbcb.com/providers/index.shtml>

1.67. **“Public Website”** means the online resource for the public to obtain information about Company, its products and policies and other information and which is currently located at [www.excellusbcs.com](http://www.excellusbcs.com).

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

1.69. **Provision Deleted**

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

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

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

