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Memo

To: All Physicians who provided Covered Out-of-Network Services for United Healthcare

From: Jason E. Lopata, Esq., Senior Consultant, Legal Services

Date: 5/26/2010

Re: Notice of Proposed Settlement of Class Action – AMA vs. United Healthcare Corp.

Notice of Proposed Settlement of Class Action – AMA vs. United Healthcare

The United States District Court, Southern District of New York, has recently issued a Notice of Proposed Settlement of the Class Action titled *The American Medical Association (AMA), et al. v. United Healthcare Corporation, et al*. The notice spells out the procedures that must be taken for the receipt of cash payments to both persons who received Out-of-Network healthcare services and providers who furnished services to a United Healthcare (hereinafter "United") patient. Individuals and physicians are eligible for health care benefits received at any time between March 15, 1994 through November 18, 2009.

Filed in 2000 and still pending before the court, the action brought by Plaintiffs (which included not only the AMA, but also such groups such as the Medical Society of the State of New York, the Missouri State Medical Association, and other New York employee organizations) alleges that United, and its numerous subsidiaries, provided insufficient reimbursement for Covered Out-of-Network Services and Supplies. The lawsuit alleged that reimbursements were insufficient due to United using flawed databases, which improperly reduced payment amounts for Covered Out-of-Network health benefits. The allegations included not only breach of contract, but also violations of ERISA, RICO and the Sherman Antitrust Act.

The parties to the litigation have agreed to a settlement package, which if approved by the Court at a September 13, 2010 hearing, would establish a $350,000,000 cash settlement fund for both United subscribers and providers, and force United to adopt a number of commitments and initiatives regarding its business practices. The main initiative would include no longer using the Ingenix Databases that Plaintiffs alleged are flawed. Instead, United would use a New Database independently established and operated by a consortium of New York State university-level schools of public health led by Syracuse University, funded with a $50,000,000 payment made by United (in addition to the $350 million cash settlement). United would also coordinate with the consortium to create the Healthcare Information Transparency website that would allow the public to access information about the range of provider charges, by geographical region, contained in the new database for common medical services.

Providers and subscribers have the option of joining this class action, submitting proof of a claim and getting a payment if they qualify. All claim forms must be submitted no later than October 5, 2010. Should an eligible party request to be excluded from this class action, they would not receive

payment from the cash settlement fund. Instead, this option would allow individual to pursue their own claims against any of the Defendants (at their own legal expense). Also, parties who fail to submit a timely claim, but would have been otherwise eligible for payments, will waive their rights against United for similar claims. Inclusion in the Settlement Class will make the most practical and economical sense for most practices.

The settlement fund will be allocated to eligible members of the settlement class based on the recognized loss of each United subscriber and provider. Should the settlement fund, after payment of attorneys' fees and litigation expenses, have sufficient funds, each claimant will receive their full recognized loss. However, if the amount of all submitted claims is greater than the net settlement fund, claimants will receive a percentage based on a pro rata allocation.

Whether or not a person submits a proper claim, unless they specifically opt-out of the Settlement Class with a signed Request for Exclusion, all potential claimants will be bound by the release and covenant not to sue provisions found in the proposed Settlement Agreement.

Qualifications for Providers

Providers will only be eligible for maximum payments if they meet ALL of the 4 conditions set out under the settlement agreement:

1. An assignment was received from a subscriber patient;

2. The Provider submitted a claim for reimbursement to United for Covered Out-of-Network Services or Supplies based on the assignment and the claim was processed or reimbursed by United using the Ingenix Database or one of the Seven Out-of-Network Reimbursement Policies (listed below);

3. The Provider sent an adjusted bill to a subscriber patient (with exceptions explained below); and

4. The subscriber patient did not pay the full amount of the adjusted bill.

The seven Out-of-Network Reimbursement Policies relevant to this lawsuit are:

- ✓ Anesthesia Policy
- ✓ Assistant Surgeon Policy
- ✓ Co-Surgeon/Team Surgeon Policy
- ✓ Multiple Procedure Policy
- ✓ Preventative Medicine Policy
- ✓ Professional/Technical Policy
- ✓ Reduced Services Policy

Levels of reimbursement will depend on factors including whether subscriber patients were sent an adjusted bill, followed by whether that adjusted bill was submitted to a collection agency, reported to a credit agency or had a payment plan entered into with their subscriber patients. If all of the conditions are properly met, Providers will receive 90% of the adjusted bill amount that the patient did not pay, minus 20% per claim, up to a total of $2,000 for all of the Provider's submitted claims, to take into account the co-payments, co-insurance or deductibles the patient would ordinarily owe under the healthcare plan. If unpaid claims were not sent to a collection or credit agency, Providers will receive

70% of the unpaid adjusted bill amount (minus the 20%), provided that the adjusted bill was sent to patients on or after January 1, 2002. Finally, even if an adjusted bill was not sent to a subscriber patient at all, Providers will be eligible for 50% reimbursement (minus the 20%) of the difference between what was billed to United and the amount paid by either United or the subscriber patient.

Documentation Needed

Despite the fact that claims can be filed for services provided as far back as 1994, Defendants will only need to make available certain claims information for the benefit of claimants. Upon request, claimants can request from the Claims Administrator (third party administrator, Berdon Claims) to be provided with dates that Covered Out-of-Network Services or Supplies were either received or provided and the Allowed Amounts from January 1, 2002 through May 28, 2010. You must authorize the Claims Administrator to send you this information, by way of the authorization form found either online at www.berdonclaim.com or as part of the mailed Notice of Proposed Settlement. This authorization should be sent **as soon as possible** to assist you in filing a proper claim prior to October 5, 2010.

Valid document during the relevant time period includes: a claim for Out-of-Network Services or Supplies furnished and submitted to United (or any affiliate or subsidiary), cancelled checks from United for services, an EOB/EOP/Remittance Advice from United indicating that payment was made to you for services, evidence from your practice management system records or internal accounting records (such as a print-out or electronic version of your A/R or paid account records) that reflects that a claim form was addressed and sent to United pursuant to an assignment for services and that a payment was received from United for such service, or finally, evidence of payments from a subscriber patient for services. Also, for maximum reimbursement payments, evidence from your practice management system records, including written correspondences, reflecting that adjusted bills were submitted to a collection agency, reported to a credit agency or payment plans were formed with the patient. Documentation can be provided in electronic format, such as scanned image files (".bmp") or PDF files and can either be copied onto a CD or sent via e-mail. CDs should be clearly labeled and it's preferable that accounting records be prepared in MS Excel format or tab-delimited text files.

If Providers cannot provide documentation of an assignment, but are owed money for providing Covered Out-of-Network Services or Supplies to a subscriber patient, you may request information from the Claims Administrator as to whether the patient has made claims for payment from the Settlement Fund by checking the applicable box on the claim form and informing the Claims Administrator of the patient's name and the amount of debt outstanding. While this would not necessarily result in a Settlement Fund payment, it would give a practice further support and justification for seeking payment of the outstanding debt from the patient. However, if a proper assignment was received by the practice, and a subscriber patient makes a claim for the same services, payment would only be sent to the Provider.

For More Information

More information can be found out about this Settlement Fund and submission of claims at www.unitedUCRsettlement.com or www.berdonclaim.com (which has appropriate additional forms for download). The Claims Administrator can also be contacted by phone at 800-443-1073, by fax at 516-222-0271, or by email at unitedhealthcare@berdonclaimllc.com.

Claim Forms Must Be Postmarked No Later Than October 5, 2010