

HUMANA, INC. SETTLEMENT OVERVIEW

(Agreement Dated October 17, 2005; Preliminary Approval Date: October 19, 2005; Final Order Date: March 15, 2006; Effective Date: September 28, 2006)

The following is a general overview of the major provisions of the Humana Settlement likely to be of interest to physicians. It is not intended to be comprehensive. The prospective relief noted below generally extends for four years from the date Judge Moreno preliminarily approved it, with specific items on dates specified in the Agreement. Physicians interested in the specifics should read the language of the Settlement Agreement posted at www.hmosettlements.com.

Retrospective Relief: \$40 Million

- \$40,000,000 to class members, without any requirement for the submission of medical records. (§8)
- The deadline for filing claims was February 17, 2006.

Prospective Relief: Over \$75 Million

- **Better Medical Necessity Definition** - Patients are entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice, clinically appropriate and less costly alternatives are permissible only when they are “at least as likely to produce equivalent therapeutic or diagnostic results.” “Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. (§7.16)
- **Payment of Vaccine Product and Administration** - Humana will pay for recommended vaccines and injectibles, and for the administration of such vaccines and injectibles. (§7.14(b))
- **Reduced Downcoding** - In general, CPT evaluation and management codes will not be automatically downcoded or reassigned. (§7.19)
- **Fewer Contract Change and Copies of Contracts** - No material adverse change to a contract, or policies or procedures incorporated by reference may be made without 90 days written notice; physicians may then terminate their contract as a result. Copies of contracts available upon written request. (§7.6, §7.29(l))
- **Fairer Payment Rules** - CPT coding edits specified in the agreement must be adhered to including but not limited to rules covering Modifiers -25 & -59, modifier -51 exempt codes, global surgery rules and add-on codes; non-compliant services or procedures related to Modifiers -25 & -59 must be listed on the website. (§7.20, §7.8(c)(iii))
- **CPT Edits** - Any significant edit not compliant with CTP codes, guidelines and conventions must be listed on its website, customized edits added to the standard claims editing software must also be published on the website. (§7.8(b))

- ***Consistency and Disclosure of Payment Rules*** - Company is seeking to reduce its claim platforms to two primary platforms in an effort to increase consistency. Moreover, reimbursement edits with significant volume and claims adjudication logic will be disclosed and updated. (§7.8(a)&(b))
- ***Clinical Information not Routinely Required*** - Clinical information will not be required except for unlisted codes, Modifier -22 codes, fraud investigations and other limited categories. (§7.8(b)(ii))
- ***Capitation from Date of Enrollment*** - Capitation fees will be paid when the patient chooses a PCP or is assigned to a PCP, retroactive to the date of enrollment. (§7.28(b))
- ***All Products Clauses Minimized*** - Humana will not require physicians to participate in Worker's Compensation, Medicare Advantage or Medicaid networks in order to participate in other commercial products. Reimbursement levels will not be reduced below geographic market levels for physicians choosing not to participate in specified products. (§7.13(b))
- ***Faster Credentialing*** - New physician group members will be credentialed within 90 days of application, physicians can submit applications prior to their date of employment; credentialing will be minimized when already-credentialed physicians change employment or location. (§7.13(a))
- ***Arbitration Reform*** - Arbitration fees will be refunded to those small physician groups which prevail in the proceeding. Moreover, Humana physician agreements 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(c))
- ***External Resolution Mechanism for Billing Disputes*** - An external review system will be established enabling physicians to dispute decisions on billing or medical records requests (Billing Dispute External Review Board). (§7.10)
- ***Resolution of Medical Necessity Disputes*** - Internal and external review processes defined and established enabling physicians to obtain pre- and post-service determinations and to dispute medical necessity and experimental/investigational decisions. (§7.11)
- ***Gag Clauses Prohibited*** - "Gag" clauses are prohibited; physicians will not be penalized for engaging in unrestricted communications. (§7.29(a))
- ***EOB and Remittance Advice Language Enumerated*** - Specific EOB data elements enumerated, disparaging language will be removed, the rights of non-participating physicians to balance bill patients and amount of balance billing must be listed on the EOB. (§7.21)
- ***Valid Assignment of Benefits Recognized*** - Humana will recognize and honor all valid assignment of benefits evidenced by non-participating physicians. The fact that a physician has received an assignment of benefits will not prohibit a physician from

collecting the difference between their full fee and payment from the patient. (§7.15, §7.29(q))

- ***Overpayments Recovery/Refunds*** - Refunds limited to 18 months (absent fraud) with 30-days notice of offsets; specific elements of notice enumerated; offsets will not be taken if physician practice appeals within 30 days of receipt of notice.
- ***Determination and Disclosure of Usual, Reasonable and Customary Amounts*** - On appeal, Humana will disclose to non-participating physicians the general methodology and source data used to determine the usual, reasonable and customary amount for the service or supply; the UCR methodology is defined and limited. (§7.14(c)&(d))
- ***Fee Schedule Notices*** - Fees will not be reduced more than once annually and then only with 90 days written notice (notice not required for Medicare-adjusted rates); physicians may then terminate within 30 days. (§7.14(a))
- ***Claims Submission*** - Physicians will not be forced to use electronic claims transactions, physicians have 180 days to submit claims for insured patients; Humana will propose a 180-day claims submission deadline to self insured plan sponsors who have more restrictive timeframes. (§7.17)
- ***Restrictive Endorsements Limited*** - When the check is a partial payment of allowable charges, physicians may cash a check with "Payment in Full" or other restrictive endorsement without waiving the right to pursue a remedy under the settlement agreement. (§7.29(j))
- ***Better Mental Health Coverage*** - Humana will generally apply the §7.16 definition of medical necessity described above to mental health care, including treatment for psychiatric illness and substance abuse and it will adhere to the prudent layperson standard for mental health emergency services. (§7.33)
- ***Better state and federal law supersedes the Settlement Agreement.*** (§7.29(m))

Enforcement of Settlement Agreement

- ***Physician Advisory Committee*** - A Physician Advisory Committee will be created to address issues of regional or nationwide scope including (a) improvement of health care and clinical quality; (b) improvement of communications, relations and cooperation between Physicians and the Company; and/or (c) matters of a clinical or administrative nature that impact the interaction between Physicians and the Company. (§7.9)
- ***Compliance Dispute Resolution Process*** - Physicians who do not opt out and signatory medical societies may petition to enforce the Agreement through a compliance dispute resolution process described in the agreement. (§12)
- ***Enforcement of Better State Law and Regulation*** - The Parties retain the right to seek the enactment of better state laws and regulations, and to enforce those better protections. (§13.10)

- Compliance Reports** - Humana will file an annual Compliance Report and certification containing at least the following: Humana’s standard pre-certification lists, the dates Humana mailed notices of material adverse changes to Participating Physicians, a summary of the initiatives Humana implemented or employed to reduce claim resubmissions, a summary of the efforts made to cause its automated “bundling” and other claims payment rules to be consistent, a list of significant edits, a list of each customized edit added to any standard claims editing software product at Humana’s request, a list of categories of claims as Humana has determined that routine review of clinical information is appropriate, a list of any circumstances as to which Humana has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers, a list of the dates of meetings of the Physician Advisory Committee and of the members of the Physician Advisory Committee, a summary of any recommendations made to Company by the Physician Advisory Committee and Humana’s response, procedures for review developed by the Billing Dispute External Review Board, a summary of any decisions issued by the Billing Dispute External Review Board, a list of the dates of any annual revisions to Humana’s standard fee schedules, a list of the dates Humana issued coverage statements with respect to any new technology or treatment or new use for an established technology or treatment recommended by a Physician Specialty Society, the number of Adverse Medical Necessity Determinations sent to external review for final determination for the preceding calendar year and the percentage of such adverse medical necessity Determinations that are upheld or reversed., a summary of Humana’s policies and procedures regarding the appropriate format for claims submissions and requests for clinical information, copies of the forms of Company’s standard EOB form and Physician Remittance Advice, copies of the forms of written notice provided to Physicians before initiating Overpayment recovery efforts, a summary of the actions initiated or continued to be taken by Humana to improve accuracy of eligibility information, a summary of the actions initiated or continued to be taken by Humana to further improve the speed, accuracy and efficiency of responses to Physicians’ inquiries and concerns, a list of the dates (if any) that the Provider Website was substantially inoperable during the Effective Period, copies of the forms of the standard monthly reports provided by Humana to Participating Physicians, Physician Groups, or Physician Organizations that receive capitation. (§7.34)

Settlement Participation

- Settlement 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, or WellPoint/ Anthem).
- Signatory Medical Societies** - California Medical Association, Connecticut State Medical Society, El Paso County Medical Society (Colorado), Florida Medical Association, Medical Association of Georgia, Louisiana State Medical Society, Nebraska Medical Association, Medical Society of New Jersey, North Carolina Medical Society, Northern Virginia Medical Societies, South Carolina Medical Society, Tennessee Medical Association, Texas Medical Association and Washington State Medical Association.
- Additional Signatory Medical Societies** - American Association of Practicing Psychiatrists, American Psychoanalytic Association, Medical Society of Delaware,

Psychiatric Society of Delaware, Harris County Medical Society, Massachusetts Psychiatric Society, Ohio State Medical Society.

- ***Retired Physicians*** - Retired Physicians who filed valid claims will receive two times their pro rata share ("Retired Physician Amount") which is calculated based on the number of retired physicians who file valid proofs of claim. Retired physicians receive more than Active Physicians because they will not directly benefit from the prospective relief.
- ***Active Physicians*** - Active Physicians are entitled to receive the portion of the Settlement Fund that is available after subtracting the Retired Physician Amount.
- ***Monetary Settlement Amounts*** - Each active physician who filed a valid Proof of Claim will receive an amount based on the physician's gross receipts for providing covered services to Humana Members during a three-year calendar period of 2003, 2004, and 2005, based on: (a) receipts were less than \$5,000 (entitling the physician to a single base amount), (b) at least \$5,000 but less than \$50,000 (entitling the physician to five times the base amount), or (c) \$50,000 or greater (entitling the physician to ten times the base amount) including amounts paid by both Humana and its delegated entities. Physicians who do not specify a category of gross receipts will be deemed entitled to a single base amount.
- ***Foundation Contributions*** - Each physician had the option of receiving payments or directing his or her amount to a signatory medical society foundation, or the Foundation created by the CIGNA Settlement, the Physicians' Foundation for Health Systems Innovations, Inc.