

2 Plan Of Allocation

3 A. All defined terms contained and not otherwise defined herein shall have the same  
4 meanings as set forth in the Settlement Agreement dated November 21, 2005 ("Agreement").

5 B. This Plan of Allocation sets forth the manner in which the Net Settlement Fund will  
6 be used to make Settlement Payments to Claimants.

7 **I. DEFINITIONS**

8 As used herein, the following terms have the meanings set forth below:

9 1.1. "Claimant" means a Class Member who makes a claim for a Settlement Payment by  
10 (a) properly completing the Claim Form and mailing it to the address listed on the Claim Form for  
11 claims submission, postmarked no later than the Claim Deadline; or (b) submitting a claim  
12 electronically on the Settlement Website no later than the Claim Deadline.

13 1.2. "Claim Form" means a document substantially in the form of Exhibit A-2 hereto.

14 1.3. "Net Settlement Fund" means the balance of the Gross Settlement Fund remaining  
15 after deduction of the Fee Award, the Incentive Award, and Notice And Administrative Costs.

16 1.4. "Qualifying Dues" means the dues actually paid by a Class member during the  
17 Qualifying Period while enrolled in a Qualifying Plan in Tiers 2, 3, 4, or 5 and for which the Class  
18 member did not receive any credits or refunds.

19 1.5. "Qualifying Period" means the period of time between the date that Blue Shield's  
20 annual rate action in 2002 became effective for the Class member and the date that Blue Shield's  
21 next annual rate action in 2003 became effective for the Class member.

22 1.6. "Qualifying Plan" means a Blue Shield of California Individual and Family Plan in  
23 which a Class Member was enrolled during the Qualifying Period.

24 1.7. "Settlement Website" means the Website maintained by Class Counsel and the  
25 Claims Administrator to provide Class Members with information concerning the Settlement and  
26 receive claims for Settlement Payments electronically.

1 **II. ALLOCATION AND DISTRIBUTION OF NET SETTLEMENT FUND**

2 2.1. After expiration of the Claim Deadline, the Claims Administrator shall transmit to  
3 Blue Shield each Claimant's name, address, and first nine digits of his or her Blue Shield subscriber  
4 number, as reported on the Claim Form or electronic claim submitted by the Claimant ("Identifying  
5 Information").

6 2.2. No later than 21 days after the Claims Administrator transmits the Identifying  
7 Information for all Claimants, Blue Shield shall (a) provide the Claims Administrator with the total  
8 dollar amount of Qualifying Dues paid by each Claimant ("Individual Total"), in such format as may  
9 be reasonably requested by the Claims Administrator (e.g., in electronic form, paper form, or both);  
10 and (b) notify the Claims Administrator of any Claimant for whom Blue Shield is unable to provide  
11 an Individual Total because the Claimant's Identifying Information does not reasonably correspond  
12 to information in Blue Shield's records or is otherwise deficient ("Deficient Claimant").

13 2.3. The Claims Administrator shall contact each Deficient Claimant and notify the  
14 Deficient Claimant that he or she has thirty days to provide the Claims Administrator with  
15 supplemental information to address the deficiency in his or her originally submitted Identifying  
16 Information. After expiration of the deadlines for all Deficient Claimants to submit supplemental  
17 information, the Claims Administrator shall transmit to Blue Shield all supplemental information  
18 received from Deficient Claimants. No later than 14 days thereafter, Blue Shield shall (a) provide  
19 the Claims Administrator with the Individual Total of each Deficient Claimant whose supplemental  
20 information enables Blue Shield to obtain the Deficient Claimant's Individual Total; and (b) notify  
21 the Claims Administrator of all Deficient Claimants whose supplemental information is insufficient  
22 for that purpose.

23 2.4. Using the Individual Totals provided by Blue Shield pursuant to paragraphs 2.2-2.3,  
24 the Claims Administrator shall calculate the total dollar amount of Qualifying Dues paid by all  
25 Claimants ("Group Total") and each Claimant's Payment Factor, consisting of the Claimant's  
26 Individual Total divided by the Group Total. The Claims Administrator shall also calculate each  
27 Claimant's Proposed Settlement Payment, consisting of the Claimant's Payment Factor multiplied  
28 by the amount available in the Net Settlement Fund for distribution to Claimants.

1           2.5.    The Claims Administrator shall provide Class Counsel with a report setting forth each  
2 Claimant's Individual Total, the Group Total, each Claimant's Payment Factor, each Claimant's  
3 Proposed Settlement Payment, and the names of all Deficient Claimants who submitted insufficient  
4 or no supplemental information pursuant to paragraph 2.3 ("Remaining Deficient Claimants").

5           2.6.    At Class Counsel's discretion and direction, the Claims Administrator may attempt to  
6 contact the Remaining Deficient Claimants to give them a further opportunity to submit  
7 supplemental information to remedy the deficiencies in their originally submitted Identifying  
8 Information. In such case, no later than 14 days after the Claims Administrator transmits to Blue  
9 Shield any further supplemental information submitted by Remaining Deficient Claimants, Blue  
10 Shield shall (a) provide the Claims Administrator with the Individual Total of each Remaining  
11 Deficient Claimant whose further supplemental information enables Blue Shield to obtain the  
12 Remaining Deficient Claimant's Individual Total; and (b) notify the Claims Administrator of all  
13 Remaining Deficient Claimants whose further supplemental information is insufficient for that  
14 purpose. Using such Individual Totals, the Claims Administrator shall recalculate the Group Total,  
15 each Claimant's Payment Factor, and each Claimant's Proposed Settlement Payment, and shall  
16 provide Class Counsel with a report setting forth the foregoing figures and the names of all  
17 Remaining Deficient Claimants who submitted insufficient or no supplemental information pursuant  
18 to this paragraph 2.6.

19           2.7.    Subject to Class Counsel's approval, the Claims Administrator shall send each  
20 Claimant, by first-class mail at the address reported on the Claim Form or electronic claim submitted  
21 by the Claimant, a check payable to the Claimant in the amount of the Claimant's Proposed  
22 Settlement Payment and with an expiration date of 120 days after issuance.

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EXHIBIT A-2

**BLUE SHIELD CLASS ACTION SETTLEMENT CLAIM FORM**

**YOUR CLAIM FORM MUST BE POSTMARKED OR SUBMITTED ELECTRONICALLY ONLINE  
NO LATER THAN \_\_\_\_\_, 2006**

TO MAKE A CLAIM FOR A CASH PAYMENT UNDER THE BLUE SHIELD CLASS ACTION SETTLEMENT AS DESCRIBED IN THE ACCOMPANYING NOTICE OF PENDENCY OF CLASS ACTION AND PROPOSED SETTLEMENT, PLEASE:

- ✓ CHECK THE ACCURACY OF THE PRE-PRINTED ADDRESS IN SECTION A BELOW. IF THE PRE-PRINTED ADDRESS IS INCORRECT OR OUT OF DATE, CHECK THE ADDRESS CHANGE BOX IN SECTION B AND PROVIDE YOUR CORRECT OR NEW ADDRESS.
- ✓ PROVIDE YOUR TELEPHONE NUMBER IN SECTION C BELOW. PROVISION OF THIS INFORMATION WILL ASSIST THE CLAIMS PROCESS.
- ✓ SIGN AND DATE THE STATEMENT IN SECTION D.
- ✓ MAIL THIS FORM, POSTMARKED NO LATER THAN [CLAIM DEADLINE], TO:  
  
[CLAIM SUBMISSION ADDRESS]
- ✓ YOU MAY ALSO COMPLETE AND SUBMIT YOUR CLAIM ELECTRONICALLY ONLINE BY VISITING WWW.HEALTHPLANSSETTLEMENT.COM. YOU MUST COMPLETE AND SUBMIT YOUR CLAIM ONLINE NO LATER THAN [CLAIM DEADLINE].

**SECTION A (NAME AND ADDRESS)**

[Pre-printed Name]

[Pre-printed Street Address]

[Pre-printed City/State/Zip Code]

**SECTION B (ADDRESS CORRECTIONS)**

Complete this section only if the address pre-printed in Section A above is not your current address.

- The address printed above in Section A is not my current address. My current address is:

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**SECTION C (TELEPHONE NUMBER)**

\_\_\_\_\_  
Area Code and Telephone Number

**SECTION D (CERTIFICATION)**

By signing below, you are certifying that, to the best of your knowledge and belief, you: (1) are a current or former subscriber to one of the Blue Shield of California Individual and Family Plans covered by the settlement; (2) are eligible to receive the benefits available under the settlement; (3) you paid the premiums for this plan; and (4) are entitled to receive any refund or recovery of premiums paid on the plan.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

**YOU HAVE TWO OPTIONS FOR SUBMITTING YOUR CLAIM:**

**1. BY MAIL: COMPLETE, SIGN AND SEND THIS CLAIM FORM, POSTMARKED NO LATER THAN \_\_\_\_\_, 2006, TO:**

**BLUE SHIELD OF CALIFORNIA SETTLEMENT CLAIMS  
ADMINISTRATOR  
[ADDRESS]  
[CITY/STATE/ZIP CODE]**

**2. ONLINE: COMPLETE AND SUBMIT YOUR CLAIM ELECTRONICALLY NO LATER THAN \_\_\_\_\_, 2006 BY VISITING:**

**[WWW.HEALTHPLANSETTLEMENT.COM](http://WWW.HEALTHPLANSETTLEMENT.COM)**

**IF YOU HAVE ANY QUESTIONS ABOUT THE SETTLEMENT OR THE CLAIMS PROCESS, PLEASE VISIT THE OFFICIAL SETTLEMENT WEBSITE AT [WWW.HEALTHPLANSETTLEMENT.COM](http://WWW.HEALTHPLANSETTLEMENT.COM), OR CONTACT CLASS COUNSEL AT [WWW.HEALTHPLANSETTLEMENT@GIRARDGIBBS.COM](mailto:WWW.HEALTHPLANSETTLEMENT@GIRARDGIBBS.COM).**

***PLEASE DO NOT CONTACT BLUE SHIELD REGARDING THE SETTLEMENT.***