UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO. 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO PROVIDER TRACK CASES

NOTICE OF COMMENCEMENT OF THE CLAIMS PERIOD IN SETTLEMENT OF CLASS ACTION AMONG CIGNA HEALTHCARE AND PHYSICIANS

This Notice applies to the following Class: Any and all Physicians, Physician Groups and Physician Organizations (and all Persons claiming by or through them, such as Physicians' Assistants and Advanced Practice Registered Nurses) who or which provided Covered Services to any CIGNA HealthCare member or any individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in *Shane, et al. v. Humana Inc., et al.* or by any of their respective current or former Subsidiaries from August 4, 1990 through September 5, 2003.

The Class does not include any Physician who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing such Covered Services. This Notice does not apply to you if you have filed a timely and valid notice to opt out of the Settlement.

PLEASE READ THIS NOTICE CAREFULLY. YOU MAY BE ENTITLED TO COMPENSATION UNDER THE TERMS OF THE SETTLEMENT. THIS NOTICE DESCRIBES HOW YOU CAN SUBMIT REQUESTS FOR COMPENSATION.

THE COURT HAS APPROVED THE SETTLEMENT. THE FINAL APPROVAL DATE IS APRIL 22, 2004. THE CLAIMS PERIOD BEGINS AUGUST 23, 2004 AND WILL END FEBRUARY 18, 2005. PLEASE NOTE THAT THE COURT HAS APPROVED AMENDED DATES FOR IMPLEMENTING CERTAIN COMMITMENTS IN THE SETTLEMENT AGREEMENT.

This notice is intended to provide you with information regarding when and how you may submit requests for payment in accordance with the Settlement Agreement ("Agreement"). You may view a copy of the entire Agreement at www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com and *www.whatleydrake.com.*

Capitalized terms used in this Notice that are not otherwise defined herein have the meaning assigned to them in the Settlement Agreement.

I. INTRODUCTION

If you are, or have been, a Physician, Physician Group, or Physician Organization (or a person or entity claiming by or through them, such as a Physicians' Assistant or Advanced Practice Registered Nurse) who or which provided Covered Services to any individual enrolled in or covered by a health benefit plan insured or administered by CIGNA HealthCare or a health benefit plan insured or administered by any other managed care company named as a defendant in *Shane, et al. v. Humana, Inc., et al.* from August 4, 1990 through September 5, 2003, and you have not filed a timely and valid Opt Out notice, you are a member of the Class in the Settlement with CIGNA Corporation and its subsidiaries engaged in the business of insuring or administering health benefit plans (collectively, "CIGNA HealthCare") in the class action lawsuit known as *In re Managed Care Litigation,* MDL Docket No. 1334 (the "Litigation"). The other defendants in the Litigation are Aetna, Inc., Aetna-USHC, Inc., Anthem, Inc., Coventry Health Care, Inc., Health Net, Inc., Humana Health Plan, Inc., Humana, Inc., PacifiCare Health Systems, Inc., Prudential Insurance Company of America, United Health Care, United Health Group and WellPoint Health Networks, Inc. (collectively, "defendants"). The Class does not include any Physician who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing Covered Services.

This federal multi-district Litigation is pending in the U.S. District Court for the Southern District of Florida (the "Court"). The Class Representatives and certain medical societies have agreed to settle all claims against CIGNA HealthCare in the Litigation in exchange for CIGNA HealthCare's adoption of a number of commitments and initiatives regarding its disclosures and business practices, the funding of a not-for-profit foundation and the establishment of alternate settlement funds against which Class Members can submit requests for payment. The Notice of Proposed Settlement that was mailed to you last October outlined the terms of the Settlement and stated that, if the Court approved the Settlement, you would receive this second notice indicating when the Claims Period would begin and providing detailed instructions on how to seek payment under the Settlement.

II. WHEN CAN I SUBMIT REQUESTS FOR PAYMENT?

The Claims Period begins on August 23, 2004 and runs through February 18, 2005. Any requests for payment sent to the Settlement Administrator (except as described in Section VIII) after February 18, 2005 will be denied by the Settlement Administrator. Any requests for payment submitted before August 23, 2004 will be treated as if received on that date.

III. WHAT KINDS OF REQUESTS FOR PAYMENT CAN I MAKE?

Under the Settlement, **Class Members may receive compensation from either one of two funds established by CIGNA HealthCare:**

1) The "Category A Settlement Fund" (described in Section 8.2 of the Agreement); or

2) The "Claim Distribution Fund" (described in Section 8.3 of the Agreement), which includes compensation related to Claim Coding and Bundling Edits and denials of claims on Medical Necessity grounds. To be eligible for either category of compensation, a Class Member must submit Proofs of Claim, as described below.

Category A Settlement Fund:

CIGNA HealthCare will establish a Category A Settlement Fund in an aggregate amount of Thirty Million Dollars ($30,000,000.00). All Class Members are eligible to apply for payment from this settlement fund, whether or not they have submitted any claims to CIGNA HealthCare from August 4, 1990 through September 5, 2003, as long as they have submitted claims for payment to any one of the defendants listed above during that period. Each Class Member who files a valid Category A request for payment will receive a proportionate share of the Fund, calculated in accordance with the formula set forth in the Agreement and as described below.

Claim Distribution Fund:

CIGNA HealthCare will also establish the uncapped Claim Distribution Fund, which will be replenished by CIGNA HealthCare as needed to pay all Valid Proofs of Claim. Three categories of compensation will be paid from the Claim Distribution Fund to Class Members who submitted claims to CIGNA HealthCare and were affected by Claim Coding and Bundling Edits and/or Medical Necessity denials and who submit valid requests for payment.

• Category One Compensation (described in Section 8.3.c(1) of the Agreement) is available to Class Members affected by certain Claim Coding and Bundling Edits during the Class Period (August 4, 1990 through April 22, 2004). The parties have agreed to a list of specific CPT® Code combinations which qualify for Category One Compensation.

• Category Two Compensation (described in Section 8.3.c(2) of the Agreement) is available to Class Members affected by Claim Coding and Bundling Edits during the Class Period that are not eligible for Category One Compensation. Category Two Compensation is not limited to specific codes or code combinations.

• Medical Necessity Denial Compensation (described in Section 8.3.d of the Agreement) is available to Class Members affected by certain claims denied as not Medically Necessary or as experimental or investigational during the Class Period.

IV. WHAT ARE CLAIM CODING AND BUNDLING EDITS?

"Claim Coding and Bundling Edits" mean adjustments to CPT® Codes or HCPCS Level II Codes included in claims in which (a) CIGNA HealthCare's payment is or was based on some, but not all, of the CPT® Codes or HCPCS Level II Codes included in the claim; (b) CIGNA HealthCare's payment was based on different billing codes than those billed to CIGNA HealthCare; (c) CIGNA HealthCare's payment for one or more CPT® Codes is or was reduced by application of Multiple Procedure Logic; or (d) any combination of the above.

V. MAY I SEEK PAYMENT UNDER ALL CATEGORIES?

No. **You may seek compensation from either the Category A Settlement Fund or the Claim Distribution Fund, but not both.** If you choose to seek compensation from the Claim Distribution Fund, you may submit requests for payment in any or all of the three separate categories paid from that Fund.

If you inadvertently seek relief from both the Category A Settlement Fund and the Claim Distribution Fund, the Settlement Administrator will process the request that is received first. If both are received on the same day, the Settlement Administrator will send you a letter asking which request you would like to have processed. If the Settlement Administrator does not receive a response from you within 20 days of the date of that letter, it will process the Category A Proof of Claim and will deny all requests for payment from the Claim Distribution Fund.

VI. WHAT ABOUT PROTECTION OF CONFIDENTIAL HEALTH INFORMATION PURSUANT TO HIPAA?

If you seek compensation from the Claim Distribution Fund, the supporting documentation you submit will include confidential health information. CIGNA HealthCare and the Settlement Administrator have entered into a Business Associate Agreement with respect to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") that protects the confidentiality of such information provided by you to the Settlement Administrator. The Settlement Administrator has taken appropriate steps to insure that the information will be maintained confidentially.

VII. WHO MAY SUBMIT REQUESTS FOR PAYMENT?

You are a member of the Class if you are a Physician, Physician Group, or Physician Organization (or person or entity claiming by or through them, such as a Physicians' Assistant or Advanced Practice Registered Nurse) who or which provided Covered Services to any individual enrolled in or covered by a health benefit plan insured or administered by CIGNA HealthCare or a health benefit plan insured or administered by any other managed care company named as a defendant in *Shane, et al. v. Humana, Inc., et al.* from August 4, 1990 through September 5, 2003, and you have not filed a timely and valid Opt Out notice. The Class does not include any Physician who is or was an employee of a CIGNA HealthCare staff-model HMO at the time of providing Covered Services.

Class Members may seek payment from either the Category A Settlement Fund or the Claim Distribution Fund, but not both.

Requests to the Category A Fund: All Class Members (or their heirs or legal representatives in the case of deceased Class Members) may submit requests for payment from the Category A Settlement Fund, whether or not they have submitted any claims to CIGNA HealthCare during the period from August 4, 1990 through September 5, 2003, as long as they have submitted claims for payment to any one of the defendants listed in the Introduction above during that period.

Requests to the Claim Distribution Fund: Class Members (or their heirs or legal representatives in the case of deceased Class Members) whose claims for payment for services provided to CIGNA HealthCare Members during the Class Period (August 4, 1990 through April 22, 2004) were reduced or denied by CIGNA HealthCare based on Claim Coding or Bundling Edits or on grounds of Medical Necessity may make requests for payment from the Claim Distribution Fund.

Physician Groups and Physician Organizations may submit Proofs of Claim for compensation from the Category A Settlement Fund on behalf of Physicians employed by or otherwise working with them at the time the Proof of Claim Form is submitted without the necessity of individual signatures from the individual Physicians. Physician Groups and Physician Organizations may submit Proofs of Claim for compensation from the Claim Distribution Fund on behalf of Physicians employed by or otherwise working with them at the time the claims were originally submitted without the necessity of individual signatures from the individual Physicians. However, the Class Member that submits a Proof of Claim Form for compensation from the Claim Distribution Fund must be the Physician, Physician Group or Physician Organization that originally submitted the claim and must use the *same tax identification number as was used on the original claim.*

You may <u>not</u> submit requests for compensation if you are a non-physician health care provider, employed by or otherwise working with a Physician, Physician Group or Physician Organization, who provided services to a CIGNA HealthCare Member from August 4, 1990 through April 22, 2004 and claims for those services were submitted to CIGNA HealthCare by or through the Physician, Physician Group or Physician Organization. Proofs of Claim for such services can <u>only</u> be submitted by the Physician, Physician Group or Physician Organization that originally submitted the claim and must use the *same tax identification number as was used on the original claim.*

VIII. HOW DO I MAKE A REQUEST FOR PAYMENT?

A. *Category A Settlement Fund - $30 Million Settlement Fund*

INSTRUCTIONS

All Class Members are eligible for Category A Compensation regardless of whether or not you have submitted claims to CIGNA HealthCare from August 4, 1990 through September 5, 2003, as long as you have submitted claims for payment during that period to any one of the defendants listed in the Introduction above.

To request Category A Compensation, you must submit a Category A Proof of Claim Form by mail to the Settlement Administrator, Poorman-Douglas Corporation, at the following address:

CIGNA Physician Settlement
Settlement Administrator
P.O. Box 3170
Portland, OR 97208-3170

You ***must sign*** the Proof of Claim Form, certifying that:

• you are a member of the Class, *i.e.,* you are either a Physician in active practice or a retired Physician who was in active practice at any time from August 4, 1990 through September 5, 2003 (or their heirs or legal representatives in the case of deceased Class Members) and

• you have not submitted a Proof of Claim Form for Category One Compensation, Category Two Compensation or Medical Necessity Denial Compensation.

By submitting a Proof of Claim, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to that Proof of Claim.

Physician Groups and Physician Organizations may file a Proof of Claim Form on behalf of Physicians employed by or otherwise working with them at the time the Proof of Claim Form is submitted, without the necessity of individual signatures from the individual Physicians.

You must indicate on the Proof of Claim Form whether you elect to receive your share of the Category A Settlement Fund or to direct that your share be contributed on your behalf to the not-for-profit Foundation (described in more detail in the first mailed notice and at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com*) or to a foundation established by any medical society that signed or joined the Settlement Agreement. A list of such eligible foundations may be found at *www.CIGNAPhysicianSettlement.com*. If you do not make an election on the Proof of Claim Form, the payment will be made directly to you.

At the end of the Claims Period, the Settlement Administrator will determine the total number of Valid Category A Proofs of Claim submitted:

1) by or on behalf of retired and deceased Physicians, and

2) by Physicians in active practice.

The total number of Valid Category A Proofs of Claim submitted by, or on behalf of, retired and deceased Physicians will be doubled to reflect the fact that each such individual will receive twice the share of the Category A Settlement Fund as will each Physician in active practice.

The Settlement Administrator will add the total number of Physicians in active practice submitting Valid Proofs of Claim to the doubled number of retired and deceased Physicians. The resulting number will be divided into Thirty Million Dollars ($30,000,000.00).

The result is the base amount to be distributed to each Class Member, with twice the base amount to be distributed to each retired Physician or estate of a deceased Physician.

All payments from the Category A Settlement Fund will be made approximately two weeks after the Claims Period has ended.

Proof of Claim Forms are available at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com*. You may also obtain these forms by calling the Settlement Administrator, toll-free, at 1-877-683-9363.

B. *Claim Distribution Fund- Uncapped Settlement Fund*

GENERAL INSTRUCTIONS

If you do not choose to submit a claim under Category A and you previously submitted claims to CIGNA HealthCare that were denied or for which payment was reduced, you may seek compensation from the Claim Distribution Fund for certain of these claims. This Fund contains three categories: Category One Compensation, Category Two Compensation, and Medical Necessity Denial Compensation. There is no limit on the number of requests for payment from this Fund you may submit. All valid requests for payment supported by adequate documentation will be considered for payment regardless of the total number or amount of such requests. Any claim submitted to CIGNA HealthCare from August 4, 1990 through April 22, 2004 (except for Retained Claims, as described in Section IX, below) that was denied or reduced based on a Claim Coding or Bundling Edit or on Medical Necessity grounds and that has been fully adjudicated may be submitted.

General Guidelines

These guidelines apply to all claims submitted to the Claim Distribution Fund. For those Class Members who maintain electronic data, please note the process described in (5) below, which may be utilized to ensure compliance with the requirements for submitting claims to the Settlement Administrator.

(1) Requests for payment must be made on the appropriate Proof of Claim Form. You may submit one or more of each such Proof of Claim Form, as long as the requests for payment submitted with any subsequent Proof of Claim are not duplicative of requests for payment included with a previously submitted Proof of Claim Form.

(2) All Proofs of Claim seeking payment from the Claim Distribution Fund must be sent (by U.S. Postal Service or a delivery company such as Federal Express or U.P.S.) to the Settlement Administrator, Poorman-Douglas Corporation, at the following address:

CIGNA Physician Settlement
Settlement Administrator
P.O. Box 3170
Portland, OR 97208-3170

The postmark or airbill date is critical to the Settlement Administrator's procedures.

(3) All Proofs of Claim, including all supporting documents, must be submitted to the Settlement Administrator in paper form or on a CD, diskette or DVD. If submitted on a CD, diskette or DVD, the documents must be formatted in .pdf or .tif files. No other media or file format will be accepted by the Settlement Administrator. Please be sure all documentation is legible. E-mail and faxes will not be accepted. **If supporting documentation is required, do not send original documents, as they will not be returned to you. Do not send x-rays or any other type of film.**

(4) You must include a separate cover sheet with the documentation supporting each individual request for payment submitted with that Proof of Claim Form. Each individual request for payment must relate to a single episode of care, although it may seek compensation for multiple CPT® Codes. The information required for each cover sheet depends on the category under which the claim is submitted (*i.e.,* Category One, Category Two, or Medical Necessity) and the type of supporting documentation attached (*i.e.,* HCFA 1500 or CMS 1500, Remittance Forms or accounting records).

Cover Sheets are attached to the Proof of Claim Forms and are available at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com*. You may also obtain these forms by calling the Settlement Administrator, toll-free, at 1-877-683-9363.

(5) For those Class Members who maintain electronic records containing the information that would otherwise be included in a HCFA 1500 or CMS 1500 form, plaintiffs' counsel have made available a process to assist you in meeting the requirements for submitting Proofs of Claim. If your practice management software can generate a print image file, it may be submitted electronically to a web portal. The appropriate HCFA 1500 or CMS 1500 will then be generated in the form required by the Settlement Administrator. Where supporting documentation other than a HCFA 1500 or CMS 1500 form is required, it can be uploaded to the web portal if it is first scanned into a .pdf file or a .tif file. The operator of the web portal, Infinedi LLC, will mail the claims to the Settlement Administrator in the format required above. **Infinedi has no responsibility for determining whether the claims you submit meet the requirements of the Settlement or are eligible for payment. If you submit claims through this method, you still must complete the required certification. No claims will be submitted by Infinedi to the Settlement Administrator until you complete the certification.** Full instructions on how to submit claims electronically may be found on the web portal at *www.cignaeclaims.com*.

(6) Physicians or Physician Groups using Infinedi are responsible for complying with all requirements and deadlines for claims submissions. It is anticipated that claims must be submitted before February 8, 2005 in order to ensure that Infinedi can complete all necessary steps for the submission of claims, including Physician certification, prior to the close of the Claims Period. The Infinedi website *www.cignaeclaims.com* will have updates on timing requirements throughout the Claims Period. Please note that it is the Physician's responsibility to verify the accuracy of information submitted to Infinedi and to complete all necessary steps to enable Infinedi to submit the Physician's information to the Settlement Administrator. For more information and instructions on how to submit claims through the Infinedi process, please log on to *www.cignaeclaims.com*. To avoid the possibility that your claim will be denied as untimely, you are encouraged to submit claims to Infinedi as soon as possible after the beginning of the Claims Period.

1. *Category One Compensation - Uncapped Settlement Fund*

INSTRUCTIONS

Availability of Category One Compensation: Category One Compensation applies only to denials of or reductions in payments resulting from certain specific Claim Coding and Bundling Edits. The list of code combinations that qualify for Category One treatment is attached to the Agreement as Exhibit 1. The Category One Code List can be obtained by visiting *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com* or by calling the Settlement Administrator, toll-free, at 1-877-683-9363.

The following are not eligible for Category One Compensation: denials of or reductions in payment for Category One Codes resulting from the application of other payment and benefit limitations (*e.g.,* coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, and limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the claim or with other health care providers).

Physician Groups and Physician Organizations may file a Proof of Claim Form on behalf of Physicians employed by or otherwise working with them at the time that the claims were originally submitted without the necessity of individual signatures from the individual Physicians; provided, however, that the Class Member that submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization that originally submitted the claim and must use the *same tax identification number as was used on the original claim* when submitting the Proof of Claim.

Requirements for Category One Proofs of Claim: In order to receive Category One Compensation, you must submit a Proof of Claim Form for Category One Compensation. A single Proof of Claim Form may be used to submit multiple requests for Category One Compensation, provided the required supporting documentation for each separate request for payment is included. Each individual request for payment must relate to a single episode of care, although it may seek compensation for multiple CPT® Codes. **A separate *cover sheet* must precede each individual request for payment.** If you are submitting a HCFA 1500, a CMS 1500 or a Remittance Form as supporting documentation, on each cover sheet, you must indicate the CPT® Code(s) for which you are seeking payment, the date of service and the provider TIN (or Social Security number, if a TIN is not available). If you are submitting accounting records, you must also include the subscriber Social Security number and the patient name. The cover sheet is attached to the Category One Proof of Claim Form, which can be found at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com*.

For those codes ***without* an asterisk on the list of Category One Code combinations,** each separate request for payment must include separate documentation showing that codes were *submitted* for one or more Category One Codes listed in the Category One Code List under the circumstances (*i.e.,* in the specific combination) and within the date of service limitations (if any) listed in that table. Unless the Settlement Administrator determines that it is false or fraudulent, acceptable documentation includes:

- A copy of your HCFA 1500 form or CMS 1500 form showing the Category One Codes that were originally submitted to CIGNA HealthCare for payment under the circumstances and within the date of service limitations (if any) specified in the Category One Code List; or

- A copy of the relevant CIGNA HealthCare Remittance Form showing the Category One Codes that were submitted for payment under the circumstances and within the date of service limitations (if any) specified in the Category One Code List; or

• If you certify that the CIGNA HealthCare Remittance Form and the HCFA 1500 form or CMS 1500 form cannot be located and are not available for submission, you may submit copies of internal accounting records (such as a printout of accounts receivable records or paid account records) with the Proof of Claim Form, *if* those records show, for the underlying claim and specific date of service concerned, the Category One Codes that were originally submitted to CIGNA HealthCare for payment under the circumstances and within the date of service limitations (if any) specified in the Category One Code List.

For those codes ***with* an asterisk on the Category One Code List,** each separate request for payment must include separate documentation showing both the relevant codes that were *submitted* and that payment was *denied or reduced* for one or more Category One Codes listed in the Category One Code List under the circumstances (*i.e.,* in the specific combinations) and within the date of service limitations (if any) listed in that table. Unless the Settlement Administrator determines that it is false or fraudulent, acceptable documentation includes any combination of the following, so long as it demonstrates the relevant codes that were both submitted and denied or reduced:

• A copy of the relevant CIGNA HealthCare Remittance Form;

• A copy of your HCFA 1500 form or CMS 1500 form;

• If you certify that the CIGNA HealthCare Remittance Form and the HCFA 1500 form or CMS 1500 form cannot be located and are not available for submission, or if those documents are insufficient to establish that the Category One Codes were submitted and denied or reduced, you may submit copies of internal accounting records (such as a printout of accounts receivable records or paid account records) with the Proof of Claim Form, *if* those records show, for the underlying claim and specific date of service concerned, the Category One Codes that were originally submitted to CIGNA HealthCare for payment under the circumstances and within the date of service limitations (if any) specified in the Category One Code List, and payment was denied as submitted.

Result of Inadequate Documentation: If the Settlement Administrator determines that any individual request for Category One Compensation does not include adequate documentation, it will notify you by mail that the request for payment has been rejected, and identify the reason(s) for the rejection. (The Settlement Administrator will process all other separate requests for payment attached to the same Proof of Claim Form that are supported by adequate documentation.)

You will have the right to resubmit any rejected requests for payment in an effort to correct the deficiencies noted by the Settlement Administrator, provided that your resubmission is sent to the Settlement Administrator no later than **thirty (30) calendar days** from the date on which the Settlement Administrator's notice of the deficiencies was postmarked. If the Settlement Administrator still concludes that the documentation is inadequate, then that request for payment will be denied. The Settlement Administrator will mail notification of this final determination to you.

Invalid request for Category One Compensation: If the Settlement Administrator determines that any request for Category One Compensation is not valid, either because you were seeking compensation for codes not on the Category One Code List or because you are seeking compensation for services that were provided outside the circumstances and/or date of service limitations specified in the Category One Code List, the notification of denial will explain this. (The Settlement Administrator will process all other separate requests for payment attached to the same Proof of Claim Form that are determined to be valid.)

You may be eligible for Category Two Compensation and the Settlement Administrator will indicate that you may submit a Category Two Proof of Claim Form regarding that request for payment within **thirty (30) calendar days** from the date the notification of denial was postmarked. If the Settlement Administrator already has adequate documentation to process that request for payment as a Category Two Proof of Claim, the Settlement Administrator will *automatically* process the request as such.

Certification by Class Member: No Proof of Claim Form for Category One Compensation will be accepted by the Settlement Administrator for processing unless you sign (or digitally sign, for those claims submitted through Infinedi) the certification indicating that:

- the Category One Code(s) for which you are requesting payment describe services that were actually provided to a CIGNA HealthCare Member; and
- the additional payment requested has not already been made by CIGNA HealthCare on resubmission of the claim or on an appeal; and
- the claim to which the request relates has not been finally adjudicated and determined in a court of law or in an arbitrable forum, or resolved by a final and binding settlement.

If you submit internal accounting records in support of a Category One Proof of Claim, you must also certify that the CIGNA HealthCare Remittance Form and the claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

If you billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed you for such amount, it is expected that you will reimburse the CIGNA HealthCare Member by the amount you are compensated as a result of this Settlement.

By submitting a Proof of Claim, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to that Proof of Claim.

Timing of decision on Proof of Claim: The Settlement Administrator will use its best efforts to determine the validity of requests for payment for Category One Compensation within thirty (30) days of their receipt by the Settlement Administrator, and will make payments in the amount listed in the Category One Code List within **fourteen (14) calendar days** of determining that a request is a Valid Proof of Claim. Individual requests for payment seeking more than $100 are subject to review by CIGNA HealthCare, which will have **thirty (30) calendar days** from the date the Settlement Administrator provides the request for payment to CIGNA HealthCare to object to the payment. However, if the Settlement Administrator approves a request after consideration of an objection by CIGNA HealthCare, such approval is final.

If the Settlement Administrator denies a request for Category One Compensation, the Settlement Administrator will notify you by mail of this rejection, and identify the reason(s) for rejection. You will have the right to seek reconsideration, provided that the request for reconsideration is sent to the Settlement Administrator within **thirty (30) calendar days** of the date on which the Settlement Administrator's notification of its denial decision was postmarked.

Upon reconsideration, if the Settlement Administrator upholds its denial, the Settlement Administrator will notify you of the denial and of the reasons for denial. An adverse decision by the Settlement Administrator upon reconsideration is final and is not subject to further reconsideration by the Settlement Administrator, the Court or any other form of review.

2. ***Category Two Compensation - Uncapped Settlement Fund***

INSTRUCTIONS

Availability of Category Two Compensation: Category Two Compensation may be sought for all denials of or reductions in payment with respect to claims submitted to CIGNA HealthCare resulting from the application of Claim Coding and Bundling Edits, other than those for which Category One Compensation applies. If Category One Compensation applies, it is the exclusive remedy.

The following are not eligible for Category Two Compensation: denials of or reductions in payment for CPT® Codes or HCPCS Level II Codes resulting from the application of payment and benefit limitations other than Claim Coding and Bundling Edits (*e.g.,* coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, and limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the Proof of Claim or with other health care providers).

Physician Groups and Physician Organizations may file a Proof of Claim on behalf of Physicians employed by or otherwise working with them at the time that the original claims were submitted, without the necessity of individual signatures from the individual Physicians; provided, however, that the Class Member that submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization that *originally* submitted the claim and must use the *same tax identification number as was used on the original claim* when submitting the Proof of Claim.

Facilitation List: In order to assist you in identifying claims which are eligible for Category Two Compensation, CIGNA HealthCare has used its best efforts to create an electronic Facilitation List. The Facilitation List is specific to each individual Class Member and includes the following types of claims:

- claims for which CIGNA HealthCare denied payment for CPT® Codes 99201-99499 (CPT® Evaluation and Management Codes) due to the application of Claim Coding and Bundling Edits;
- claims in which CIGNA HealthCare made payment on the basis of code 90769 (CIGNA HealthCare's "well woman" benefit code);
- claims in which Evaluation and Management Codes were billed with a procedure code and either code was denied payment; and
- claims in which Evaluation and Management Codes were billed with add-on codes, and either code was denied payment.

Please note that, depending on the nature of the claims involved, the Facilitation List will be limited as to the time period covered, claim systems from which payment was made and the level of detail that can be provided. The Facilitation List may therefore not include all claims in these categories that may be eligible for Category Two Compensation. You may submit requests for payment relating to claims that do not appear on the Facilitation List. The Facilitation List may also include claims that are not eligible for Category Two Compensation.

To request a Facilitation List specifically related to your potential claims, visit *www.CIGNAPhysicianSettlement.com* or call the Settlement Administrator.

Requirements for Category Two Proofs of Claim: In order to receive Category Two Compensation, you must submit a Category Two Proof of Claim Form. A single Proof of Claim Form may be used to submit multiple requests for Category Two Compensation, provided the required supporting documentation for each separate request for payment is included. Each individual request for payment must relate to a single episode of care, although it may seek compensation for multiple CPT® Codes. **A separate *cover sheet* must precede each individual request for payment.** On each cover sheet, you must indicate the CPT® Code(s) for which you are seeking payment, the subscriber Social Security number, the patient name, the date of service, and the provider TIN (or Social Security number, if the TIN is not available). The cover sheet is attached to the Category Two Proof of Claim Form, which can be found at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com.*

Proof of Claim Forms for Category Two Compensation must include the following with each separate request for payment:

(a) documentation evidencing that, for the underlying claim concerned,

(i) you were denied payment, in whole or in part; or

(ii) you received reduced payment, including payment for a different billing code than the one(s) billed, for one or more CPT® Code(s) or HCPCS Level II Code(s); or

(iii) you received a reduced payment based upon the application of Multiple Procedure Logic; and

(b) a complete copy of the Clinical Information (including but not limited to clinical notes and/or operative reports as appropriate) generated in connection with your services on the specific date of service concerned (except for those specific types of claims described below).

Permissible documentation: For purposes of requirement (a) above, a copy of the relevant CIGNA HealthCare Remittance Form showing that payment was denied as submitted on the CPT® Codes or HCPCS Level II Codes in question, in whole or in part, will be adequate documentation unless the Settlement Administrator determines that the records are false or fraudulent.

In the event that you cannot locate the CIGNA HealthCare Remittance Form applicable to a given claim, you may submit copies of internal accounting records (such as printouts of accounts receivable records or paid account records) *if* those records show for the underlying claim and specific date of service concerned, all CPT® Codes or HCPCS Level II Codes that were submitted to CIGNA HealthCare for payment and those that remain unpaid, in whole or in part. If your internal accounting records do not show all CPT® Codes or HCPCS Level II Codes that were submitted to CIGNA HealthCare for payment on the claim in question, then you may supplement the internal accounting records with additional documentation for that claim, such as the HCFA 1500 form or CMS 1500 form.

Exceptions to Clinical Information requirement: There are two exceptions to the requirement that clinical notes, operative reports or other Clinical Information be submitted with a Category Two request for payment:

1. The requirement does not apply to requests for payment based on claims that:

(a) CIGNA HealthCare failed to recognize modifiers 50, RT, LT, FA-F9, or TA-T9, and thus denied payment for one or more CPT® Codes as duplicative of other CPT® Codes reported; and/or

(b) HCPCS Level II "J" Code was translated into an incorrect or overbroad CPT® Code and payment was denied based on that incorrect translation.

For claims of this type, you only need to submit:

- a copy of the HCFA 1500 or CMS 1500 form used to submit the original claim to CIGNA HealthCare showing the precise manner in which all services or supplies included in the claim were originally billed to CIGNA HealthCare; and
- documentation showing that payment was denied, in whole or in part, for the CPT® Codes or HCPCS Level II Codes concerned (such as a copy of the relevant CIGNA HealthCare Remittance Form or your internal accounting records).

If you are unable to show, through the above documentation, how the services or supplies were originally billed to CIGNA HealthCare (inclusive of the modifiers submitted with each CPT® Code or HCPCS Level II Code billed), then you may not submit the request for payment under these special documentation exceptions, but instead must submit the request for payment with the Clinical Information documentation described above.

2. The requirement that clinical notes, operative reports or other Clinical Information be submitted also does not apply to requests for payment based on the contention that CIGNA HealthCare incorrectly processed one or more modifier 51 exempt CPT® Codes and/or add-on CPT® Codes using CIGNA HealthCare's Multiple Procedure Logic when those codes were exempt from multiple procedure reduction. However, for these claims, you must submit a copy of the documentation showing that payment was denied, in whole or in part, for the CPT® Codes concerned. Such documentation may include a copy of the relevant CIGNA HealthCare Remittance Form or your internal accounting records.

CIGNA HealthCare has used reasonable efforts to compile a list of those modifier 51 exempt codes and add-on codes for which CIGNA HealthCare may have systematically applied Multiple Procedure Logic during the Class Period. The Settlement Administrator will make the list available to you within **fourteen (14) calendar days** upon request. The list may also be found at w*ww.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com*.

Timing of decision on adequacy of documentation:

The Settlement Administrator will use its best efforts to determine the adequacy of the documentation accompanying each request for Category Two Compensation within **fourteen (14) calendar days** of the date of receipt by the Settlement Administrator.

If the Settlement Administrator determines that any individual request for Category Two Compensation does not include adequate documentation, it will notify you by mail that the request for payment has been rejected, and identify the reason(s) for the rejection. (The Settlement Administrator will process all other separate requests for payment attached to the same Proof of Claim Form that are supported by

adequate documentation.)

You will have the right to resubmit any rejected requests for payment in an effort to correct the deficiencies noted by the Settlement Administrator, provided that your resubmission is sent to the Settlement Administrator no later than **thirty (30) calendar days** from the date on which the Settlement Administrator's notice of the deficiencies was postmarked.

If the Settlement Administrator still concludes that the documentation is inadequate, then that request for payment will be denied. The Settlement Administrator will mail notification of this final determination to you.

If the Settlement Administrator determines that a request for payment submitted under Category Two should have been submitted under another category, and the Settlement Administrator has adequate documentation to process the request for payment in the proper category, the Settlement Administrator will *automatically* do so.

Certification by Class Member: No Proof of Claim Form for Category Two Compensation will be accepted by the Settlement Administrator for processing unless you sign the certification (or digitally sign, for those claims submitted through Infinedi) indicating that:

(i) the CPT® Code(s) or HCPCS Level II Code(s) for which you are requesting payment (or additional payment) describe services or supplies that were actually provided to a CIGNA HealthCare Member;

(ii) the additional payment requested has not already been made by CIGNA HealthCare on resubmission of the claim or on an appeal; and

(iii) the claim to which the request for payment relates has not been finally adjudicated and determined in a court of law or in an arbitrable forum, or resolved by a final and binding settlement.

If you billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed you for such amount, it is expected that you will reimburse the CIGNA HealthCare Member by the amount you are compensated as a result of this Settlement.

If you submit internal accounting records in support of a Category Two Proof of Claim, you must also certify that the CIGNA HealthCare Remittance Form and the claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

By submitting a Proof of Claim, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to that Proof of Claim.

Timing of Decision on Proof of Claim: Upon determining that you have made a timely Proof of Claim for Category Two Compensation, that the Proof of Claim Form contains all required information and documentation and you have properly certified the Proof of Claim, the Settlement Administrator will forward the individual requests for payment to CIGNA HealthCare for processing within **fourteen (14) calendar days** of receipt by the Settlement Administrator.

CIGNA HealthCare will have **thirty (30) calendar days** from the date that the Settlement Administrator transmits a request for payment to CIGNA HealthCare to make a determination whether to approve or deny, in whole or in part, the request for payment and to notify the Settlement Administrator of that determination.

If CIGNA HealthCare approves (or fails to deny within **thirty (30) calendar days**) a Category Two request for payment, the request for payment will be deemed a Valid Proof of Claim, and payment will be mailed to you.

Denials of Category Two Requests for Payment and External Review of Denials: If CIGNA HealthCare denies a Category Two request for payment based on CIGNA HealthCare's determination that the original decision to reduce or deny payment was an appropriate application of Claim Coding and Bundling Edits, that request for payment will automatically be forwarded to an Independent Review Entity to determine the appropriateness of CIGNA HealthCare's decision. The parties have agreed that **Millennium Healthcare Consulting, Inc.** will serve as the Independent Review Entity.

If the denial is based on any other determination (*e.g.,* that the claim to which the Proof of Claim relates is a Resolved Claim, that the individual to whom the services or supplies were provided was not a CIGNA HealthCare Member at the time, etc.), the denied request will be subject to automatic review by the Settlement Administrator.

In either case, CIGNA HealthCare will be responsible for creating a review file and transmitting that file to the Settlement Administrator within **thirty (30) calendar days** of its denial. The Settlement Administrator will provide you with a copy of that file.

Timing of External Review Decision: The Settlement Administrator or the Independent Review Entity, as appropriate, will use its best efforts to complete External Review within **thirty (30) calendar days** of receiving the review file. If the Settlement Administrator or the Independent Review Entity overturns CIGNA HealthCare's decision, payment will be mailed to you.

If CIGNA HealthCare's decision is upheld, you will be notified by mail of the denial and of the reason(s) for the denial. Decisions of the Settlement Administrator and Independent Review Entity are final and are not subject to review by the Court or any other court or tribunal. No requests for reconsideration are permitted.

Claims Originally Submitted to CIGNA HealthCare On or After August 24, 2003: Any payment for claims relating to services or supplies delivered to a CIGNA HealthCare Member on or after August 24, 2003 will be made at the CIGNA HealthCare Member's benefit amount (*i.e.,* the applicable fee schedule amount or reasonable and customary charge less the CIGNA HealthCare Member's required coinsurance payments, copayments, and deductible contributions, if applicable). You will be free to collect any applicable coinsurance payments, copayments, and deductible contributions directly from the CIGNA HealthCare Member to whom the services were provided. Please note that because these payments will be "bulked" with other claim payments, you will not receive separate documentation that these settlement claims have been paid; instead, you will receive documentation along with that normally received in the ordinary course of business.

Claims Submitted to CIGNA HealthCare On or Before August 23, 2003: Any payments made for claims relating to services or supplies delivered to a CIGNA HealthCare Member on or before August 23, 2003 will be made from the Claim Distribution Fund by the Settlement Administrator on the basis of the National Medicare Fee Schedule in effect on June 1, 2001, without any deductions for the CIGNA HealthCare Member's coinsurance payments, copayments, and deductible contributions. You may not seek further compensation from the CIGNA HealthCare Member or the CIGNA HealthCare Member's employer or employer plan.

3. *Medical Necessity Denial Compensation - Uncapped Settlement Fund*

INSTRUCTIONS

Availability of Medical Necessity Denial Compensation: Medical Necessity Denial Compensation may be sought for claims that you believe were improperly denied as not Medically Necessary or as experimental or investigational. Upon the submission of timely and proper Proof of Claim Forms and all other required documentation, CIGNA HealthCare will reconsider and, where appropriate, make or fund additional payments to Class Members for claims that were submitted to CIGNA HealthCare and denied, in whole or in part, on the grounds that the services or supplies were either experimental or investigational or not Medically Necessary. Medical Necessity Denial Compensation will be available under this Agreement only for denials of payment based on CIGNA HealthCare's judgment that the services or supplies were either experimental or investigational or were not Medically Necessary.

The following are not eligible for Medical Necessity Denial Compensation: denials of or reductions in payment for CPT® Codes or HCPCS Level II Codes resulting from the application of other payment and benefit limitations (*e.g.,* coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, and limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the Proof of Claim or with other health care providers). In addition, no Medical Necessity Denial Compensation is available where the services or supplies were excluded from coverage (other than under a general exclusion for cosmetic services or supplies) under the CIGNA HealthCare Member's Plan Documents.

Physician Groups and Physician Organizations may file a Proof of Claim on behalf of Physicians employed by or otherwise working with them at the time that the original claim was submitted, without the necessity of individual signatures from the individual Physicians; provided, however, that the Class Member that submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization that *originally* submitted the claim and must use the *same tax identification number as was used on the original claim* when submitting the Proof of Claim.

Documentation Requirements: In order to receive Medical Necessity Denial Compensation, you must submit a Proof of Claim Form for Medical Necessity Denial Compensation. A single Proof of Claim Form may be used to submit multiple requests for Medical Necessity Denial Compensation, provided the required supporting documentation for each separate request for payment is included. Each individual request for payment must relate to a single episode of care, although it may seek compensation for multiple CPT® Codes. **A separate *cover sheet* must precede each individual request for payment.** On each cover sheet, you must indicate the CPT® code(s) for which you are seeking payment, the subscriber Social Security number, the patient name, the date of service, and the provider TIN (or Social Security number, if a TIN is not available). The cover sheet is attached to the Proof of Claim Form for Medical Necessity Denial Compensation, which can be found at *www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com* and *www.whatleydrake.com.*

Proof of Claim Forms for Medical Necessity Denial Compensation must include with each separate request for payment:

(a) documentation showing that you submitted claims for payment to CIGNA HealthCare for services or supplies provided to a CIGNA HealthCare Member, and thereafter payment was denied for one or more CPT® Codes or HCPCS Level II Codes due to CIGNA HealthCare's determination that the medical services, procedures or supplies corresponding to such codes were either not Medically Necessary or were experimental or investigational; and

(b) a complete copy of the Clinical Information generated in connection with your services. You are not required to submit Clinical Information that relates to dates of service occurring more than **ninety (90) calendar days** before the date of service at issue.

For purposes of requirement (a) above, a copy of the relevant CIGNA HealthCare Remittance Form showing that payment was denied for one or more CPT® Codes or HCPCS Level II Codes will constitute adequate documentation unless the Settlement Administrator determines that the records are false or fraudulent. If you cannot locate the CIGNA HealthCare Remittance Form applicable to a given claim, you may submit copies of internal accounting records (such as printouts of accounts receivable records or paid account records) *if* those records show that the CPT® Codes or HCPCS Level II Codes in question were submitted to CIGNA HealthCare for payment and remain unpaid.

How to request information about the types of required clinical information: To assist you in determining what types of Clinical Information to include with your Medical Necessity Denial Proofs of Claim, CIGNA HealthCare has provided the Settlement Administrator with information about the types of Clinical Information, by billing code, that CIGNA HealthCare has traditionally required to be submitted for review in order to make Medical Necessity determinations. This information is available to you from the Settlement Administrator within **fourteen (14) calendar days** after you request it. It may also be found at *www.CIGNAPhysicianSettlement.com*.

Procedures for Medical Necessity Proofs of Claim: Except for the documentation requirements just described, the procedures for submitting and processing a Proof of Claim Form for Medical Necessity Denial Compensation are identical to the procedures for submitting and processing a Proof of Claim Form for Category Two Compensation. The parties have agreed that **Hayes Plus, Inc.** will serve as the Independent Review Entity for denials of requests for Medical Necessity Denial Compensation.

IX. WHAT CLAIMS ARE EXCLUDED FROM CONSIDERATION BY THE SETTLEMENT ADMINISTRATOR?

Retained Claims are not adjudicated by the Settlement Administrator. Retained Claims are essentially claims that were in the pipeline as of April 22, 2004. Specifically, a Retained Claim is a claim for payment for the provision of Covered Services if, as of April 22, 2004: (1) a claim has been filed with CIGNA HealthCare, but not finally adjudicated by it; or (2) no claim has yet been filed with CIGNA HealthCare and the period for filing such a claim has not expired. A claim is considered finally adjudicated when CIGNA HealthCare's internal appeals process has been completed. Physicians with Retained Claims must still go through CIGNA HealthCare's internal appeals process.

All other claims for services rendered before April 22, 2004 are released by the Settlement and are thus no longer subject to challenge by Class Members (except as specified in the next paragraph with respect to certain claims that were finally adjudicated between March 24 and April 21, 2004).

Retained Claims that involve the application of CIGNA HealthCare's coding and payment rules and methodologies will be handled by the Billing Dispute External Review Process established under the terms of Section 7.10 of the Settlement Agreement. For this type of claim only, Retained Claims also includes claims that were finally adjudicated between March 24 and April 21, 2004.

After any internal appeal has been exhausted, Class Members may submit such Retained Claims to the Billing Dispute External Review Process. This is the ONLY way to resolve Retained Claims that relate to the application of coding and payment rules and methodologies to patient specific factual situations, including, for example, the appropriate payment amount when two or more CPT® Codes are billed together, or whether the physician used modifiers appropriately.

Any such Retained Claim may be submitted to the Billing Dispute External Review Process if

- it was not finally adjudicated by CIGNA HealthCare by April 22, 2004;
- it was finally adjudicated within thirty (30) days before April 22, 2004 (*i.e.,* between March 24 and April 21, 2004); and
- it is submitted by no later than August 31, 2004, or within thirty (30) days of final adjudication under CIGNA HealthCare's internal appeals process, whichever is later.

Additional information about how to submit claims to the billing dispute process will be available by July 20, 2004 on the following websites: *www.CIGNA.com* and *www.hmosettlements.com.* Please continue to check for details.

Retained Claims NOT involving the application of coding and payment rules and methodologies are not subject to resolution under any adjudication process created in connection with the Settlement. However, your right to sue or seek other legal redress is not waived under the Settlement as to these Retained Claims.

If you have any questions, please visit *www.CIGNAPhysicianSettlement.com*, *www.hmosettlements.com* or call the Settlement Administrator at 1-877-683-9363

CIGNA Physician Settlement
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