UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE AMERICAN MEDICAL ASSOCIATION, et al.,
Plaintiffs,
-against-
UNITED HEALTHCARE CORPORATION, et al.,
Defendants.

Master File No.
00 Civ. 2800 (LMM) (GWG)

NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION AND FINAL SETTLEMENT HEARING

A CLASS ACTION SETTLEMENT INVOLVING UNITED HEALTHCARE CORPORATION (NOW KNOWN AS UNITEDHEALTH GROUP), AND ITS SUBSIDIARIES AND AFFILIATES WILL PROVIDE CASH PAYMENTS TO PERSONS WHO RECEIVED OR FURNISHED OUT-OF-NETWORK HEALTHCARE SERVICES AND WHO QUALIFY

YOUR LEGAL RIGHTS ARE AFFECTED WHETHER OR NOT YOU ACT
PLEASE READ THIS NOTICE CAREFULLY

A court authorized this Notice. This is not a solicitation from a lawyer.

- If you were or are:

  (1) a **Subscriber**, which means a member of a healthcare plan insured or administered by a Defendant, and received Covered Out-of-Network ("OON") healthcare benefits at any time from March 15, 1994 through November 18, 2009 that were processed or reimbursed by a Defendant using the Ingenix Databases or one of the Seven OON Reimbursement Policies; or

  (2) a **Provider** or **Provider Group**, which means a healthcare Provider or healthcare Provider Group who furnished Covered OON Services or Supplies to a Subscriber at any time from March 15, 1994 through November 18, 2009 and whose claim for payment was processed or reimbursed by a Defendant using the Ingenix Databases or one of the Seven OON Reimbursement Policies,

  you are a member of the Settlement Class and may be eligible for a payment if you qualify and submit a valid Claim Form.

- Defendants are United HealthCare Corporation (now known as UnitedHealth Group), Ingenix, Inc., Metropolitan Life Insurance Company, American Airlines, Inc., and their subsidiaries and affiliates. Please note the following non-exhaustive list of subsidiaries and affiliates of United HealthCare Corporation or UnitedHealth Group:

  Oxford Health Plans, Inc.
  Sierra Health Services, Inc.
  PacifiCare Health Systems, Inc.
  Mid-Atlantic Medical Services, Inc.
  Golden Rule Insurance Company
  HealthWise
  HealthPartners of Arizona, Inc.
  PHP, Inc.
  MetraHealth
  GenCare Health Systems, Inc.
  Student Resources (former student insurance division of MEGA Life and Health Insurance Co.)
  MAMSI
  Fidelity Insurance Group
  Touchpoint Health Plan, Inc.
  Neighborhood Health Partnership, Inc.
  Definity Health Corp.
  John Deere Health Care, Inc.
  IBA Health & Life Assurance Co. and IBA Self-Funded Group, Inc.
  Arnett Health Plans, Inc.
  HCT
  United Medical Resources, Inc. (UMR) Fiserv, Inc.

- The Seven OON Reimbursement Policies are Defendants' (1) Anesthesia Policy, (2) Assistant Surgeon Policy, (3) Co-Surgeon/Team Surgeon Policy, (4) Multiple Procedure Policy, (5) Preventative Medicine Policy, (6) Professional/Technical Policy, and (7) Reduced Services Policy.
- The Ingenix Databases are the Prevailing Healthcare Charges System ("PHCS") database and the MDR Payment System database.
- An in-patient or out-patient hospital or facility is a Provider Group *if and only to the extent* that it bills for Covered OON Services or Supplies delivered by a Provider.
- If you have a question whether you were insured by United HealthCare, UnitedHealth Group, or a subsidiary or affiliate thereof, please contact the Claims Administrator, as detailed in Section XIV, below.

YOUR LEGAL RIGHTS AND OPTIONS IN THIS SETTLEMENT

SUBMIT A PROOF OF CLAIM	The way to get a payment if you qualify. You must fill out and return the attached Proof of Claim by first class mail, postmarked no later than October 5, 2010.
ASK TO BE EXCLUDED	Get no payment. The only option that allows you to individually sue the Defendants over the claims resolved by this Settlement.
OBJECT	Write to the Court about why you do not agree with the Settlement.
GO TO A HEARING	The Final Settlement Hearing will be held on September 13, 2010 at 10:30 a.m. At or following this hearing, the federal court judge will make a final decision as to whether the Settlement is fair to all members of the Settlement Class. If you wish, you or your counsel may attend the hearing and ask to speak in Court about the Settlement.
DO NOTHING	Get no payment and give up your rights.

- These rights and options – **and the deadlines to exercise them** – are explained in this Notice.
- The Settlement will resolve all claims against the Defendants as explained in the Settlement Agreement. The Court in charge of this case still has to decide whether to approve the Settlement. Payments will only be made if the Court approves the Settlement and any appeals are resolved. Please be patient.

BASIC INFORMATION

I. WHY DID I RECEIVE THIS NOTICE?

The United States District Court for the Southern District of New York authorized this Notice because you have a right to know about a proposed Settlement of this class action, including the right to claim money, and about all of your options, before the Court decides to give "final approval" to the Settlement. If the Court approves the Settlement, payment will be made to everyone who submits a valid claim form and qualifies. This Notice explains the lawsuit, the Settlement, your legal rights, what benefits are available, who may be eligible for them, and how to get them.

Your rights may be affected by a proposed Settlement in the class action lawsuits consolidated under the case caption *American Medical Association, et al. v. United HealthCare Corporation, et al.,* pending in the United States District Court for the Southern District of New York, Master File No. 00 Civ. 2800 (LMM) (GWG) (collectively, the "Action"). The Class Representative Plaintiffs, Medical Association Plaintiffs, and Union Plaintiffs have agreed to settle all claims against Defendants in the Action in exchange for Defendants' establishment of a $350,000,000 cash settlement fund, against which members of the Settlement Class can make claims for a settlement payment, and Defendants' adoption of a number of commitments and initiatives regarding their business practices.

The Honorable Lawrence M. McKenna of the United States District Court for the Southern District of New York (the "Court") has scheduled a hearing to consider the fairness, reasonableness, and adequacy of the Settlement, to be held on September 13, 2010 at 10:30 a.m. at the United States Courthouse, United States District for the Southern District of New York, 500 Pearl Street, New York, NY (the "Final Settlement Hearing").

You may elect to opt-out of the Settlement Class and the Settlement, as explained below. You also have a right to object to the Settlement or to the application for attorneys' fees that counsel for the Settlement Class intends to make to the Court, but only if you comply with the procedures described in this Notice. If you do not opt out of the Settlement Class and the Court approves the Settlement, you will be entitled to receive the benefits of the Settlement, and you will be bound by the Settlement's provisions, including the release of claims against Defendants. **Because your right to pursue certain types of claims against Defendants may be affected by the Settlement, you should read this Notice carefully.**

II. WHAT IS THIS LITIGATION ABOUT?

The Action has been brought against Defendants by the individual Subscriber and Provider Class Representative Plaintiffs, as well as the American Medical Association, the Medical Society of the State of New York, the Missouri State Medical Association, the Civil Service Employees Association, the New York State Police Investigators Association, New York State United Teachers, and the Organization of New York State Management/Confidential Employees.

Plaintiffs allege that Defendants provided insufficient reimbursement for Covered OON Services or Supplies, including by:

- using flawed databases (the Ingenix Databases) in determining reimbursement amounts for Covered OON health benefits;
- using the OON reimbursement policies to reduce reimbursement amounts improperly for Covered OON health benefits; and
- inadequately disclosing the use of the Ingenix Databases and their OON reimbursement policies in determining reimbursement amounts for Covered OON health benefits.

Plaintiffs allege that Defendants violated various state and federal statutes, including the Employment Retirement Income Security Act ("ERISA"), the Racketeer Influenced and Corrupt Organizations ("RICO") Act, the Sherman Antitrust Act, as well as common law, including breach of contract. Defendants deny all of Plaintiffs' allegations. **To obtain further information about the claims asserted in the Action, you may review a copy of the complaints filed in the Action from the websites at www.unitedUCRsettlement.com or www.berdonclaims.com.**

III. WHAT IS A CLASS ACTION, AND WHY IS THIS CASE A CLASS ACTION?

In a class action, one or more people, called Class Representatives, sue on behalf of others with similar legal claims. All of these people together are called a Settlement Class or Settlement Class Members. One court resolves the issues for all Settlement Class Members, except for

those who specifically ask to be excluded from the Settlement Class, since the claims alleged by the Class Representatives apply similarly to all Settlement Class Members.

This case was filed as a class action because the Class Representatives believed that Defendants' method of making OON reimbursement determinations resulted in a number of Subscribers and Providers receiving less than they were entitled to, in violation of ERISA, the Sherman Antitrust Act, RICO, and state law. The Court preliminarily ordered that whether all members of the Settlement Class have been under-reimbursed by Defendants' use of the Ingenix Databases represents a claim that should be treated on a class basis pursuant to Fed. R. Civ. P. 23(c)(2)(B). The following represents additional claims, issues and defenses that the Court ordered shall be treated on a class basis:

- whether Defendants' use of the Ingenix Databases in determining reimbursement for Covered OON Services or Supplies violated ERISA, the Sherman Antitrust Act, RICO, or state law;
- whether Defendants' use of OON Reimbursement Policies that reduced reimbursement for Covered OON Services or Supplies violated ERISA or state law;
- whether ERISA requires each Subscriber to prove exhaustion or futility as to each ERISA claim;
- whether ERISA requires each Provider to prove exhaustion or futility as to each ERISA claim;
- whether RICO requires each Subscriber to prove exhaustion or futility;
- whether RICO requires each Provider to prove exhaustion or futility;
- whether ERISA requires each Provider to prove the existence of an assignment;
- whether the Sherman Antitrust Act or RICO requires each Provider to prove the existence of an assignment;
- whether Subscribers or Providers may recover damages if a Subscriber is not balanced billed by a Provider;
- whether the contractual terms of the relevant health plans permit Defendants' reimbursement practices for Covered OON Services or Supplies;
- whether Settlement Class Members have standing to assert claims for prospective relief; and
- what the applicable statute of limitations periods are for the ERISA, Sherman Antitrust Act, RICO, and state law claims of Settlement Class Members.

IV. WHY IS THERE A SETTLEMENT?

The Court did not decide in favor of either side. Rather, both sides agreed to settle all claims that were or could have been asserted against Defendants in the Action in exchange for monetary consideration and business practice changes. That way, the parties avoid the uncertainties and cost of a trial and possible appeal, and the affected members of the Settlement Class who qualify will receive compensation.

V. WHAT ARE THE TERMS OF THE PROPOSED SETTLEMENT?

In the Settlement Agreement, the individual Class Representative Plaintiffs, Medical Association Plaintiffs, and Union Plaintiffs agreed to settle all claims that were or could have been asserted against Defendants in exchange for monetary consideration and business practice changes. **The terms of the Settlement Agreement are summarized in this Notice, and a copy of the entire Settlement Agreement, dated January 14, 2009, and Amendment to Settlement Agreement, dated October 1, 2009, may be reviewed on the websites www.unitedUCRsettlement.com or www.berdonclaims.com.**

A. Settlement Consideration

If the Settlement is finally approved by the Court, the Settlement Agreement provides for both monetary and non-monetary benefits to be provided by Defendants to members of the Settlement Class who have *not* opted-out of the Settlement.

1. The Cash Settlement Fund. The Settlement establishes a Cash Settlement Fund in the amount of $350,000,000 plus accrued interest. If the Settlement is finally approved by the Court, members of the Settlement Class will be entitled to payments from the Cash Settlement Fund as set forth in the Plan of Allocation below, subject to the provisions of the Settlement Agreement. Various expenses, such as the costs of notice and claims administration and attorneys' fees for Settlement Class Counsel, also will be paid out of the Cash Settlement Fund.

2. Business Practices Initiatives. As a part of the Settlement and consistent with the terms of the separate Office of New York Attorney General Assurance of Discontinuance, Defendants have agreed to certain commitments regarding their reimbursement practices and procedures for OON healthcare benefits. UnitedHealth Group and its affiliates have agreed that they (a) will stop using the Ingenix Databases that Plaintiffs allege are flawed and, in their place, will 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; and (b) will contribute $50,000,000 towards the funding and implementation of the New Database (*in addition to* the Cash Settlement Fund described above). UnitedHealth Group and its affiliates will also coordinate with the consortium to create the Healthcare Information Transparency ("HIT") Website that will allow the public to access information about the range of provider charges, by geographical region, contained in the New Database for common medical services.

B. The Release and Dismissal with Prejudice

If the Settlement Agreement is finally approved, the Action will be dismissed with prejudice as to Defendants. In addition, Defendants will be released and discharged of any and all claims, up through a final order in this case, that are, were, or could have been asserted against any of the

parties based on or arising from the factual allegations made by Plaintiffs, whether any such claim was or could have been asserted by any member of the Settlement Class on his or her own behalf or on behalf of other persons. These claims include claims that may not currently exist, or that members of the Settlement Class may not know or suspect to exist, in their favor at the time of the final approval of the Settlement Agreement. In substance, members of the Settlement Class are releasing Defendants (which include their subsidiaries and affiliates) and certain other insurance companies from claims that they are entitled to additional reimbursement for Covered OON Services or Supplies because of Defendants' reimbursement practices relating to the allegations in the Action. Members of the Settlement Class will be barred from suing Defendants or the other released parties for claims that are covered by the releases.

The release and "covenant not to sue" provisions of the Settlement Agreement affect your legal rights and you should review these provisions carefully. A complete copy of the Settlement Agreement and Amendment to Settlement Agreement may be reviewed on the websites www.unitedUCRsettlement.com or www.berdonclaims.com.

VI. HOW WILL THE SETTLEMENT FUND BE ALLOCATED?

The Settlement Fund shall total $350,000,000, plus interest. The Net Settlement Fund is the Settlement Fund less attorneys' fees and reimbursement of expenses as approved by the Court, the costs of notice and administration of the Settlement Fund, and service fees to Class Representative Plaintiffs as approved by the Court.

The Net Settlement Fund will be allocated to members of the Settlement Class based on the Recognized Loss of each member of the Settlement Class as determined below. Should the amount of all submitted claims be less than or equal to the Net Settlement Fund, all claimants shall receive their full Recognized Loss. Should the amount of all submitted claims be greater than the Net Settlement Fund, claimants shall receive a percentage of their Recognized Loss based on a *pro rata* allocation.

Terms that appear frequently in this section:

- "Allowed Amount" means the amount a Defendant reimbursed a member of the Settlement Class for Covered OON Services or Supplies. Any amounts representing services or supplies that were determined not to be covered are not included in the calculation of a Settlement Class Member's Recognized Loss. If a Defendant determined that an OON service or supply was not covered, the Allowed Amount would equal $0. Therefore, for purposes of this Plan of Allocation, an Allowed Amount must be greater than $0 to be used to calculate a Recognized Loss.
- "Adjusted Bill" means a bill sent by a Provider to a Subscriber reflecting the unpaid portion of the amount initially billed by a Provider for Covered OON Services or Supplies.

Other terms appearing in this section are defined where they are first used.

All members of the Settlement Class must submit a Claim Form to be eligible to share in the Net Settlement Fund. You may submit a Claim Form for Covered OON Services or Supplies received or furnished up through the Final Order and Judgment Date, which is the date the Court finally approves the Settlement and signs the Final Order and Judgment. If you file the Claim Form prior to the Final Order and Judgment Date but you have additional claims, you may submit an update to your previously filed claim.

There are two types of Settlement Class Members – Subscribers and Providers, or Provider Groups. The options available to Subscribers under the Settlement are different from those available to Providers and Provider Groups. The options for Subscribers are listed in the Proof of Claim Form as Groups A, B and C. The option for Providers is listed as Group D. The Claim Form is attached to this Notice.

Group A allows eligible Subscribers to file a simplified claim form without the requirement of submitting any supporting documentation. For payments under all other Groups, you must submit appropriate documentation supporting your claims, as detailed below and in the Claim Form.

Important information. In order to assist **Subscribers** and **Providers** in filing their Group B, C or D claims, Defendants will make available to the Claims Administrator certain claims information, including the dates that Covered OON Services or Supplies were either received or provided and the Allowed Amounts, from January 1, 2002 through May 28, 2010. You may request such information and use it to complete your claim form **(see page 8, paragraph 4)**. You must provide information concerning Covered OON Services or Supplies prior to January 1, 2002, and after May 28, 2010 from other sources, and use this information to complete your claim form.

If you are a Subscriber and either paid out-of-pocket for Covered OON Services or Supplies or did not assign your benefit payments to a Provider, payments from the Net Settlement Fund will be made directly to you. If you are a Subscriber and assigned benefit payments to a Provider and this Provider submits a valid claim, payments from the Net Settlement Fund will be made to the Provider. If you are a Provider with an assignment but do not submit a claim, but the Subscriber does, payment from the Net Settlement Fund will be made to the Subscriber. Therefore, **Subscribers may wish to submit claims whether or not they assigned benefit payments to a Provider.**

If a Subscriber owes a Provider money for Covered OON Services or Supplies and the Subscriber receives proceeds from the Net Settlement Fund for such Covered Out-of-Network Services or Supplies, the Subscriber may owe these funds to the Provider. **Providers may request information from the Claims Administrator as to whether Subscribers who owe them money for Covered OON Services or Supplies have made claims for payments from the Net Settlement Fund** by checking the applicable box on the bottom of page 14 of the Claim Form. **Requests for such information will be processed at the time distribution of the Net Settlement Fund is made.**

A Subscriber who elects to make a Group A claim may **not** elect to be included in any other group. However, if a Subscriber paid a portion (but not all) of an Adjusted Bill and continues to owe monies to a Provider, the Subscriber may elect to make a Group B claim (for the portion of the Adjusted Bill paid) *and* a Group C claim (for the portion of the Adjusted Bill not paid).

Options for Subscribers

Group A – Simplified Claim Form for Subscribers. You may check the applicable box on page 11 of the Claim Form requesting the Group A option, and you are *only* required to provide the number of years, during the period from 1994 through 2009, that you were a member of any Defendant's healthcare plan that provided Covered OON Services or Supplies. Please note that any portion of a given year should be treated as a whole year.

If you are a Group A claimant, your Recognized Loss will be $50.00 for each such year. This Recognized Loss amount is based on the average amount that more than 90% of United HealthCare's healthcare plan members who submitted claims for Covered OON benefits received in reductions, in total, over a one-year period.

If you elect to be a Group A Claimant you may *not* elect to be included in Groups B or C even if you satisfy the conditions for inclusion in such group(s). However, if you elect to make a Group B or C claim you will receive a Recognized Loss of not less than what you would have received had you made a Group A claim.

If valid claims under Group A require a distribution of more than $50,000,000, the Recognized Loss of Group A claimants will be paid on a *pro rata* basis up to a cap of $50,000,000 in total for all Group A claims, except as specified below. If valid claims under Group A require a distribution of less than $50,000,000, the remaining amount will be made available for allocation to the Recognized Loss of claimants in Groups B, C and D to the extent that such Recognized Loss would not otherwise have been paid fully. If the Recognized Loss of claimants in Groups B, C and D does not exhaust the remainder of the Settlement Fund, the remaining amount will be made available for allocation to the Recognized Loss of claimants in Group A to the extent that such Recognized Loss would not otherwise have been paid fully.

Group B – Out-of-Pocket Subscriber Claimants. You are eligible to participate as a claimant in Group B *only* if you **paid** to your Provider **any portion above the Allowed Amount** (hereinafter, "Out-of-Pocket Amount") for Covered OON Services or Supplies.

The Recognized Loss for Group B Claimants is 100% of the Out-of-Pocket Amount. However, we will subtract from this amount 20% per claim, up to a total of $2,000 over all of your claims, to take into account the co-payments, co-insurance, or deductibles you would ordinarily owe under your healthcare plan.

Group C – Subscriber Claims for Adjusted Bill Amounts Not Fully Paid by Subscriber Claimants. You are eligible to participate as a Group C Claimant *only* if you **did not pay – in whole or in part –** an Adjusted Bill which you received from your Provider for Covered OON Services or Supplies.

The Recognized Loss for a Group C Claimant is 90% of the portion of the Adjusted Bill amount you did not pay, **provided, however,** that (a) you received an Adjusted Bill, and (b) the Adjusted Bill was submitted to a collection agency, or was reported to a credit agency, or if you entered into a payment plan with your Provider. We will subtract from this amount 20% per claim, up to a total of $2,000 over all of your claims, to take into account the co-payments, co-insurance, or deductibles you would ordinarily owe under your healthcare plan.

If you received an Adjusted Bill but the Adjusted Bill was neither submitted to a collection agency, or reported to a credit agency, or if you did not enter into a payment plan with your Provider, your Recognized Loss is 70% of the portion of the Adjusted Bill you did not pay, **provided however,** that you received the Adjusted Bill on or after January 1, 2002. If you received the Adjusted Bill prior to January 1, 2002, your Recognized Loss is 50% of the portion of the Adjusted Bill you did not pay. We will subtract from these amounts 20% per claim, up to a total of $2,000 over all of your claims, to take into account the co-payments, co-insurance, or deductibles you would ordinarily owe under your healthcare plan.

Option for Providers

Group D — Provider Claims for Adjusted Bill Amounts. You are eligible to participate as a Group D claimant *only* if:

- You received an assignment from a Subscriber; and
- You submitted a claim for reimbursement to a Defendant for Covered OON Services or Supplies based on the assignment and the claim was processed or reimbursed by a Defendant using an Ingenix Database or one of the Seven OON Reimbursement Policies; and
- You sent an Adjusted Bill to a Subscriber (except as provided below); and
- The Subscriber did not pay the full amount of your Adjusted Bill (except as provided below).

The Recognized Loss for a Provider is 90% of the Adjusted Bill amount the Subscriber did not pay you, **provided, however,** that you submitted the Adjusted Bill to a collection agency, reported it to a credit agency, or entered into a payment plan with the Subscriber. We will subtract from this amount 20% per claim, up to a total of $2,000 over all of your claims, to take into account the co-payments, co-insurance, or deductibles the Subscriber would ordinarily owe under the Subscriber's healthcare plan.

If during the Settlement Class Period you did not submit the Adjusted Bill to a collection agency, reported it to a credit agency, or if you did not enter into a payment plan with the Subscriber, your Recognized Loss is 70% of the Adjusted Bill amount the Subscriber did not pay you, **provided however,** that you sent the Adjusted Bill on or after January 1, 2002.

If you did not send an Adjusted Bill to a Subscriber at all, or if you did but it does not satisfy the requirements in the above two paragraphs, your Recognized Loss is 50% of the difference between what you billed a Defendant and the amount the Defendant and/or the Subscriber paid you.

We will subtract from each of these amounts 20% per claim, up to a total of $2,000 over all of your claims, to take into account the co-payments, co-insurance, or deductibles the Subscriber would ordinarily owe under the Subscriber's healthcare plan.

When you receive a payment from the Net Settlement Fund you will be deemed to have released the Subscriber from further liability relating to the specific claim you make. When you and the Subscriber submit the same claim, as the assignee you will receive the payment.

Additional Provisions for All Settlement Class Members

- Your participation as a member of a Defendant's healthcare plan should be counted in whole years, and any portion of a given year should be treated as an entire year.
- If you do not submit a Claim Form, you will not receive any money from the Net Settlement Fund, but you will nonetheless be bound by the judgment of the Court and any claims you have against Defendants will still be released.
- All Recognized Losses are rounded off to the nearest dollar.
- If the total amount of valid claims submitted by claimants is greater than the Net Settlement Fund, your Recognized Losses will be paid on a *pro rata* basis.

VII. WHAT WILL HAPPEN AT THE FINAL SETTLEMENT HEARING?

The Final Settlement Hearing will be held on September 13, 2010 at 10:30 a.m. at the United States Courthouse, United States District for the Southern District of New York, 500 Pearl Street, New York, NY. The hearing, however, may be adjourned by the Court without additional notice to the Settlement Class, other than an announcement in open court. Members of the Settlement Class who support the Settlement do not need to be present at the hearing or take any action to indicate their approval, as Lead Counsel for the Settlement Class will be present to address any questions or concerns raised by the Court.

At the Final Settlement Hearing, the Court will consider:

- whether the Settlement of the Action that is reflected in the Settlement Agreement is fair, reasonable, and adequate to the members of the Settlement Class;
- whether the Court should unconditionally certify the Settlement Class in accordance with Federal Rule of Civil Procedure 23; and
- what attorneys' fees and expenses should be paid to Settlement Class Counsel from the Cash Settlement Fund.

VIII. MAY I PARTICIPATE IN THE FINAL SETTLEMENT HEARING?

Any Settlement Class Member who objects to the Settlement, the Settlement Agreement, the application for attorneys' fees, or the other matters to be considered at the Final Settlement Hearing may appear and present such objections. You may also appear by counsel, if you wish. In order to be permitted to do so, however, you must, on or before July 27, 2010:

- file with the Court a notice of your intention to appear, together with a statement setting forth your objections, if any, to the matters to be considered and the basis for those objections, along with any documentation that you intend to rely upon at the Final Settlement Hearing; and
- serve copies of all such materials, either by hand delivery or by first-class mail, postage prepaid, upon the following counsel:

Lead Counsel for the Settlement Class

Stanley M. Grossman, Esq.
D. Brian Hufford, Esq.
Robert J. Axelrod, Esq.
POMERANTZ HAUDEK GROSSMAN & GROSS LLP
100 Park Avenue
New York, NY 10017

Defense Counsel

Jeffrey S. Klein, Esq.
Nicholas J. Pappas, Esq.
WEIL, GOTSHAL & MANGES LLP
767 Fifth Avenue
New York, NY 10153

If you do not comply with the foregoing procedures and deadlines for submitting written objections and/or appearing at the Final Settlement Hearing, you may lose substantial legal rights, including, but not limited to: (1) the right to appear and be heard at the Final Settlement Hearing; (2) the right to contest approval of the proposed Settlement or the application for an award of attorneys' fees and expenses; and (3) the right to contest any other orders or judgments of the Court entered in connection with the Settlement.

You cannot request exclusion from the Settlement Class and also object to the Settlement. Only members of the Settlement Class may object to the Settlement. You should consult the Court's Preliminary Approval Order for additional information on the requirements for objecting to the proposed Settlement or participating in the Final Settlement Hearing. **A copy of the Order may be reviewed on the websites www.unitedUCRsettlement.com or www.berdonclaims.com.**

IX. HOW DO I FILE A CLAIM FOR PAYMENT?

The Settlement provides for payments to members of the Settlement Class who qualify and timely submit Claim Forms to the Claims Administrator. In order to qualify for a settlement payment, you must complete the annexed Claim Form, sign it, and mail it to:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001

YOUR CLAIM FORM MUST BE POSTMARKED NO LATER THAN OCTOBER 5, 2010.

Whether or not you mail in a Claim Form, if you are a member of the Settlement Class you will be bound by all orders and judgments entered in connection with the Settlement and Settlement Agreement, including the release, covenant not to sue, and dismissal with prejudice provisions described above, unless you exclude yourself from the Settlement Class.

X. WHAT IF I DO NOT WANT TO BE PART OF THE SETTLEMENT?

If you do not want to be a Settlement Class Member and participate in the Settlement (including being eligible to receive monetary payments), then you must send a signed Request for Exclusion by mail stating: (1) your name, address, and federal Social Security Number or Tax Identification Number, and (2) a statement that you wish to be excluded from the Settlement Class. Requests for Exclusion must be mailed to the following:

United HealthCare Class Action Litigation – EXCLUSIONS
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001

YOUR REQUEST FOR EXCLUSION MUST BE POSTMARKED NO LATER THAN JULY 27, 2010.

By requesting to be excluded from the Settlement Class, you will not share in the Settlement, and you may maintain any claim you believe you have against the Defendants by filing your own lawsuit at your own expense.

XI. DO I HAVE A LAWYER IN THIS CASE?

The Court has appointed Pomerantz Haudek Grossman & Gross LLP as Lead Counsel for settlement purposes to represent you and other members of the Settlement Class.

You do not have to pay Lead Counsel. If you want to have your own lawyer, and have that lawyer appear in court for you in this case, you must hire one at your own expense.

XII. HOW WILL THE LAWYERS BE PAID?

Since the beginning of this litigation in 2000, Lead Counsel as well as other Settlement Class Counsel have not received any payment for their services in prosecuting the Action or to reimburse them for out-of-pocket expenses. If the Court approves the proposed Settlement, Settlement Class Counsel will apply to the Court for an award of attorneys' fees in an amount not to exceed 25% of the Cash Settlement Fund and reimbursement of expenses not to exceed $1,500,000. Any attorneys' fees and expenses awarded by the Court will be paid from the Cash Settlement Fund. In addition, Lead Counsel may apply to the Court for the approval of a service fee to each of the Class Representative Plaintiffs not to exceed $25,000 each.

XIII. WHAT IF I DO NOTHING AT ALL?

If you do nothing, you will get no money from the Settlement. But unless you exclude yourself from the Settlement Class, you will be bound by the release and covenant not to sue provisions of the Settlement Agreement described above.

XIV. HOW DO I GET MORE INFORMATION?

This Notice is a summary and does not describe all details of the Settlement. Complete copies of the Settlement Agreement, the Amendment to Settlement Agreement, the complaints filed in the Action, the Preliminary Approval Order, and certain other Court orders in this case, except for those filed under seal, may be examined and copied during regular office hours, and subject to customary copying fees, at the Clerk of the Court's Office, United States District Court, Southern District of New York, New York, NY. Certain of these documents – including the Settlement Agreement and Amendment to the Settlement Agreement – may also be obtained on the website www.unitedUCRsettlement.com.

You also may obtain copies of the above-described documents, as well as additional copies of this Notice and the Proof of Claim Form, Request for Information forms and responses to frequently asked questions (FAQ's) on the Claims Administrator's website at www.berdonclaims.com, or by contacting the Claims Administrator at:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001
Toll-Free Phone: 800-443-1073
Fax: 516-222-0271
Email: unitedhealthcare@berdonclaimsllc.com

DO NOT CALL OR WRITE THE COURT OR THE CLERK OF THE COURT FOR INFORMATION OR LEGAL ADVICE

Dated: May 28, 2010

BY ORDER OF
THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED HEALTHCARE CLASS ACTION LITIGATION

PROOF OF CLAIM FORM

Deadline for Submission: October 5, 2010

You may be entitled to a proportionate share of the $350,000,000 Settlement Fund, if you are a qualified Settlement Class Member and if you fully complete and sign this Claim Form and mail it to the address provided in the following instructions, postmarked by the deadline indicated above. **Please see the Notice for the definition of Settlement Class Member.**

Subscriber. A Subscriber's claim(s) may fall into Group A, B, and/or C, as described below, if your claim(s) meet the requirements. **Please see the Notice for the definition of Subscriber.** You need only submit one Claim Form for each insurance policy ID number (including claims for all family members covered by your policy).

Provider. A Provider's claim(s) may fall into Group D *only*, as described below. **Please see the full Notice for the definition of Provider.**

IF YOU WISH TO BE ELIGIBLE TO RECEIVE THE CASH SETTLEMENT PAYMENT DESCRIBED IN THE NOTICE, YOU MUST COMPLETE AND SIGN THIS CLAIM FORM AND SUBMIT IT BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010, TO:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001

YOUR FAILURE TO SUBMIT THIS CLAIM BY THE DEADLINE MAY CAUSE YOUR CLAIM TO BE REJECTED AND PREVENT YOU FROM RECEIVING ANY MONEY IN CONNECTION WITH THIS SETTLEMENT.

DO NOT MAIL OR DELIVER YOUR CLAIM TO THE COURT OR TO ANY OF THE PARTIES OR THEIR COUNSEL. ANY SUCH CLAIM WILL BE DEEMED NOT TO HAVE BEEN SUBMITTED. SUBMIT YOUR CLAIM *ONLY* TO THE CLAIMS ADMINISTRATOR.

GENERAL INSTRUCTIONS

1. A **Subscriber** who elects to make a Group A claim is not required to provide any documentation in connection with this claim. Please note that you are responsible for your claim being complete.

2. Only **Subscribers** may make claims in Groups A, B, and C. Only **Providers** may make claims in Group D. However, if you are a Provider and **also** meet the definition of a Subscriber (for example, you are a Provider and you are also insured by one of the Defendants), you may be eligible to make a Group D claim (with respect to a claim for which you received an assignment from a Subscriber) **and** to make a claim in Groups A, B and/or C (with respect to your own claims).

3. A **Subscriber** who elects to make a Group B or C claim, and all **Providers** making a Group D claim, are required to provide documentation in connection with their claims. Please note that **you are responsible for your claims being complete and properly documented.**

4. For assistance as a **Subscriber** or **Provider** filing a **Group B, C or D** claim, you may request the Claims Administrator to send you certain information furnished by Defendants (described in Section VI on pages 4-6 of the appended Notice) regarding the Covered Out-of-Network Services or Supplies you either received or provided from January 1, 2002 through May 28, 2010. However, **you must authorize the Claims Administrator to send you this information.** Please complete and sign the **authorization form** available to download from the website at www.berdonclaims.com (preferred), or you may use the authorization form on the bottom of page 15. The **"Notice Number"** requested on the form can be found under the return address on the Notice mailed to you by the Claims Administrator. If you did not receive a mailed Notice from the Claims Administrator, enter "Not Available." Return your completed and signed form to the Claims Administrator by mail, fax or email ***(see the bottom of page 9 for the Claims Administrator's contact information)***.

5. If you are a **Provider** who cannot furnish documentation of an assignment, but you are owed money for providing Covered Out-of-Network Services or Supplies to a Subscriber, you may request information from the Claims Administrator as to whether the Subscriber has made claims for payment from the Settlement Fund by checking the applicable box on page 14 and completing the chart on page 15. *Your request will be processed at the time distribution of the Net Settlement Fund is made.*

6. **Group B, C and D claims only:** Your claims extend from the date **within the Class Period** that you became a Settlement Class **Subscriber** or **Provider** until the Final Order and Judgment Date, which is the date the Court finally approves the Settlement and signs the Final Order. **Your participation as a member of a Defendant's healthcare plan should be counted in whole years, and any portion of a given year should be treated as an entire year.**

7. If you file the claim form *prior* to the Final Order and Judgment Date, but you have additional claims between the date you file the claim form and the Final Order and Judgment Date, you may submit an update to your previously filed claim.

8. If you have any questions concerning your claim, you should **first consult the websites** at www.unitedUCRsettlement.com or www.berdonclaims.com for answers to common, frequently asked questions concerning the Settlement. You may also contact the Claims Administrator toll-free at 800-443-1073, by fax at 516-222-0271, or by email at unitedhealthcare@berdonclaimsllc.com. **You bear all risks of delay and non-delivery of your claim(s).**

9. **For those making Group B, C and/or D claims,** please use a single Claim Form and provide all required information regarding the healthcare services relevant to your claim(s) in the respective charts on pages 11, 12 and 14. If you need additional space, you may download the appropriate chart(s) from the Claims Administrator's website at www.berdonclaims.com, which may be photocopied or replicated in the *same* format. Print your name and insurance policy ID number, social security number, billing tax ID number and/or tax ID number at the top of each numbered chart and attach all additional sheets to your Claim Form with the necessary documentation.

10. Although **Claim Forms *must* be submitted** to the Claims Administrator **by first class mail *(see page 8)***, **Subscribers** and **Providers *may* submit copies of any required documentation electronically**. If you prefer to furnish your supporting documentation in an electronic format, such as scanned image files (".bmp") or PDF files, you may do so by copying the files onto a CD. Please make sure that all CDs are clearly labeled. Alternatively, you may submit documentation by email at unitedhealthcare@berdonclaimsllc.com. Please include on all electronic documentation your name and insurance policy ID number, social security number, billing tax ID number and/or tax ID number.

11. **Providers** making claims under Group D **may furnish**, as part of their claim submission, **data from their practice management system and/or accounting records.** It is preferable that your data file be prepared in MS Excel format or tab-delimited text files, and sent to the Claims Administrator on a CD (preferred) or by email at unitedhealthcare@berdonclaimsllc.com.

12. For a list of the Defendants and their subsidiaries and affiliates, please see the Notice.

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THIS CLAIM FORM MUST BE COMPLETED, SIGNED AND SUBMITTED BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010.

REMINDER CHECKLIST

1. Remember to sign and date the above Certification.
2. If you are making claims in Groups B, C, or D, remember to attach your paper or electronic supporting documentation to this Claim Form ***(see above, paragraphs 10 & 11)***.
3. If you want an acknowledgment of receipt of your claim form, please send it by Certified Mail, Return Receipt Requested. **You will bear all risks of delay or non-delivery of your claim.**
4. If your address changes in the future, or if these documents were sent to an old or incorrect address, please send the Claims Administrator **written** notification of your new address. Include your Policy ID Number or Tax ID Number.
5. If you have any questions concerning your claim, please contact the Claims Administrator at:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001
Toll-Free Phone: 800-443-1073
Fax: 516-222-0271
Website: www.berdonclaims.com
Email: unitedhealthcare@berdonclaimsllc.com

PLEASE TYPE OR PRINT

1. Check *one* of the following:

☐ I am a **Subscriber** submitting this Claim Form on my own behalf ***(see page 1 of the appended Notice for a definition of who is a Subscriber under the Settlement).***

Name of Subscriber

Address of Subscriber

Daytime Telephone Number | Email Address

Social Security Number | Insurance Policy ID Number

Providers: First determine whether a Provider Group Representative, such as your medical group or IPA, intends to file on your behalf.

☐ I am a **Provider** submitting this Claim Form on my own behalf ***(see page 1 of the appended Notice for a definition of who is a Provider under the Settlement).***

Name of Provider | Contact Name

Office Address of Provider

Daytime Telephone Number | Email Address

Tax ID Number | Billing Tax ID Number

☐ I am a **Provider Group Representative** submitting this Claim Form on behalf of one or more Providers employed or associated with the Provider Group. A Provider Group has the right to file claims on behalf of Providers on whose behalf they billed a Defendant for Out-of-Network Services or Supplies covered by the Settlement.

Name of Provider Group | Contact Name

Address of Provider Group

Daytime Telephone Number | Email Address | Billing Tax ID Number

Provider Group Representative: List the name and office address of each Provider for whom you are submitting a claim (*attach additional sheets as necessary*):

Name(s) of Provider(s)	Office Address(es)

☐ I am a **Legal Heir or Representative** of a Subscriber, Provider, or Provider Group Class Member.

Legal Heir or Representative of a Class Member: ***(Attach documentation showing your authority to act on behalf of a Class Member.)***

Name of Legal Heir or Representative | Address of Legal Heir or Representative

Daytime Telephone Number | Email Address

Name of Person or Entity Represented | Address of Person or Entity Represented

Social Security Number **OR** Tax Identification Number **OR** Estate Tax ID Number

DETACH HERE

If you are a Subscriber, proceed to Section 2. If you are a Provider or Provider Group Representative, proceed directly to Section 5.

2. Group A: Simplified Claim Form for Subscribers

☐ I am a Subscriber and I wish to make a Group A claim.

State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies **(any portion of a given year should be treated as a whole year). Number of membership years: ______**.

Only *Subscribers* Are Eligible to Make a Group A Claim

As a Group A claimant, you need *only* to provide the number of years **you** have been a member of a Defendant's healthcare plan that provided coverage for Out-of-Network medical services or supplies, and **you need not furnish any further documentation.**

However, if you elect to be a Group A claimant you may **not** elect to be included in Group B or C even if you satisfy the conditions for inclusion in such group(s). You must certify to the accuracy of this information ***(see Section 6, below)***, and the Claims Administrator may review data to determine the accuracy of the information you provide.

Please ***review the Plan of Allocation included in Section VI, pages 4-6, of the appended Notice*** for further information on the Recognized Losses allocated for Groups B and C before deciding whether it may be to your advantage to make a Group B and/or C claim rather than a Group A claim.

After reading the instructions above, Group A claimants should proceed directly to Section 6 of this Claim Form. You do not need to complete any other sections.

Group B and Group C Subscribers and Group D Providers: Use a single Claim Form to list information in the respective charts below regarding all of the healthcare services relevant to your claim(s). If you need additional space, download the appropriate chart(s) from the Claims Administrator's website at www.berdonclaims.com. The charts may be photocopied or replicated in the same format. Print your name and insurance policy ID number, social security number or tax ID number at the top of each numbered chart and attach all additional sheets to your Claim Form with the necessary documentation.

DETACH HERE

3. Group B: Subscribers Who Paid Out-of-Pocket

☐ I am a Subscriber and I wish to make a Group B claim.

☐ I received an Adjusted Bill(s) from my Out-of-Network Provider(s).

For information concerning eligibility to make a Group B claim, see Section VI, page 5, of the appended Notice.

3(a) State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies **(any portion of a given year should be treated as a whole year)**: ______ *(must be completed)*.

3(b) For **each** Covered OON Service or Supply received, please provide the following information (*must be documented*):

Date of Service or Purchase of Supply	Name of Provider	Name of Patient	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Paid Portion of Adjusted Bill
						Total:	$

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

Only *Subscribers* Are Eligible to Make a Group B Claim

You are eligible to participate as a Group B claimant *only* if you paid out-of-pocket to your Out-of-Network Provider an amount above the Allowed Amount for Covered Out-of-Network Services or Supplies, and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraph 10)***.

If you paid a portion of the amount to your Out-of-Network Provider but did not pay the remainder, you may have both a Group B claim (for the amount you paid), and a Group C claim (for the amount you did not pay).

Attach to this Claim Form paper or electronic copies of documentation for *each* of your out-of-pocket payment(s) to your Out-of-Network Provider(s), including:

- copies of cancelled checks; ***or***
- receipts for cash payments; ***or***
- invoices from your Out-of-Network Provider(s) indicating your payment(s); ***or***
- internal accounting records from your Out-of-Network Provider (such as paid account records) reflecting your payment(s); ***and***
- Explanation(s) of Benefits ("EOBs") or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies.

4. Group C: Adjusted Bill Claims Not Fully Paid by *Subscribers*

☐ I am a Subscriber and I wish to make a Group C claim.

☐ I received an Adjusted Bill(s) from my Out-of-Network Provider(s).

For information concerning eligibility to make a Group C claim, see Section VI, page 5, of the appended Notice.

4(a) State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies (**any portion of a given year should be treated as a whole year**): ______ *(must be completed)*.

4(b) For **each** Covered OON Service or Supply received, please provide the following information (*must be documented*):

Date of Service or Purchase of Supply	Name of Provider	Name of Patient	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Unpaid Portion of Adjusted Bill	Percent of Recognized Loss Claimed: 50%/70%/90%
						Total:	$	

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

Only *Subscribers* Are Eligible to Make a Group C Claim

You are eligible to participate as a Group C claimant ***only*** if you received an Adjusted Bill from an Out-of-Network Provider for Covered Out-of-Network Services or Supplies, and did **not** pay the Adjusted Bill in whole or in part. (An Adjusted Bill means a bill sent to you by your Out-of-Network Provider reflecting the unpaid portion of the amount the Provider initially billed to a Defendant) and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraph 10)***.

If your Out-of-Network Provider did **not** initially bill a Defendant but sent you the initial bill, the Adjusted Bill amount is the amount of the initial bill for which you were not reimbursed by a Defendant and you did not pay to the Provider.

If you paid a portion of the amount to your Out-of-Network Provider but did not pay the remainder, you may have both a Group B claim (for the amount you paid), and a Group C claim (for the amount you did not pay).

Attach to this Claim Form paper or electronic copies of documentation proving your receipt of an Adjusted Bill and that the amount you did not pay was for Covered Out-Of-Network Services or Supplies rendered by a Provider who was Out-of-Network, including:

- a copy of *each* Adjusted Bill; ***or***
- evidence from your Out-of-Network Provider's records that each Adjusted Bill was sent to you; **and**
- Explanation(s) of Benefits ("EOBs") or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies.

DETACH HERE

Adjusted Bill Submitted to Collection Agency

You may have a higher Recognized Loss under the Plan of Allocation if you also furnish evidence that the Adjusted Bill was submitted to a collection agency, reported to a credit agency, or that you entered into a payment plan with your Out-of-Network Provider. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for more information.)***

Attach to this Claim Form paper or electronic copies of documentation, including:

- a written notice from a collection agency; ***or***
- evidence of telephone contact with a collection agency (complete the information below); ***or***
- a printout of your credit report showing that the debt to your Out-of-Network Provider was reported to a credit agency; ***or***
- an agreement with your Out-of-Network Provider to enter into a payment plan with you.

Telephone Contact(s) From Collection Agency(ies):

Date(s) of Contact(s)	Name(s) of Agency(ies)
______________________________	____
______________________________	____
______________________________	____

The amount of your Recognized Loss also depends on the date(s) of the above documents, as well as the date(s) you received an Adjusted Bill. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information.)***

If you are a Group B or Group C Subscriber, go directly to Section 6.

5. Group D: *Provider* Claims

☐ I am a Provider (or Provider Group Representative or Legal Representative) and I wish to make a claim. I received an assignment from a Subscriber.

5(a) Simplified Claim for Providers

You may choose to file your claim based **solely** on the information furnished to the Claims Administrator by Defendants regarding the Covered Out-of-Network services or Supplies you provided to Subscribers from January 1, 2002 through May 28, 2010. **If you wish to review this information for accuracy prior to filing a Simplified Group D claim, you must submit an authorization form for its release *(for instructions, see page 8, paragraph 4)***. You will be eligible to receive 50% of the Recognized Loss (the difference between what you billed a Defendant and the amount the Defendant and/or the Subscriber paid you), limited to the period available for the report. Indicate your intention to file a Simplified claim, by checking the box below:

☐ I choose to file a Simplified Group D claim.

5(b) Claim for Providers Seeking Increased Damages

To recover for claims in addition to those included on the Claims Administrator's report (1/1/02 through 5/28/10), or to have a higher Recognized Loss, you must complete the chart at the end of this section and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraphs 10 and 11). IMPORTANT: Claims added for services or supplies provided before 1/1/02 or after 5/28/10 require complete supporting documentation.***

To be eligible to have 50% of the Recognized Loss (the difference between what you billed a Defendant and the amount the Defendant and/or the Subscriber paid you), ***attach paper or electronic copies of the following:***

- a claim for OON Services or Supplies furnished during the Class Period and submitted to a Defendant; ***or***
- a cancelled check from a Defendant for services furnished during the Class Period, ***or***
- an Explanation of Benefits/Explanation of Payment/Remittance Advice from a Defendant indicating that payment was made to you for services furnished during the class period; ***or***
- evidence from your practice management system records or internal accounting records (such as a print-out or electronic version of your accounts receivable or paid account records) that reflects that you sent a claim form addressed to a Defendant pursuant to an assignment for services furnished during the class period, or received payment from a Defendant for such services; ***and***
- evidence of payment (if any) from a Subscriber for services furnished during the Settlement Class Period.

To be eligible to have 70% of the Recognized Loss, *attach paper or electronic copies of the following*:

- the documentation listed in the section above; ***and***
- the Adjusted Bill sent to a Subscriber on or after January 1, 2002; ***or***
- evidence from your practice management system records or internal accounting records that reflects that you sent an Adjusted Bill to the patient on or after January 1, 2002.

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To be eligible to have 90% of the Recognized Loss, ***attach paper or electronic copies of the following:***

- the documentation listed in the first section above; ***and***
- correspondence with or notice to a collection agency or credit agency; ***or***
- a payment plan you entered into with a Subscriber; ***or***
- evidence from your practice management system records or internal accounting records that reflects that you submitted the Adjusted Bill to a collection agency, reported the Adjusted Bill to a credit agency or entered into a payment plan with the patient.

5(c) For **each** Covered OON Service or Supply provided, please complete the following information:

Date of Service or Purchase of Supply	Name of Patient	Patient's Policy ID Number	Provider's UHC Claim ID Number	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Amount Paid*	Choose % of Recognized Loss Claimed: 50%/70%/90%

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)
***Excluding co-payment and/or deductible.**

Only *Providers* (or Provider Group Representatives) Are Eligible to Make a Group D Claim

You are eligible to participate as a Group D claimant **only** if you (1) received an assignment from a Subscriber, (2) submitted a claim for reimbursement to a Defendant for Covered Out-of-Network Services or Supplies based on the assignment, and the claim was processed or reimbursed by a Defendant using an Ingenix Database or one of the Seven OON Reimbursement Policies, and (3) have not transferred, sold, or assigned the claim. You must furnish documentation that you received an assignment from a Subscriber, and certify in Section 6 that you received such an assignment. **(*See page 1 of the appended Notice for a list of the Seven OON Reimbursement Policies.*)**

You may have a higher Recognized Loss if you sent an Adjusted Bill to a Subscriber and the Subscriber did not pay some of the Adjusted Bill amount. ***(Review the Plan of Allocation in Section VI, page 5, of the appended Notice for additional information.)*** Valid documentation of an Adjusted Bill includes a copy of *each* Adjusted Bill you sent, or documentation from your practice management software records or internal accounting records (such as a print out or electronic version of your accounts receivable or paid account records) that *each* Adjusted Bill was sent. Attach copies to this Claim Form.

You may have a higher Recognized Loss if you *also* furnish documentation that the Adjusted Bill was submitted to a collection agency, reported to a credit agency, or that you entered into a payment plan with a Subscriber. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information)***. Valid documentation includes a written notice to a collection agency, a notice or other correspondence to a credit agency reporting the debt, or an agreement with a Subscriber to enter into a payment plan (or evidence from your practice management software records). Attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraphs 10 and 11).***

The amount of your Recognized Loss also depends on the date(s) of the above documents as well as the date(s) you sent an Adjusted Bill, if at all. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information.)***

To receive payment from the Settlement Fund you must release the Subscriber from further liability relating to the specific claim you make.

Providers ***who cannot furnish documentation*** **and certify in Section 6 that they received an assignment (and, therefore, who cannot make a Group D claim)** ***may nonetheless request information*** **from the Claims Administrator as to whether a Subscriber who owes them money for Covered Out-of-Network Services or Supplies has made a claim for payment from the Net Settlement Fund. This request may be made by checking the box below and providing the Subscribers' names and amounts of debt to the Provider in the chart on page 15:**

☐ I am a Provider (or Provider Group Representative or Legal Representative) and I wish to request information as to whether the Subscriber(s) listed in the chart on page 15 made a claim for payment from the Net Settlement Fund.

DETACH HERE

Name of Subscriber	Subscriber's Policy ID Number	Amount of Debt to Provider
	Total:	$

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

A Provider making a request for this information *must furnish documentation to demonstrate that the Provider is owed money by a Subscriber* for Covered Out-of-Network Services or Supplies.

6. Certification

I hereby certify under penalty of perjury that, to the best of my knowledge, the information above and all supporting documentation attached are true and correct.

____
Signature of Subscriber, Provider, Provider Group, or Legal Heir or Representative

____
Print Your Name Here

Date: ________________________

____
Capacity of Legal Heir or Representative (Administrator, Executor, Attorney, Custodian, Parent, or Guardian)

THIS CLAIM FORM MUST BE COMPLETED, SIGNED AND SUBMITTED BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010. ***(SEE REMINDER CHECKLIST ON PAGE 9.)***

DETACH HERE

CLAIMS INFORMATION REQUEST AUTHORIZATION FORM

☐ I am a Class Member in the United HealthCare Class Action Litigation, and I authorize the Defendants to send the Claims Administrator, and the Claims Administrator to send me a copy of the information furnished by Defendants regarding the Covered Out-of-Network Services or Supplies that I received/provided from January 1, 2002 through May 28, 2010 to assist me in filing a Group B, C or D claim.

Name: ____

Address: ____

____

Subscribers Only

Notice Number:
(see page 8, paragraph 4) ________________________

Insurance Policy ID No.: ________________________

Social Security Number: ________________________

Providers Only

Notice Number:
(see page 8, paragraph 4) ________________________

Billing Tax ID No.: ________________________

Tax ID No.: ________________________

I certify under penalty of perjury that to the best of my knowledge, the information above is true and correct. This authorization form is executed this _____ day of ______________ 2010 in __________________ (City), ________ (State).

____
Signature

____
Print your name

(This Authorization Form should be completed, signed and returned to the Claims Administrator only if you wish to receive claims information to assist you in filing a Group B, C or D claim. For detailed instructions, see page 8, paragraph 4.)