ATTACHMENT A
TO
ANTHEM'S RESPONSES TO OCI'S COMMENTS

Description of Anthem's Material Pending Litigation

A number of managed care organizations have been sued in class action lawsuits asserting various causes of action under federal and state law. These lawsuits typically allege that the defendant managed care organizations employ policies and procedures for providing health care benefits that are inconsistent with the terms of the coverage documents and other information provided to their members, and because of these misrepresentations and practices, a class of members has been injured in that they received benefits of lesser value than the benefits represented to and paid for by such members. One such proceeding, which alleges various violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), has been filed in Connecticut against the Company's Connecticut subsidiary. *The State of Connecticut v. Anthem Blue Cross and Blue Shield of Connecticut, Anthem Health Plans, Inc., et. al.,* No. 3:00 CV 1716 filed on September 7, 2000 in the United States District Court, District of Connecticut, was brought by the Connecticut Attorney General on behalf of a purported class of HMO and Point of Service members in Connecticut. No monetary damages are sought, although the suit does seek injunctive relief from the court to preclude the Company from allegedly utilizing arbitrary coverage guidelines, making late payments to providers or members, denying coverage for medically necessary prescription drugs and misrepresenting or failing to disclose essential information to enrollees. The complaint contends that these alleged policies and practices are a violation of ERISA. This case was dismissed by the trial court on September 19, 2003; the Connecticut Attorney General filed a motion for reconsideration by the trial court, which was denied on October 1, 2003. The Attorney General filed an appeal to the Eleventh Circuit on December 1, 2003. The Eleventh Circuit has not decided whether to accept the appeal.

In addition, the Company's Connecticut subsidiary is a defendant in three class action lawsuits brought on behalf of professional providers in Connecticut. *Edward Collins, M.D., et. al., v. Anthem Health Plans, Inc.,* No. CV 99 0156198 S was filed on December 14, 1999 in the Superior Court Judicial District of Waterbury, Connecticut and *Stephen R. Levinson, M.D., Karen Laugel, M.D. and J. Kevin Lynch M.D. v. Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut*, No. 3:01 CV 426 was filed on February 14, 2001, in the Superior Court Judicial District of New Haven, Connecticut. The suits allege that the Connecticut subsidiary has breached its contracts by, among other things, failing to pay for services in accordance with the terms of the contracts. The suits also allege violations of the Connecticut Unfair Trade Practices Act, breach of the implied duty of good faith and fair dealing, negligent misrepresentation and unjust enrichment. *Collins* and *Levinson* seek injunctive relief and monetary damages (both compensatory and punitive). The third suit, brought by the Connecticut State Medical Society, *Connecticut State Medical Society v. Anthem Health Plans, Inc.*, seeks injunctive relief only. *Levinson* and *Connecticut State Medical Society* were transferred to

the Multi District Litigation ("MDL") docket in Miami, Florida, as tag-along cases (see below). All of the tag-along cases in the MDL are being stayed, until all motions in the main provider track cases have been ruled on.

On July 19, 2001, in the *Collins* suit the Connecticut state court certified a class as to three of the plaintiff's fifteen allegations. The class is defined as those physicians who practice in Connecticut or group practices which are located in Connecticut that were parties to either a Participating Physician Agreement or a Participating Physicians Group Agreement with the Company and/or its Connecticut subsidiary during the period from 1993 to the present, excluding risk-sharing arrangements and certain other contracts. The claims which were certified as class claims are: the Company's alleged failure to provide plaintiffs and other similarly situated physicians with consistent medical utilization/quality management and administration of covered services by paying financial incentive and performance bonuses to providers and the Company's staff members involved in making utilization management decisions; an alleged failure to maintain accurate books and records whereby improper payments to the plaintiffs were made based on claim codes submitted; and an alleged failure to provide senior personnel to work with plaintiffs and other similarly situated physicians. The Company appealed the class certification decision, and on September 22, 2003, the Connecticut Supreme Court reversed the class certification decision, and remanded the matter back to the trial court for further proceedings. The trial court is to consider four claims, and determine whether the claims are appropriate for treatment as class claims.

On September 26, 2002, Anthem, Inc. was added as a defendant to a MDL class action lawsuit pending in the United States District Court for the Southern District of Florida, Miami Division, captioned *In Re: Humana, Inc. Managed Care Litigation* , MDL No. 1334. Other defendants include Humana, Aetna, Cigna, Coventry, Health Net, PacifiCare, Prudential, United and WellPoint. The managed care litigation around the country has been consolidated to the U.S. District Court in Miami, Florida, under MDL rules. The Court has split the case into two groups, a "provider track" involving claims by doctors, osteopaths, and other professional providers, and a "subscriber track" involving claims by subscribers or members of the various health plan defendants. The complaint against Anthem and the other defendants alleges that the defendants do not properly pay claims, but instead "down-code" claims, improperly "bundle" claims, use erroneous or improper cost criteria to evaluate claims and delay paying proper claims. The suit also alleges that the defendants operate a common scheme and conspiracy in violation of the Racketeer Influenced Corrupt Organizations Act ("RICO"). The suit seeks declaratory and injunctive relief, unspecified monetary damages, treble damages under RICO and punitive damages. The court certified a class in the provider track cases on September 26, 2002, but denied class certification in the subscriber track cases. Defendants in the provider track cases sought, and on November 20, 2002 were granted, an interlocutory appeal of the class certification in the Eleventh Circuit. Due to the Company's late addition to the case, it was not included in the September 26, 2002 class certification order, and is therefore not part of the appeal; however, the Company may be affected by the outcome of the appeal. The appeal was argued to the Eleventh Circuit panel on September 11, 2003; a ruling will issue in due course.

On October 10, 2001, the Connecticut State Dental Association and five dental providers filed suit against the Company's Connecticut subsidiary. *Connecticut State Dental Association, Dr. Martin Rutt, Dr. Michael Egan, Dr. Sheldon Natkin, Dr. Suzanna Nameth and Dr. Bruce Tandy v. Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield of Connecticut,* No. CV-0100003, was filed in the Superior Court Judicial District of Hartford, Connecticut. The suit alleged breach of contract and violation of the Connecticut Unfair Trade Practices Act. The suit was voluntarily withdrawn on November 9, 2001. The claims were refiled on April 15, 2002, as two separate suits; one captioned *Connecticut State Dental Association v. Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield of Connecticut,* No. CV-000101, was filed in the Superior Court Judicial District of New Haven,and the second by two dental providers, purportedly on behalf of a class of dental providers captioned *Martin Rutt, D.D.S. and Michael Egan D.D.S. et. al., v Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield of Connecticut,* No. CV-0001-03, was filed in the Superior Court Judicial District of Hartford, Connecticut. Both suits seek injunctive relief, and unspecified monetary damages (both compensatory and punitive). Both cases were transferred to the MDL docket as tag along cases, and have been consolidated with the MDL suits pending before Judge Moreno in Miami, Florida. Both cases are being stayed, as are all of the tag along suits in the MDL.

On May 22, 2003, in a case titled *Kenneth Thomas, M.D., et al., v. Blue Cross Blue Shield Association, et al.*, No. 03-21296, several medical providers filed suit in federal court in Miami, Florida against the Blue Cross Blue Shield Association and Blue Cross Blue Shield Plans across the country, including the Company. The suit alleges that the BCBS Association and the BCBS Plans violated RICO and challenges many of the same practices as other suits in the MDL. On May 8, 2003, in a case titled *Dr.Allen Knecht, et al., v. Cigna, et al.,* No. 03-6109-AA, several chiropractors filed a purported class action in federal court in Portland, Oregon, naming two Blue Cross Blue Shield Plans, including the Company, as well as several commercial insurers. This case also alleges that the defendants violated RICO and challenges many of the same practices in regards to chiropractors. Both cases are now assigned to Judge Moreno in Miami. Both cases are in the early stages of the pleadings.

On October 17, 2003, in a case titled *Jeffrey Solomon, D.C., et al., v. Cigna, et al.,* No. 03-CV-22804, several chiropractors and a podiatrist, along with chiropractic and podiatric associations, filed suit in federal court in Miami, Florida, against ten managed care companies, including the Company. The suit alleges that the companies violated RICO and challenges many of the same practices as other suits in the MDL. On November 4, 2003, in a case titled *Jeffrey Solomon, D.C., et al., v. Blue Cross Blue Shield Association, et al.*, No. 03-22935, several chiropractors, podiatrists, a psychologist and a physical therapist, along with their professional corporations and trade associations, filed suit in federal court in Miami, Florida against the Blue Cross Blue Shield Association and Blue Cross Blue Shield Plans across the country, including the Company. The suit alleges that the BCBS Association and the BCBS Plans violated RICO and challenges many of the same practices as other suits in the MDL. Both cases

have been transferred to the MDL docket and are now assigned to Judge Moreno. Both cases are in the early stages of the pleadings.

Anthem's primary Ohio subsidiary and primary Kentucky subsidiary were sued on June 27, 2002, in their respective state courts. The suits were brought by the Academy of Medicine of Cincinnati, as well as individual physicians, and purport to be class action suits brought on behalf of all physicians practicing in the greater Cincinnati area and in the Northern Kentucky area, respectively. In addition to the Anthem subsidiaries, both suits name Aetna, United Healthcare and Humana as defendants. The first suit, captioned *Academy of Medicine of Cincinnati and Luis Pagani, M.D. v. Aetna Health, Inc., Humana Health Plan of Ohio, Inc., Anthem Blue Cross and Blue Shield, and United Health Care of Ohio, Inc., No. A02004947* was filed on June 27, 2002 in the Court of Common Pleas, Hamilton County, Ohio. The second suit, captioned *Academy of Medicine of Cincinnati and A. Lee Greiner, M.D., Victor Schmelzer, M.D., and Karl S. Ulicny, Jr., M.D. v. Aetna Health, Inc., Humana, Inc., Anthem Blue Cross and Blue Shield, and United Health Care, Inc., No. 02-CI-903* was filed on June 27, 2002 in the Boone County, Kentucky Circuit Court.

Both suits allege that the four companies acted in combination and collusion with one another to reduce the reimbursement rates paid to physicians in the area. The suits allege that as a direct result of the defendants' alleged anti-competitive actions, health care in the area has suffered, namely that: there are fewer hospitals; physicians are rapidly leaving the area; medical practices are unable to hire new physicians; and, from the perspective of the public, the availability of health care has been significantly reduced. Each suit alleges that these actions violate the respective state's antitrust and unfair competition laws, and each suit seeks class certification, compensatory damages, attorneys' fees, and injunctive relief to prevent the alleged anti-competitive behavior against the class in the future. Motions to dismiss or to send the cases to binding arbitration, per the provider contracts, were filed in both courts. The Ohio court overruled the motions on January 21, 2003 and the Kentucky court overruled the motions on February 19, 2003. Defendants have appealed both rulings. The Ohio appeal was heard on September 23, 2003. The Ohio appellate court affirmed the trial court's ruling on November 21, 2003. On January 2, 2004, Anthem filed a motion seeking a discretionary appeal to the Ohio Supreme Court. A ruling will issue in due course. In the Kentucky case, no date has been set for oral argument. Plaintiffs filed a motion for class certification, which was heard and rejected by the trial court on July 24, 2003. Plaintiffs have filed a renewed motion for class certification, which is set for hearing on October 24, 2003. These suits are in the preliminary stages. The Company intends to vigorously defend the suits and believes that any liability from these suits will not have a material adverse effect on its consolidated financial position or results of operations.

On October 25, 1995, Anthem Insurance and two Indiana affiliates were named as defendants in a lawsuit titled *Dr. William Lewis, et al. v. Associated Medical Networks, Ltd., et al.*, that was filed in the Superior Court of Lake County, Indiana. The plaintiffs are three related health care providers. The health care providers assert that the Company failed to honor contractual assignments of health insurance benefits and violated

equitable liens held by the health care providers by not paying directly to them the health insurance benefits for medical treatment rendered to patients who had insurance with the Company. The Company paid its customers' claims for the health care providers' services by sending payments to its customers as called for by their insurance policies, and the health care providers assert that the patients failed to use the insurance benefits to pay for the health care providers' services. The plaintiffs filed the case as a class action on behalf of similarly situated health care providers and seek compensatory damages in unspecified amounts for the insurance benefits not paid to the class members, plus prejudgment interest. The case was transferred to the Superior Court of Marion County, Indiana, where it is now pending. On December 3, 2001, the Court entered summary judgment for the Company on the health care providers' equitable lien claims. The Court also entered summary judgment for the Company on the health care providers' contractual assignments claims to the extent that the health care providers do not hold effective assignments of insurance benefits from patients. On the same date, the Court certified the case as a class action. As limited by the summary judgment order, the class consists of health care providers in Indiana who (1) were not in one of the Company's networks, (2) did not receive direct payment from the Company for services rendered to a patient covered by one of the Company's insurance policies that is not subject to ERISA, (3) were not paid by the patient (or were otherwise damaged by the Company's payment to its customer instead of to the health care provider), and (4) had an effective assignment of insurance benefits from the patient. The Company filed a motion seeking an interlocutory appeal of the class certification order in the Indiana Court of Appeals. On May 20, 2002 the Indiana Court of Appeals granted the Company's motion seeking an interlocutory appeal of the class certification order. In February 2003, the Indiana Court of Appeals affirmed the trial court's class certification. The Company filed a petition for the transfer to the Indiana Supreme Court in March 2003. The petition for transfer was argued on October 2, 2003, and the Indiana Supreme Court accepted transfer in an order dated October 2, 2003. An opinion will issue in due course. In any event, the Company intends to continue to vigorously defend the case and believes that any liability that may result from the case will not have a material adverse effect on its consolidated financial position or results of operations.

In addition to the lawsuits described above, the Company is also involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its insurance and investment operations, and is from time to time involved as a party in various governmental and administrative proceedings. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on its consolidated results of operations or financial position.

The Company, like a number of other Blue Cross and Blue Shield companies, serves as a fiscal intermediary for Medicare Parts A and B. The fiscal intermediaries for these programs receive reimbursement for certain costs and expenditures, which is subject to adjustment upon audit by the Federal Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration. The laws and regulations governing fiscal intermediaries for the Medicare program are complex, subject to interpretation and can expose an intermediary to penalties for non-compliance. Fiscal intermediaries may be

subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. While the Company believes it is currently in compliance in all material respects with the regulations governing fiscal intermediaries, there are ongoing reviews by the federal government of the Company's activities under certain of its Medicare fiscal intermediary contracts.

AdminaStar Federal, Inc. ("AdminaStar"), a subsidiary of Anthem Insurance, has received several subpoenas prior to May 2000 from the Office of Inspector General ("OIG") and the U.S. Department of Justice, one seeking documents and information concerning its responsibilities as a Medicare Part B contractor in its Kentucky office, and the others requesting certain financial records and information of AdminaStar and Anthem Insurance related to the Company's Medicare fiscal intermediary (Part A) and carrier (Part B) operations. The Company has made certain disclosures to the government relating to its Medicare Part B operations in Kentucky. The Company was advised by the government that, in conjunction with its ongoing review of these matters, the government has also been reviewing separate allegations made by individuals against AdminaStar, which are included within the same timeframe and involve issues arising from the same nucleus of operative facts as the government's ongoing review. The Company is not in a position to predict either the ultimate outcome of these reviews or the extent of any potential exposure should claims be made against the Company. However, the Company believes any fines or penalties that may arise from these reviews would not have a material adverse effect on the consolidated financial position or results of operations.

As a Blue Cross Blue Shield Association licensee, the Company participates in the Federal Employee Program ("FEP"), a nationwide contract with the Federal Office of Personnel Management to provide coverage to federal employees and their dependents. On July 11, 2001, the Company received a subpoena from the OIG, Office of Personnel Management, seeking certain financial documents and information, including information concerning intercompany transactions, related to operations in Ohio, Indiana and Kentucky under the FEP contract. The government has advised the Company that, in conjunction with its ongoing review, the government is also reviewing a separate allegation made by an individual against the Company's FEP operations, which is included within the same timeframe and involves issues arising from the same nucleus of operative facts as the government's ongoing review. The Company is currently cooperating with the OIG and the U.S. Department of Justice on these matters. The ultimate outcome of these reviews cannot be determined at this time.

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