

**ADDENDUM TO PARTICIPATING PHYSICIAN, PHYSICIAN GROUP AND  
PHYSICIAN ORGANIZATION CONTRACT**

THIS IS AN ADDENDUM TO YOUR CURRENT AETNA PARTICIPATING PHYSICIAN, PHYSICIAN GROUP OR PHYSICIAN ORGANIZATION CONTRACT.

THIS ADDENDUM SUPERCEDES ANY AND ALL PROVISIONS IN YOUR EXISTING AETNA CONTRACT TO THE EXTENT THAT CONTRACT IS INCONSISTENT WITH THE PROVISIONS OF THIS ADDENDUM. ANY ADDITIONAL RIGHTS YOU HAVE UNDER FEDERAL LAW OR THE LAW OF YOUR STATE WILL PREVAIL OVER THAT CONTRACT AND THIS ADDENDUM.

THIS ADDENDUM WILL EXPIRE ON THE DATES AND IN THE MANNER DESCRIBED IN PARAGRAPHS 19-20 BELOW. PARTICIPATING PHYSICIAN MAY TERMINATE THIS AGREEMENT UPON EXPIRATION OF THIS ADDENDUM UPON 90 DAYS WRITTEN NOTICE.

THIS ADDENDUM REFERS TO “PARTICIPATING PHYSICIANS.” IF YOUR CONTRACT IS BETWEEN AETNA AND A PHYSICIAN GROUP OR PHYSICIAN ORGANIZATION, THEN “PARTICIPATING PHYSICIAN” SHALL MEAN “PHYSICIAN GROUP” OR “PHYSICIAN ORGANIZATION,” AS APPLICABLE.

THE SETTLEMENT AGREEMENT DATED MAY 21, 2003 BY AND AMONG AETNA INC., THE REPRESENTATIVE PLAINTIFFS, THE SIGNATORY MEDICAL SOCIETIES AND CLASS COUNSEL CONTAINS CERTAIN DISPUTE RESOLUTION PROCESSES. NOTWITHSTANDING SPECIFIC FILING DEADLINES FOR THESE DISPUTE PROCESSES, OR AETNA’S INTERNAL DISPUTE PROCESSES, A PARTICIPATING PHYSICIAN MAY FILE ANY DISPUTES CONCERNING ANY TOPIC ADDRESSED IN THIS ADDENDUM PURSUANT TO ANY OF THE DISPUTE RESOLUTION PROCESSES ESTABLISHED BY THE SETTLEMENT AGREEMENT WITHIN 90 DAYS FROM THE DATE OF THIS ADDENDUM.

FOR THE PURPOSE OF THIS ADDENDUM, “COMPANY” SHALL MEAN THE AETNA PARTY TO YOUR AGREEMENT.

FOR THE PURPOSE OF THIS ADDENDUM, “SETTLEMENT AGREEMENT” SHALL MEAN THE SETTLEMENT AGREEMENT DATED AS OF MAY 21, 2003 IN THE MATTER OF *IN RE MANAGED CARE LITIGATION*, MASTER FILE NO.: 00-1334-MD-MORENO, BETWEEN AETNA INC. AND THE REPRESENTATIVE PLAINTIFFS AND SIGNATORY MEDICAL SOCIETIES, AND WHICH IS LOCATED AT [WWW.HMOSETTLEMENTS.COM](http://WWW.HMOSETTLEMENTS.COM), AND AS EXTENDED PURSUANT TO PARAGRAPHS 19-20 BELOW.

FOR THE PURPOSE OF THIS ADDENDUM, ANY OTHER CAPITALIZED WORDS NOT OTHERWISE DEFINED IN THE ADDENDUM SHALL HAVE THE MEANING SET FORTH IN THE SETTLEMENT AGREEMENT.

1. To the extent that the term “**Clean Claim**” is utilized in or its use is implicated by your agreement with Aetna, “**Clean Claim**” shall be defined as follows:

**Clean Claim.** Unless otherwise required by law or applicable regulation, 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 CMS-1500 (or successor standard) forms or (ii) when submitted via an electronic transaction, uses only permitted standard code sets (e.g. CPT®-4, ICD-9, HCPCS) and has all the elements of the standard electronic formats, as required by applicable Federal authority and state regulatory authority (except where such state authority is preempted by applicable Federal authority), (d) is a claim for which Company is the primary payor or Company’s responsibility as a secondary payor has been established by agreement of Company or by order no longer subject to appeal or review (in the context of coordination of benefits), and (e) contains no defect or error.

2. To the extent that the term “**Material Change**” is utilized in or its use is implicated by your Agreement with Aetna, “**Material Change**” shall be defined as follows:

**Material Change.** Any change in Policies that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by Company to Participating Physician for Physician Services or (ii) administration of Participating Physician’s practice.

3. To the extent that the term “**Medically Necessary Services**” is utilized in or its use is implicated by your Agreement with Aetna, “**Medically Necessary Services**” shall be defined as follows:

**Medically Necessary Services.** Those health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease, and (c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease. For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

4. To the extent that the term “**Policies**” is utilized in or its use is implicated by your Agreement with Aetna, it shall be supplemented or otherwise amended as follows:

**Policies.** To the extent that the Settlement Agreement includes provisions that are applicable, all policies shall be consistent with the Settlement Agreement.

5. To the extent the terms “**Proprietary Information,**” “**Non-Competition,**” “**Non-Solicitation,**” or “**Interference with Contractual Relations**” are utilized in or their use are implicated by your Agreement with Aetna, it shall be supplemented or otherwise amended as follows:

**No Gag Clauses.** Nothing contained in Participating Physician’s agreement, including but not limited to language concerning Proprietary Information, Non-competition, Non-solicitation or Interference with Contractual Relations shall be construed to prohibit or limit the free, open and unrestricted communication between a Participating Physician and a Member regarding the nature of the Member’s medical conditions or treatment and provider options and the relative risks and benefit of such options, whether or not such treatment is covered under the Member’s Plan, and any right to appeal any adverse decision by Company regarding coverage of a treatment that has been recommended or rendered, and **Company shall not penalize or sanction a Participating Physician in any way for engaging in any free, open and unrestricted communication with a Member about any matters relevant to that particular member or for advocating for any service on behalf of a Member.**

6. The section of your Agreement with Aetna dealing with **Plan Participation or Product Participation** is supplemented or otherwise amended as follows:

**Product Participation.** Company agrees that it shall not require a Participating Physician to participate in capitated fee arrangements in order to participate in products in which such Participating Physician is compensated on a fee-for-service basis. In the event that a Participating Physician chooses not to participate in all Company products, or terminates participation in some Company products, the fee-for-service rate schedule offered to or applied by Company to such Participating Physician shall not be lower than the Company’s standard fee-for-service rate schedule for the geographic market in which such Participating Physician practices, which fee schedule Company shall update annually.

Nothing in this section is intended or shall be construed to prohibit Company from offering a higher fee-for-service rate schedule, or other incentive, to any Participating Physician who elects to participate (or continue participation) in all of Company’s products. Nothing contained herein shall restrict in any way Company’s contracting practices with respect to hospitals.

7. To the extent the section of your Agreement with Aetna dealing with “**Consents to Release Medical Information**” contains a covenant requiring you to obtain consents or authorizations to the release of member information to Company and or others, such covenant is supplemented or otherwise amended as follows:

**Consents to Release Medical Information.** You need obtain consents or authorizations to the release of information and records to Company, Plan Sponsors or others only to the extent required by law.

8. To the extent your Agreement with Aetna deals with “**Encounter Data**,” the Agreement is supplemented or otherwise amended as follows:

**Encounter Data.** Company agrees to use Encounter Data only for health care purposes or other lawful use.

9. The section of your Agreement which sets forth Aetna’s “**Company Obligations**” is supplemented or otherwise amended as follows:

**Company Obligations.** Company further agrees to comply with all the terms of the Settlement Agreement, including but not limited to all of the Business Practice Initiatives set forth in Section 7 of that Agreement regarding all of the following:

- Settlement Section 7.3 – Availability of Fee Schedules and Scheduled Payment Dates
- Settlement Section 7.5 – Reduced Pre-Certification Requirements
- Settlement Section 7.6 – Greater Notice of Policy and Procedure Changes
- Settlement Section 7.7 – Initiatives to Reduce Claims Resubmissions
- Settlement Section 7.8 – Disclosure of and Commitments Concerning Claim Payment Practices
- Settlement Section 7.10 – New Dispute Resolution Process for Physician Billing Disputes
- Settlement Section 7.11 – Medical Necessity External Review Process
- Settlement Section 7.13 – Participating in Company’s Network (a) Credentialing of Physicians; (b) All Products Clauses; and (c) Termination Without Cause
- Settlement Section 7.14 – How Much Company Shall Pay (a) Standardization of Rates; and (b) Payment Rules For Injectibles, DME, Administration of Vaccines, and Review of New Technologies
- Settlement Section 7.16 – Application of Clinical Judgment to Patient-Specific and Policy Issues
- Settlement Section 7.17 – Billing and Payment (a) Time Period for Submission of Bills for Services Rendered; and (b) Claims Submission
- Settlement Section 7.18 – Timelines for Processing of Clean Claims
- Settlement Section 7.19 – No Automatic Downcoding of Evaluation and Management Claims
- Settlement Section 7.20 – Bundling and Other Computerized Claim Editing
- Settlement Section 7.21 – EOB and Remittance Advice Content
- Settlement Section 7.22 – Overpayment Recovery Procedures
- Settlement Section 7.25 – Effect of Company Confirmation of Patient/Procedure Medical Necessity
- Settlement Section 7.27 – Information About Physicians on the Public Website
- Settlement Section 7.28 – Capitation and Physician Organization-Specific Issues

- Settlement Section 7.29 – Miscellaneous (a) “Gag” Clauses; (b) Ownership of Medical Records; (c) Arbitration; (d) Impact of this Agreement on Standard Agreements and Individually Negotiated Contracts; (e) Impact of this Agreement on Covered Services; (f) Privacy of Records; (g) Pharmacy Risk Pools; (h) Ability of Physicians to Obtain “Stop Loss” Coverage From Insurers Other Than Company; (i) Pharmacy Provisions; (l) Scope of Company’s Responsibilities; (m) Copies of Contract; (n) State and Federal Laws and Regulations; (o) Ability of Company to Modify Means of Disclosure; and (p) Limitations on Obligations of Non-Participating Physicians.
- Settlement Section 7.30 – Compliance With Applicable Law and Requirements of Government Contracts

Company further agrees that it will remain in compliance with all applicable federal and state laws related to this Agreement and the services to be provided hereunder.

10. The Section of your Agreement with Aetna dealing with the **Submission of Claims** is supplemented or otherwise amended as follows:

**Obligation to Submit Claims.** Company agrees to accept both properly completed paper claims submitted on Form CMS 1500, UB-92, or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format or fields. Company shall not require Non-Participating Physicians to utilize electronic transactions.

11. The Section of your Agreement with Aetna dealing with Aetna’s **Obligations to Pay Covered Services** is supplemented or otherwise amended as follows:

**Company Obligation to Pay Covered Services.** Company shall direct the issuance of a check or electronic funds transfer in payment for Clean Claims for Covered Services within the following time periods, in each case measured from the later of Company’s receipt of such claim or the date on which Company is in receipt of all information needed and in a format required for such claim to constitute a Clean Claim, including without limitation all documentation reasonably needed by Company to determine that such claim does not contain any material defect or error (but only to the extent consistent with the definition of Clean Claim): fifteen (15) days for claims that Participating Physician submits electronically and thirty (30) days for claims that Participating Physician submits on paper forms. For each Clean Claim with respect to which Company has directed the issuance of a check or electronic funds transfer later than the applicable period specified in the preceding sentence, Company shall pay interest at the lesser of the prime rate and eight percent (8%) per annum on the balance due on each such claim from the end of the applicable specified period up to but excluding the date on which Company issues the check (or issues instructions for electronic funds transfer) for payment of such Clean Claim; provided that to the extent that payment is made later than the period specified by applicable law, Company shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence. Notwithstanding the foregoing, Company has no obligation to make any interest payment (a) with respect to any Clean Claim if, within thirty (30) days of submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (b) for any claim that has been balance billed to a Plan Member in violation of the Participating Physician’s agreement with

Company; or (c) with respect to any time period during which an act of God, governmental act, act of terrorism, war, fire, flood, explosion or civil commotion prevents adjudication of claims.

Other than for recovery of duplicate payments, Company shall provide Participating Physician with 30 days written notice before initiating overpayment recovery efforts. This written notice shall state the patient name, service date, payment amount, proposed adjustment and explanation or other information (including without limitation procedure code, where appropriate) giving Participating Physician reasonably specific notice of the proposed adjustment. For purposes of this provision, “overpayment” or “payment made in error” shall mean any erroneous or excess payment that Company makes because of:

- (a) payment of an incorrect rate;
- (b) duplicate payment for the same Physician Service;
- (c) payment with respect to an individual who was not a Member as of the date the Participating Physician, Physician Group or Physician Organization or Participating Group Physician provided the Physician Service(s) that is the subject of such payment; or
- (d) payment for any non-Covered Service;

provided that “overpayment” or “payment made in error” shall not mean any erroneous or excess payment arising out of inappropriate coding or other error in the claim submission as to which such payment relates and shall not mean any adjustment to a prior payment when Company makes such adjustment in whole or part on the basis of information contained in a separate claim submitted by a Participating Physician for Physician Services rendered on the same date of the same Physician Services to which the original payment relates (other than duplicate bills). In the event Company is unable to secure the return of any such payment described above, within such reasonable time, Company reserves the right to offset such payment against any other monies due to Participating Physician under this Agreement provided Company has delivered to Participating Physician at least ten (10) days prior written notice and Participating Physician has otherwise failed to return such payment to Company.

Company shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment; provided that no time limit shall apply to initiation of overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Plan Sponsor, and in the event that Participating Physician asserts a claim of underpayment Company may defend or set off such claim based on overpayments going back in time as far as the claimed underpayment. To the extent that your Agreement with Company provides that you cannot seek additional payment after the expiration of a certain time period following receipt of Company’s original payment, that restriction shall not apply to the extent that Company seeks recovery of overpayments.

Company agrees to provide monthly reports to Participating Physician that receive capitation. These monthly reports will include membership information to allow reconciliation by Participating Physician of capitation payments, including without limitation Plan Member identification number or the equivalent, name, age, gender, medical

group/Physician Organization number, co-payment, monthly capitation amount, primary care Physician, provider effective date, and, in the monthly report following an applicable change (e.g., selection of new PCP) a report of such change, as well as an explanation of any deductions.

Finally, Participating Physician is not required to participate in pharmacy risk pools or to purchase stop loss insurance from Company.

12. To the extent your Agreement provides for Aetna to compensate you on a **Capitation** basis for providing primary care Covered Services to Plan Members and during the relevant time period you are located in a local market in which Company compensates all primary care Physicians on a capitated basis, the Agreement is supplemented or otherwise amended as follows:

**Capitation.** Company shall pay the assigned primary care Physician capitation or other contract rates, and the assigned primary care Physician shall become responsible for the care of the Member in accordance with the applicable terms of such Participating Physician's agreement with Company, from the date of notice of the assignment; provided that if Company sends the notice of assignment after the Member's coverage becomes effective, then Company shall pay such Participating Physician the applicable rate retroactive to the Member's effective date.

13. The Section of your Agreement with Aetna dealing with **Utilization Management** is supplemented or otherwise amended as follows:

**Utilization Management.** In adopting clinical policies (e.g., Clinical Policy Bulletins and clinical practice guidelines) with respect to Covered Services, Company shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community, and shall take into account Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Participating Physician does not have to pre-certify emergency services. Participating Physician may request pre-certification via electronic data interchange and Internet access. Company shall disclose on its Provider Website any customized pre-certification list for its self-funded products and shall update such disclosures as needed.

The following payment rules will be reflected in the performance of computerized claim editing processes engaged in by Company:

(i) No modifier 51-exempt codes shall be subject to Multiple Procedure Logic. 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.

(ii) "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.

(iii) 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 Company has disclosed that such services are not appropriately reported together.

(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), Company shall not be required to pay for supervision or interpretation by more than one Physician.

(v) 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.

(vi) 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.

(vii) During the Effective Period, no global periods for surgical procedures shall be longer than any period then designated on a national basis by CMS for such surgical procedures.

(viii) Company shall not automatically change a code to one reflecting a reduced intensity of service when such CPT code is one among a series that differentiates among simple, intermediate and complex.

(ix) 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 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 (Centers for Medicare & Medicaid Services) 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.

Company shall further disclose on its Provider Website its payment rule or approach in each area in which the Centers for Medicare & Medicaid Services has promulgated a definitive rule or approach that is relevant to payment to Participating Physicians for Covered Services. Company shall publish on its Provider Website a list, and any changes thereto, (a) of each Company-specific customization to the standard claims editing software product then used by Company; and (b) of any circumstances as to which it has determined that particular

services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers. Company shall disclose on its Public Website and Provider Website a list of any claim category or category of claims for which Company determines a routine review of medical records is appropriate. Company shall cause the above payment rules and all its automated “bundling” and other claims payment rules to be consistent in all material respects across ongoing claims systems and products. Company agrees to make available to Participating Physician a web-based pre-adjudication tool that provides Participating Physician with information regarding the manner in which Company’s claim system adjudicates invoices for specific CPT codes or combinations of such codes.

Further, Company shall not automatically reduce the code level of evaluation and management codes billed for Covered Services. Notwithstanding the preceding sentence, Company reserves the right to deny or adjust such claims for Covered Services on other bases and the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Participating Physicians) 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.

14. The section of your Agreement with Aetna dealing with **Access to Information and Records** is supplemented or otherwise amended as follows:

**Access to Information and Records.** Company confirms that, as between Company and Participating Physician, Participating Physician owns Participating Physician’s medical records.

Company has a right to receive or review medical records only as reasonably needed in the ordinary course for customary uses such as for disease management, patient management, quality review (including the investigation of member grievances or complaints), quality management, claims payment and audit purposes, including without limitation, any audit activities undertaken by Company to comply with NCQA accreditation rules; provided that nothing herein is intended or construed to convey to Participating Physician any property interest in Company’s data or intellectual property that incorporates any medical records or related data obtained by Company from Participating Physician.

Company shall not routinely require submission of clinical records before or after payment of claims, except as to claims for unlisted codes, claims to which a modifier 22 is appended, and other limited categories of claims as to which Company subsequently determines that routine review of medical records is appropriate; provided that if Company subsequently determines to routinely require submission of clinical records before or after payment of a specified category of claims, Company shall promptly disclose on the Company’s Public Website and the Company’s Provider Website any such claim category or categories. Notwithstanding the foregoing, Company may require submission of clinical records before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, Company has reasonable basis for believing that such investigation is warranted and Participating Physician may contest

such requirement pursuant to the Company's dispute resolution process for physicians. Nothing contained in this section is intended to or shall be construed, to limit Company's right to require submission of medical records for pre-certification purposes consistent with §7.5 of the Settlement Agreement.

Company and Participating Physician agree to comply with applicable state and federal laws established for the protection of the security and privacy of patient information, and patient's rights with respect to their protected health information. Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law.

15. The section of your Agreement with Aetna dealing with **Termination Without Cause** is supplemented or otherwise amended as follows:

**Termination without Cause.** If you are a Participating Physician Group or Physician Organization consisting of fewer than five (5) Participating Group Physicians, either party may terminate this Agreement without cause on not less than ninety (90) calendar days prior written notice, provided that if the Participating Physician Group or Physician Organization Physician provides notice of termination of such Agreement not more than fifteen (15) calendar days after receipt of a notice of an adverse Material Change, then the Agreement shall terminate coincident with the effective date of such adverse Material Change.

16. The section of your Agreement with Aetna dealing with **Arbitration** is supplemented or otherwise amended as follows:

**Arbitration.** Notwithstanding the provisions of this section as it relates to mandatory and exclusive nature of arbitration as a dispute resolution mechanism, Participating Physician, Physician Group or Physician Organization and Participating Group Physicians may avail themselves of the **External Compliance Dispute Resolution Process** (Settlement Section 12), **External Billing Dispute Resolution Process** (Settlement Section 7.10) and **External Medical Necessity Dispute Resolution Process** (Settlement Section 7.11) established by the Settlement Agreement.

In any arbitration proceeding between Company and a Participating Physician who practices individually or in a Physician Group or Physician Organization of less than five Participating Physicians, the maximum fee payable by such Participating Physician shall be the lesser of (i) fifty percent (50%) of the total fee or (ii) One Thousand Dollars (\$1,000).

17. The section in your Agreement with Aetna dealing with **Amendments** is supplemented or otherwise amended as follows:

**Amendments.** In the event any change, amendment or alteration involves a Material Change, Company shall provide Participating Physician with such written notice ninety (90) days prior to implementation of said change, amendment or alteration, unless a shorter period is required by law.

18. The section of your Agreement with Aetna dealing with **Entire Agreement** is supplemented or otherwise amended as follows:

**Entire Agreement.** This Agreement incorporates herein by reference the provisions of the Settlement Agreement and nothing in this Agreement may be construed to waive any of the undertakings or other commitments Company has made pursuant to the Settlement Agreement.

#### **Extension of Settlement Agreement**

19. The following terms of the Settlement Agreement's substantive provisions shall be extended for a period of one year, to June 2, 2008. Sections 1 ("Definitions"), 7 ("Business Practice Initiatives"), 10 ("Application to Fully Funded and Self-Funded Plans"), 11 ("Limited Liability"), 12 ("Compliance Disputes Arising Under This Agreement"), 18 ("Not Evidence; No Admission of Liability"), 19 ("Entire Agreement"), 20 ("No Presumption Against Drafter"), 23 ("Counterparts"), 24 ("Additional Signatory Medical Societies"), 25 ("Successors and Assigns") and 26 ("Governing Law").

Other than as modified and expressly extended above, the Termination Date defined in Section 15(g) of the Settlement Agreement will remain as described therein. Additionally, any obligation or provision of the Settlement Agreement that terminated on a date prior to June 2, 2007 is not extended.

20. Notwithstanding the foregoing, during the one-year extension (from June 2, 2007 through June 2, 2008), the following obligations will not be in effect:

(a) Any obligation to provide annual reports, such as the Internal Compliance Report referred to in paragraph 12.7 of the Settlement Agreement;

(b) The requirements set forth in paragraph 7.16(b) of the Settlement Agreement requiring the filing of Clinical Policy Bulletins with the Physician Advisory Board;

(c) The provisions set forth in paragraph 7.15 of the Settlement Agreement and

(d) Section 7.10 – billing dispute resolution process.