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## **FORM 10-K**

**FIRST HEALTH GROUP CORP - N/A**

**Filed: March 26, 2003 (period: December 31, 2002)**

Annual report which provides a comprehensive overview of the company for the past year

SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE  
SECURITIES EXCHANGE ACT OF 1934  
For the fiscal year ended December 31, 2002

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE  
SECURITIES EXCHANGE ACT OF 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_  
Commission file number 0-15846

First Health Group Corp.  
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(Exact name of registrant as specified in its charter)

Delaware  
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36-3307583  
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(State or other jurisdiction of  
incorporation or organization)

(I.R.S. Employer  
Identification Number)

3200 Highland Avenue  
Downers Grove, Illinois  
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60515  
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(Address of principal executive offices)

(Zip Code)

Registrant's telephone number, including area code: (630) 737-7900  
Securities registered pursuant to Section 12(b) of the Act: None  
Securities registered pursuant to Section 12(g) of the Act:

Common Stock \$.01 par value  
(Title of Class)

Indicate by check mark whether the registrant (1) has filed all reports  
required to be filed by Section 13 or 15(d) of the Securities Exchange Act  
of 1934 during the preceding 12 months (or for such shorter period that the  
registrant was required to file such reports) and (2) has been subject to  
such filing requirements for the past 90 days. Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item  
405 of Regulation S-K is not contained herein, and will not be contained, to  
the best of registrant's knowledge, in definitive proxy or information  
statements incorporated by reference in Part III of this Form 10-K or any  
amendment to this Form 10-K.

Indicate by check mark whether the registrant is an accelerated filer (as  
defined in Rule 12b-2 of the Act). Yes  No

The aggregate market value of voting stock held by non-affiliates of the  
registrant on March 15, 2003, was approximately \$1,821,241,687. For the  
purposes of the foregoing calculation only, all directors, executive  
officers and five percent stockholders of the registrant have been deemed to  
be affiliates. On that date, there were 95,099,520 shares of Common Stock  
issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

2002 Annual Report to Stockholders.....	Parts I, II and IV
Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on May 13, 2003.....	Parts I and III

PART I

Item 1. Business  
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Forward-Looking Statements

This report includes certain forward-looking statements within the meaning of the federal securities laws. Words such as "expects," "anticipates," "intends," "plans," "believes," "seeks," "estimates," "could" and "should" and variations of these words and similar expressions are intended to identify these forward-looking statements. Forward-looking statements made by us are based on estimates, projections, beliefs and assumptions of management at the time of such statements and are not guarantees of future performance. We disclaim any obligation to update or revise any forward-looking statements based on the occurrence of future events, the receipt of new information or otherwise. Actual future performance, outcomes and results may differ materially from those expressed in forward-looking statements made by us as a result of a number of risks, uncertainties and assumptions. For representative examples of these factors, we refer you to the "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2002 Annual Report to Stockholders.

General

First Health Group Corp., together with its consolidated subsidiaries (referred to as "First Health," "FH," "us," "we," or "our"), is a full-service national health benefits company. We specialize in providing large, national employers and payors with a single source for their group health programs by offering comprehensive, cost-effective and innovative solutions for the health benefits needs of their employees nationwide. Through The First Health[R] Network, we offer group health payors the means to manage healthcare costs by reducing the per-unit price of medical services provided. Through our workers' compensation service line, we provide a full range of managed care services for insurance carriers, state insurance funds, third party administrators, auto insurers and large, self-insured national employers. Through our First Health Services service line, we provide services to various state Medicaid and entitlement programs for claims administration, pharmacy benefit management programs and medical management and quality review services.

First Health is a Delaware corporation that was organized in 1982. Our executive offices are located at 3200 Highland Avenue, Downers Grove, Illinois 60515, and our telephone number is (630) 737-7900. Our Internet website is located at [www.FirstHealth.com](http://www.FirstHealth.com). Our periodic and current reports are available on our website, free of charge, as soon as practicable after such reports are filed with the Securities and Exchange Commission.

Significant Developments

Mail Handlers Benefit Plan On April 16, 2002, the Company increased its business relationship with the National Postal Mail Handlers Union (the "Union"), the sponsors of the Mail Handlers Benefit Plan (the "Plan"). As a result of the Company's acquisition of Claims Administration Corporation ("CAC"), the prior underwriter and claims administrator of the Plan, the Company was able to assume underwriting and claims administration services to the Union and Plan in mid-2002. The new arrangements were built on an existing contract through which the Company provides The First Health[R] Network to the Plan's members. Through two important new contracts effective January 1, 2003, the Company and its wholly-owned subsidiary insurance companies, First Health Life and Health Insurance Company and Cambridge Life Insurance Company, will continue to be the underwriter and the claims administration provider to the Plan and, in addition, provide health benefit services to the Plan. Health benefit services include PPO and clinical management services. In addition, the Union has notified us that we have been awarded a third contract for Pharmacy Benefit Administration services, effective January 1, 2003, and that contract is being negotiated with the Union. The Plan has nearly 400,000 federal employees and annuitants representing approximately one million members nationwide, and is one of the nation's largest health plans.

On July 1, 2002, the Company acquired the stock of CAC, a subsidiary of Continental Casualty Company, which was the provider of many of the services required by the Plan (see Note 2 to the Consolidated Financial Statements), for a purchase price of \$18 million. In connection with this acquisition, the Company assumed the responsibility for supporting the Plan effective July 1, 2002. The acquisition includes the transfer of approximately 1,000 CAC employees and related assets which support the Plan in various offices throughout the United States. These employees have assumed the same function for First Health, providing the Company with an experienced team of personnel already accustomed to administering the one-million-member Plan. The Company believes this acquisition significantly reduced the need for typical implementation efforts related to these new contracts. The acquisition was financed from borrowings under the Company's existing line of credit.

HCVM Acquisition. On May 1, 2002, the Company completed the acquisition of HealthCare Value Management ("HCVM") for an initial purchase price of \$24 million. The Company will pay \$3.1 million in March 2003 and anticipates paying an additional \$3.3 million in 2003 for contractual obligations based on financial performance measures that HCVM has met. HCVM is a small New England based PPO company, headquartered in suburban Boston. The acquisition was financed from borrowings under the Company's existing line of credit.

#### Introduction to Our Products and Services

We assist our clients through an integrated health plan offering that positively impacts their medical cost trends while promoting the well being and satisfaction of plan participants. The components of our integrated health plan offering are:

- \* A broad, national preferred provider organization (PPO) of quality, cost-effective healthcare providers,
- \* Medical and pharmacy claims administration,
- \* Clinical and care support programs,
- \* Workers' compensation managed care solutions,
- \* Managed care programs for public-sector clients, and
- \* Insurance products.

Through The First Health[R] Network, our national PPO network, we offer our clients services designed to control the price of a healthcare unit of service. We specialize in the creation of a client-specific network, made up of participating providers in The First Health[R] Network. Our ability to analyze healthcare cost data allows us to use a client's actual history of healthcare usage to structure a network of providers tailored to its needs. While a client's cost savings are greatest when plan participants utilize our network resources, our non-network products, such as The First Health[R] U&C (a usual and customary schedule), also help our clients manage the cost of medical services.

For many of our corporate clients, we process medical claims and provide various clinical and care support programs designed to help our clients control the number of units of medical services, manage costly diseases and increase compliance with prescribed treatment. These programs include a full range of medical and mental healthcare and integrate our pharmacy benefit management program to manage the full range of benefits. An important feature of our health plan offering that distinguishes us from our competitors is the availability of 24-hours-a-day, 7-days-a-week telephonic assistance to aid plan participants with all benefits-related needs. We believe that the continuous offering of new and improved programs and services is important to the expansion of our business.

We have also integrated our managed care assets and clinical management services with our ownership of small life and health insurance companies to offer our group health clients stop-loss protection.

In the workers' compensation area, our national network is coupled with our medical management and bill review programs to provide a comprehensive product offering. This product offering allows us to meet the needs of workers' compensation payors in 49 states including those with state legislated managed care programs. We also make available to our workers' compensation clients technology solutions that decrease the costs of paper administration through scanning and optical character recognition ("OCR") with record storage and retrieval. Given rapidly increasing loss ratios in the workers' compensation area in recent years, we believe that our product offering can generate substantial savings for our workers' compensation clients.

Through First Health Services, we provide claims administration, pharmacy benefits management and medical management and quality review services to public sector payors such as state Medicaid and state entitlement programs.

#### Healthcare Reform, Expenditures and Managed Care

In recent years, political, economic and regulatory influences have subjected the healthcare industry to fundamental change and consolidation. Since 1993, the federal government has proposed various programs to reform the healthcare system and expressed its commitment to:

- \* Increasing health care coverage for the uninsured,
- \* Controlling the continued escalation of health care expenditures, and
- \* Allowing insureds to sue their ERISA or HMO health plan.

Even though Congress rejected various proposals, several potential approaches remain under consideration, including broad insurance reform

proposals, tax incentives for individuals and the self-employed to purchase insurance, controls on the growth of Medicare and Medicaid spending, the creation of insurance purchasing groups for small businesses and individuals, and market-based changes to the healthcare delivery system. Proposals under consideration at the federal level also would provide incentives for the provision of cost-effective, quality healthcare through encouraging managed care systems. In addition, many states are considering various healthcare reform proposals. At both the federal and state level, there is growing interest in legislation to regulate how managed care companies interact with providers and health plan participants. We anticipate that Congress and state legislatures will continue to review and assess alternative healthcare delivery systems and payment methodologies, and that the public debate of these issues will likely continue in the future. Although we believe that we are well-positioned to respond to those concerns, we cannot predict what impact the proposed measures may have on our business. The volatility of stock prices of companies in healthcare and related industries reflects these concerns about proposed reform measures and their potential effect.

We are monitoring developments concerning healthcare reform and preparing strategic responses to different reform scenarios. In response to pending legislation and market pressures and in anticipation of future healthcare reform, we are broadening and diversifying our services so that we will be less affected if healthcare reform proposals are enacted.

We offer numerous programs designed to help payors of healthcare control their medical costs. Unlike HMOs, PPO companies typically do not underwrite health insurance or assume related risks. While clinical management and PPO services have been offered on a commercially significant scale for the last ten years, the industry continues to be fragmented with many independent companies providing medical utilization review, PPO services and claims administration, primarily on regional or local levels. However, the rate of consolidation among these companies has been accelerating. Additionally, all major health insurance carriers have established internal clinical management and PPO departments.

In the workers' compensation area, medical costs continue to rise. Although these medical costs represent only about 5% of total healthcare expenditures, these costs have risen more than 1000% since 1970 and represent a significant cost increase for employers and insurance carriers. First Health and certain other cost management companies offer programs designed to control escalating medical expenses and indemnity payments for lost time, reduce litigation and allow injured employees to return to work as soon as possible. Many of the services used in the group health market are also applied to the workers' compensation market. PPOs are utilized to manage price. Clinical management services are targeted toward managing the number of units of service and the quality of that service, and helping the employee return to productive employment. Bill review services are applied in approximately forty-two states that have medical fee schedules and in the remaining states that allow a usual and customary review. In addition to the laws governing workers' compensation in each state, over twenty-five states have enacted specific managed care legislation. This legislation creates additional opportunities to offer comprehensive managed care programs. The combination of these services offers workers' compensation insurance carriers and employers significant cost savings.

#### Our Products and Services

##### PPO Services - The First Health[R] Network

PPOs are groups of hospitals, physicians and other healthcare providers that offer services at pre-negotiated rates to healthcare payors on behalf of employee groups. PPO networks offer the employer an additional means of managing healthcare costs by reducing the per-unit price of medical services provided. Established in 1983, our national PPO network, known as The First Health[R] Network, incorporates both group health and workers' compensation medical providers. This is the largest area of our business, from which we derive the greatest percentage of our revenues. The First Health[R] Network consists of hospitals, physicians and other healthcare providers that offer their services to our healthcare payor clients at negotiated rates in order to gain access to our growing, national client base.

As of December 31, 2002, our hospital network included approximately 4,200 hospitals in 50 states, the District of Columbia and Puerto Rico. In each case, rates are individually negotiated for the full range of hospital services, including hospital inpatient and outpatient services. In addition, we have established an outpatient care network (OCN) comprising approximately 412,000 physicians, clinical laboratories, surgery centers, radiology facilities and other providers in 50 states, the District of Columbia and Puerto Rico.

In the last several years, we have incurred substantial expense in expanding our PPO network. We have increased both the number of healthcare providers with whom we contract within existing geographical markets and the number of geographical areas we serve. We have expanded the number of contract hospitals not only in major metropolitan markets, but also in targeted secondary and tertiary markets. Many of the hospital and OCN providers that we have added to our network in recent years are located in those secondary and tertiary markets. We expect to incur significant

expenses in connection with the continued growth, development and maintenance of our network, particularly into secondary and tertiary markets, and believe that this investment will significantly differentiate us from our competitors.

The following table sets forth information with respect to the approximate number of participating providers in The First Health[R] Network at the end of each of the past five years:

	December 31,				
	1998	1999	2000	2001	2002
Number of Hospitals in Network	3,220	3,510	3,700	4,100	4,200
Outpatient Care Network Providers	288,000	321,000	348,000	390,000	412,000

The First Health[R] Network was developed in response to the needs of our national client base which is composed of a diverse group of healthcare payors, such as group health and workers' compensation insurance carriers, third party administrators, HMOs, self-insured employers, union trusts and government employee plans. The breadth and depth of our client-base allows us to negotiate favorable rates with current and prospective healthcare providers throughout the country.

Compensation. Fees for developing and managing our expansive PPO network are generally performance based. The amount of this fee varies depending on a number of factors, including number of enrollees, networks selected, length of contract and out-of-pocket benefit co-payments.

Approach to Network Development. Our strategy is to create a selective network of individual providers from within The First Health[R] Network to meet the medical, financial, geographic and quality needs of individual clients and plan participants. We attempt to contract directly with each hospital and generally do not contract with groups of hospitals or provider networks established by other organizations. We believe that this provides maximum control over the composition and rates in the network and ensures provider stability in The First Health[R] Network. To further promote stability and savings in the network, when possible, we enter into multi-year agreements with our providers with nominal annual rate increases.

The First Health[R] Network consists of a full array of providers, including hospitals and outpatient providers, such as physicians, laboratories, radiological facilities, outpatient surgical centers, mental health providers, physical therapists, chiropractors, and other ancillary providers. By establishing contractual relationships with the complete range of providers, we are able to impact the vast majority of our clients' healthcare costs and facilitate referrals within the network for all needed care. Network providers benefit from their participation in The First Health[R] Network through increased patient volume as patients are directed to them through health benefit plans maintained by our clients and other channeling mechanisms, such as our clinical and care support services and on-line provider directories.

Our rate structure maximizes the savings for the client and gives incentives to providers to deliver cost effective care. Unlike many other PPOs that negotiate price discounts or separate rates for intensive care and other specialty units, we strive to negotiate a single all-inclusive per diem for medical/surgical and intensive care unit days in hospitals. The majority of our hospital PPO contracts have such an all-inclusive rate structure. We also control the charges for hospital outpatient care through the use of reimbursement caps. These negotiated rates have resulted in typical savings in excess of 40% on inpatient hospital costs and in excess of 35% for physician and outpatient costs.

We have utilized these negotiated rates to develop The First Health[R] Network U&C, a usual and customary schedule for non-network services. The First Health[R] Network U&C, a usual and customary schedule, applies when non-network physicians or hospitals are used and yields plan savings equivalent to the average network rate within each geographic area. The schedule is possible because of our national network, large database, direct provider contracts and transactional capabilities.

After a network has been established, we provide a number of on-going services for our clients, including consulting services, renegotiating provider contracts and preparing annual evaluations profiling the effectiveness of the network. We continuously refine our networks to expand geographic coverage and improve the rate structure as care continues to shift to outpatient settings.

We have established an extensive provider relations program in order to promote ongoing and long-term positive business relationships with network providers. Dedicated staff perform a variety of activities including responding to hospital claims inquiries, conducting site visits, preparing provider newsletters and participating in joint hospital/First Health functions which are intended to promote goodwill and increased utilization of network providers. Due, in part, to the effectiveness of the provider

relations program, our retention rate has been more than 99% for hospitals and more than 96% for physicians and other outpatient providers.

CCN. Our acquisition of CCN in August 2001 has expanded our position in the group health TPA and insurance company sectors. The addition of CCN network providers has added to the national reach of our network and offers our clients and their employees more choices for their provider selection.

PPO Quality Assessment. Quality assessment of network providers is a critical component in the selection and retention process. We have established an intensive program whereby we evaluate each individual provider against standards set for various quality indicators. Provider evaluation begins prior to the selection of a provider and continues as long as the provider remains in the network.

Quality assessment activities include:

- \* Physician credentialing,
- \* Peer review of applications when credentialing criteria are not met,
- \* Physician recredentialing on a biennial basis,
- \* Claims profiling,
- \* Hospital profiling and credentialing,
- \* Ongoing monitoring based on external data and information gathered through interaction with providers, and
- \* Quality investigations.

#### Medical Claims Administration

We provide "one-stop shopping" for employers offering indemnity, PPO and point of service plans through our core competency of claims administration and customer service. We provide clients with an integrated package of healthcare benefits administration that includes:

- \* Telephonic availability to plan participants 24 hours a day, seven days a week,
- \* Medical, disability, dental and vision claims processing,
- \* Prescription drug plan administration and network management,
- \* Managed care administration, and
- \* Data analysis.

Additionally, if they so desire, clients may utilize:

- \* COBRA administration,
- \* Flexible Spending Account administration, and
- \* Stop-loss brokerage

Our claims administration product is a sophisticated, technologically-advanced claims processing, tracking and reporting system. A majority of the processing is performed by our fully integrated and proprietary system known as First Claim[R]. The system supports a broad range of benefit programs, including medical, dental and vision care, Medicare, prescription drugs, COBRA, Health Insurance Portability and Accountability Act and flexible spending accounts. Additionally, we have expanded our claims administration capabilities by adding new and advanced features such as imaging/OCR. These development efforts have significantly enhanced and improved upon the efficiency and the capabilities of First Claim[R].

Our system helps clients increase the cost effectiveness of their benefit plans by offering such features as on-line reporting capability, Electronic Data Interchange, known as EDI, rapid and responsive customer service, automatic tracking of annual, lifetime, per-case and floating maximums, and full integration with all of our other departments and services. This integration benefits our clients because we can analyze claims data as well as clinical management, pharmacy and network usage data. This analysis enables us to provide comprehensive management reports that can be used to make benefit changes to reduce medical costs. In addition, because our claims system is an on-line, "real time," interactive system, clients can expect plan participant issues to be minimized because claims can be adjusted and paid promptly and accurately.

We provide a single-vendor environment which benefits plan participants as well as our clients. Plan participants have just one number to call for all healthcare benefit information. The round-the-clock, toll-free number that they call to locate a network provider or to obtain general health information is the same number that they call with claims and eligibility

inquiries. Additionally, our claims process can be virtually paperless for the plan participant, especially when a network provider is used, which is a critical step in enhancing his or her satisfaction. This system automatically calculates benefits and issues checks, letters and Explanation of Benefits (EOBs) to plan participants and providers.

Our claims system incorporates available advanced technologies, including:

\* Imaging and OCR technology

We use imaging/OCR to turn each claim into an electronic record. This provides for greater processing efficiency, better control of inventory, management of workflow and business continuity. This capability is also being used by our carrier clients who have the need to better manage their workflow and data.

\* Online reporting and data retrieval

After a claim is entered, the system verifies eligibility, applies appropriate deductibles, adjudicates the claims against predetermined negotiated or usual and customary guidelines, matches pre-certification outcomes, searches for previous history of coordination of benefits, and auto-adjudicates or presents final adjudication information to the benefit examiner for his or her approval. Once the benefit examiner has reviewed and approved the information on the screen, the system generates a check and explanation of benefits that evening and mails them the next day.

\* EDI

We contract with several commercial claims clearinghouses to gather claims received via EDI from providers who transmit their claims to one of these clearinghouses. The clearinghouses batch claims destined for us and forward them to us every day. Performing these functions electronically enhances efficiency and accuracy.

\* Tracking annual, lifetime and floating maximums

Each client's benefit plan(s) is loaded onto our system which tracks benefit maximums on-line for every plan participant. When a participant has reached a specified maximum, the system will automatically reduce the benefit payment as specified in each client's plan document.

\* Responsive and comprehensive customer service capabilities

By integrating our managed care and claims systems, we enable health plan members to access all health benefits information including claims history, eligibility, deductibles, maximum accumulations and benefit explanation information through a single, round-the-clock, toll-free number.

Compensation. As a fee for providing claims administration services, we receive a predetermined contractual rate that is based upon the number of transactions processed.

#### Clinical and Care Support Programs

We provide centralized clinical and care support programs, including utilization review, medical case management and disease management services, through an internal staff consisting primarily of allied health professionals and registered nurses and physicians. Our staff is located at our headquarters in Downers Grove, Illinois and at a number of our claims offices. Additionally, we maintain a nationwide network of consulting physicians with a full range of specialties. These clinical and care support services are coupled with our PPO and claims processing services to provide an integrated service offering.

Our clinical and care support programs advise plan participants and their dependents of review requirements. Plan participants, or their attending physicians, utilize the program by calling one of our toll-free numbers prior to a proposed hospitalization or outpatient service or within two business days of an emergency admission or outpatient service. From these calls, our clinical management staff gathers the medical information necessary to enable it to perform a review. Applying our clinically valid, proprietary review criteria, we then determine whether to recommend certification of the proposed hospitalization or outpatient service as medically necessary under the participant's healthcare plan. Upon completion of our review, we advise the participant, the interested healthcare providers and our client as to whether the proposed hospitalization and length of stay or outpatient service can be certified as medically necessary and appropriate under the terms of the client's benefit plan. For a client for whom we pay claims, we also use the review outcome to pay claims in accordance with the client's benefit plan.

We do not practice medicine and our services are advisory in nature.

All decisions regarding medical treatment are made by the patient and the patient's attending physician. Patients can call us on a toll-free line if they have questions regarding our services. Clients and their claim administrators also can obtain additional information from our Client Services staff.

Our medical case management program is also designed to provide clients with careful management of all cases involving complex, high-cost or chronic conditions or catastrophic illnesses. Our nurse case managers and physicians identify potentially large claim cases through medical and pharmacy claim triggers and periodic reviews and interactions with individual members. Closely conferring with an attending physician and other providers to identify cost-effective treatment alternatives is our primary management tool. Such alternatives may include moving a patient from an acute-care hospital to a less expensive setting - often the home - as soon as the patient's physician determines that it is safe and medically feasible. If such a move requires a home nursing service or medical equipment, we will serve as a referral for alternative available services, provide recommendations regarding continued usage of these services and negotiate discounts with providers when network providers are not appropriate or not available. In all cases, the decision to proceed with the course of treatment initially prescribed by the attending physician or a more cost-efficient alternative identified by us is made by the patient and his or her physician.

Our care support program is a patient-focused program that enables us to identify high-risk plan participants with chronic diseases that account for a large portion of healthcare dollar expenditures. Our care support program is a comprehensive approach starting with predictive modeling of a client's specific population. The program is centered on the patient, allowing, among other things, the following:

- \* Highly-personalized patient education and support initiatives,
- \* Channeling to network providers,
- \* Medication compliance support and other activities aimed at increasing patient compliance with health and treatment programs,
- \* Inpatient monitoring,
- \* Discharge planning, and
- \* Intensive case management.

This approach allows for coordination of information for plan participants with a series of needs which often overlap among many diseases.

Compensation. As a fee for providing clinical services, we receive a predetermined contractual rate that is based upon the number of eligible participants or fees based on time and materials.

#### Workers' Compensation Services

Our medical management process for workers' compensation cases monitors an injured worker's care and identifies opportunities for cost-effective alternative care and treatment with the goal of returning the worker to the client's work force or to reach maximum medical improvement, as soon as medically feasible. A case manager is responsible for the overall coordination of the many comprehensive services that may be needed, such as review of rehabilitation, chiropractic care and home health services, with a constant focus on the injured worker's ability to return to productivity.

Bill Review System. We provide comprehensive workers' compensation medical bill review services through a sophisticated computer system that enforces administration policies, applies state-specific workers' compensation fee schedules, checks for billing infractions and applies provider contract rates. Our computer system consolidates all of these functions, thereby reducing the amount of paperwork and costs associated with claims processing, and is a highly cost-effective alternative for workers' compensation payors.

Our bill review services include a computer-assisted review of medical provider billings to ensure accuracy and adherence to established rates and billing rules. In 42 states, including California, Texas, Arizona, Michigan, Ohio and Florida, a schedule of presumed maximum fees has been established for workers' compensation medical claims. In these states, our bill review process identifies and corrects inappropriate billing practices and applies state fee schedules. In the remaining states that have not established maximum fees we adjust bills to the usual and customary levels authorized by the payor. Provider network discounts are applied as well during the review. Additionally, through our system, we are able to go beyond "traditional" bill review services to provide enhanced savings by identifying and repricing non-related services, upcoding and unbundling of charges and other features.

We have an agreement with Electronic Data Systems Corporation (EDS) whereby we utilize EDS' extensive data processing and communications networks for data processing, electronic claims transmission and marketing

support services. EDS also modified our comprehensive bill review and audit processing system to handle workers' compensation claims and integrated the system with our clients and financial systems. The initial term of the EDS agreement was scheduled to expire on January 1, 2005, and has been extended to at least 2010.

Our bill review services help decrease the administrative costs of workers' compensation payors because we handle virtually all aspects of bill review functions. We offer two variations of bill review services:

Systems Lease: The systems technology is brought to the client's office where their staff performs bill review.

Service Bureau: Bills are sent to our processing centers and we key the bills and perform bill review.

Marketing. We market our workers' compensation programs to insurance carriers, third party administrators, state workers' compensation funds, and self-insured, self-administered companies. We currently include six of the top ten workers' compensation insurers among our clients. We provide worksite posters, provider directories (either paper or electronic) and other materials to our payor-clients to encourage their injured employees to utilize our provider network.

Compensation. We generally receive an agreed upon percentage of total savings generated for clients through our bill review and PPO services plus a per-bill fee. Savings are generally calculated as the difference between the charges that medical providers bill the payor clients and the amount that we have recommended for payment after the application of the fee schedule and PPO rates.

#### First Health Services

First Health Services, to be referred to as FH Services, "our" or "we" (in this section only) provides value-added automation, administration, payment and healthcare management services for public sector clients. Specifically, FH Services includes the following programs:

- \* Pharmacy Benefit Management,
- \* Healthcare Management, and
- \* Fiscal Agent Services.

We have been able to utilize our Medicaid fiscal agent expertise, our base of experience in the public sector and our client relationships with over 25 state governments to provide new products and services as the public sector health programs (primarily Medicaid) move toward managed care.

Pharmacy Benefit Management (PBM). FH Services' PBM program manages pharmacy benefit plans for Medicaid programs, state senior drug programs and state-funded specialty programs. Our PBM program is one of the largest of its kind in the country and provides a full range of services, including:

- \* Pharmacy point-of-sale eligibility verification and claims processing,
- \* Provider network development and management,
- \* Disease state management programs,
- \* Prospective and retrospective drug utilization reviews, known as DUR,
- \* Provider profiling, formulary development and manufacturers' rebate administration, and
- \* First IQ, a proprietary database and decision support system for pharmacy utilization monitoring and plan management.

PBM services are increasingly required by both public and private third-party payors as prescription drug expenses grow. Our PBM program is one of the few large-scale participants in the market not aligned with or controlled by a drug manufacturer. We believe our role as an independent provider of PBM services gives us a distinct competitive advantage in the growing sector of state government plans, where clinical autonomy is often a requirement. Furthermore, we believe that FH Services is a national leader in this area with substantial experience managing pharmacy plans for Medicaid and elderly populations. This clinical and management expertise gives us a competitive advantage in the rapidly growing market of managed care organizations serving the public sector on a non-risk fee basis.

FH Services also offers Clinical Management Programs (CMP) to assist physicians and network pharmacies in the appropriate treatment of patients using pharmaceuticals. This program provides physicians with diagnosis, treatment and formulary guidelines which have been developed by nationally recognized clinicians and medical academicians. FH Services' CMP focuses on those patients who experience preventable therapeutic problems such as non-compliance, inappropriate therapy and adverse drug reactions. The program

includes prior authorization initiatives, prospective DUR, retrospective DUR and educational intervention initiatives, known as concurrent DUR and counter-detailing.

Compensation. As a fee for providing our PBM services, we receive a predetermined, contractual rate that is based upon the number of transactions processed plus added fees for additional time and materials and for change orders.

Healthcare Management. FH Services' Healthcare Management program provides external quality of care evaluation, utilization review and long-term care review services to Medicaid programs, state mental health agencies and other public sector healthcare programs desiring to improve quality of care, contain costs, ensure appropriate care and measure outcomes.

The utilization review services cover a variety of behavioral health programs, including acute and chronic inpatient and outpatient psychiatric treatment of children, adult and geriatric populations, residential services and other alternative services. The Healthcare Management program also provides on-site quality reviews and inspection of care for community mental health centers, residential treatment centers and inpatient psychiatric programs. As state Medicaid programs and state departments of mental health spend increasing proportions of public funds on the treatment of mental and substance abuse illnesses, the need for utilization review services is increasing. Some states are moving toward capitated contracts with private sector firms to help manage this problem; however, many states are opting to contract for utilization review services to ensure appropriate mental healthcare while containing costs.

Under the long-term care review services, we provide level-of-care determinations as well as pre-admission screenings and annual resident reviews to determine the need for specialized services for mental illness, mental retardation or related conditions.

Compensation. As a fee for providing our healthcare management services, we receive fees on a time and materials basis.

Fiscal Agent. FH Services' fiscal agent program administers state Medicaid health plans and other state funded healthcare programs by providing clients with full fiscal agent operations and systems maintenance and enhancement. Under this product line, we provide:

- \* Enrollment services,
- \* Eligibility verification and ID card issuance,
- \* Healthcare claims receipt, resolution, processing and payment,
- \* Provider relations,
- \* Third party liability processing,
- \* Financial reconciliation functions, and
- \* Client reporting.

Our customers include state Medicaid agencies, state departments of human services and departments of health serving Medicaid populations. Public sector clients may also procure fiscal agent services to support other government programs, such as state employee benefit plans, early intervention programs or other healthcare initiatives. Typically, fiscal agent systems are modified to meet a specific state's program policy and administration requirements and services are offered for all claim types. We are one of four major competitors in the Medicaid fiscal agent field.

FH Services has developed and operates a Clinical Management Services approved information system for each client. These systems are utilized to process and adjudicate eligibility, healthcare claims and encounters, pay providers under a full range of reimbursement methods and generate reports for use in managing the program.

In addition, there are several additional benefits that FH Services receives from operating the fiscal agent business:

- \* The contracts are profitable and new system development is principally funded by new state contract awards,
- \* The expertise, capabilities and systems developed from these contracts have provided a platform for expansion into other products, services and customer segments, and
- \* Customer relationships with the states have proven valuable in developing other business in the PBM and Healthcare Management programs.

As a fee for providing our fiscal agent services, we receive a predetermined, contractual rate that is based upon the number of transactions processed plus added fees for additional time and materials and for change orders. Fees for software development contracts are recognized

as milestones are met and customer acknowledgment of such achievement of milestones is received.

#### Other Services

Pharmacy Benefit Management. In addition to FH Services offering our PBM program to Medicaid and state-funded programs, we have integrated our PBM program with our claims administration, clinical and network programs. The components of our integrated PBM program include a national pharmacy network, formulary management, drug utilization review and online pharmacy claim adjudication. These services are designed to control drug expenditures as well as overall health plan expenditures through linkage of the pharmacy data with other core data to identify high risk plan participants. Once identified, our clinical staff works with these plan participants to help them manage their conditions that require medication.

First Health[R] National Transplant Program. As medical technology advances, new and more complicated procedures, such as transplants, are becoming increasingly common. In an attempt to assist our clients in meeting these technological advances and their related costs, we have developed The First Health[R] National Transplant Program.

This program is designed to facilitate the cost-effective use of high quality transplant services through a fully-integrated system, whereby case management staff assists in the coordination of the transplant process from the determination of the need for a transplant through providing follow-up care for one year after the transplant is performed.

The goals of the program include:

- \* Enhancing quality of care and favorable outcomes through case management and direction of patients to a selected number of transplant programs that meet stringent quality and performance standards,
- \* Reducing healthcare costs by contracting a cost-effective package rate with high quality transplant centers that have a proven performance record of desirable outcomes, and
- \* Improving predictability of transplant costs by establishing fixed fees that share risk with the providers for the procedure and associated care for one year after the transplant.

Transplants included in the program include heart, lung, heart/lung, liver, kidney, kidney/pancreas and bone marrow (both allogenic and autologous).

Physician Resources. We believe that our in-house physician staff is an invaluable resource in our clinical and care support programs and in developing clinical policy and guidelines. Our staff includes experienced board certified physicians in such specialties as family practice, internal medicine, cardiology, gynecology, urology, orthopedics, psychiatry, pediatrics and surgery, as well as doctoral-level practitioners from various fields, including clinical psychology and chiropractic medicine. In addition, we have a nationwide network of consulting physicians in the significant specialties. Our staff of physicians is crucial to the development and maintenance of evidence-based review criteria and our network quality assessment efforts.

Benefit Plan Recommendations. Our clients can take various steps in benefit plan design that will help accomplish their goal of managing long-term healthcare costs. A client's ability to accomplish this goal through us is contingent on:

- \* Reasonable incentives for plan participants to comply with our notification procedures and clinical management recommendations because early notification is essential to effective case management and helps ensure not only cost effectiveness but also successful outcomes,
- \* An effective benefit differential between in-network and out-of-network services of at least 10% for inpatient and outpatient services, to include annual out of pocket maximums sufficiently large so as to reinforce co-payment/coinsurance differentials,
- \* Coverage for travel and organ-donor costs for services at network transplant providers,
- \* Distribution to all plan participants of a First Health identification card, including the toll-free telephone number, prior to the implementation date because it communicates to network providers that the member in a plan that uses First Health, and
- \* A program of effective communication to plan participants about our programs because well-planned, timely communication increases participant satisfaction and compliance significantly.

Data Analysis. Healthcare data analysis services are also made

available to our clients. With these services, we are able to provide clients with in-depth customized information concerning their healthcare cost and utilization experience. We analyze our clients' healthcare claims information and benefit plans using our internally developed proprietary software in order to provide each client with a specific healthcare cost profile and suggest appropriate cost management programs. This software also allows us to simulate how changes in a benefit plan's structure will affect the overall cost of a benefit program.

Internet Applications. Our internally developed Internet channeling tools are available for both group health and workers' compensation clients. Currently there are three channeling tools available: electronic directory, directory maker and worksite poster. Each tool provides access to the same, weekly-updated information regarding hospital and outpatient care providers in The First Health[R] Network that is also made available through our toll-free telephonic provider directory. While the electronic directory is easily accessible on the web for use by a large audience, the directory maker and worksite poster applications are currently for business-to-business use and are password-protected.

Electronic Directory. Electronic directory is easy to use and allows clients, their employer groups or plan participants to search for a hospital, physician or clinic in The First Health[R] Network. Users may search for a provider by name, city, county or zip code within a 5-mile default radius and receive a map with directions to the provider.

Directory Maker. Directory maker is designed to allow clients to create and print custom directories of The First Health[R] Network providers at their places of business. Directories can be created on an as-needed basis and will contain the most up-to-date information. By creating a directory profile, clients can pick specific cities, counties or even zip codes that will be included in a directory, as well as determine the criteria by which the data will be sorted. Directories are typically created in two hours, and then made available on the Internet in PDF format for printing.

Worksite Poster Application (for workers' compensation use only). The worksite poster application is designed to assist clients by producing posters that list hospitals, clinics/facilities and physicians closest to their site(s). Clients can search on the Internet by zip code within a 5-mile radius default to find providers in The First Health[R] Network. In addition, clients can specify physicians, clinics and hospitals or any combination of the three to print on a poster. The poster is produced immediately in a common format for easy printing.

#### Internet Sites

Member Site. We offer a customized member services website entitled "My First Health[R]" to assist plan participants in utilizing our services. The applications on this website allow plan participants to:

- \* Chat online with Member Service representatives
- \* Obtain daily health news
- \* Perform health risk assessment
- \* Access general information about us,
- \* Print commonly used health benefits forms, including claims forms,
- \* Locate a provider in The First Health[R] Network,
- \* Obtain answers to frequently asked questions about The First Health[R] Network,
- \* Accumulate total payments, deductibles and related items,
- \* Resolve a pending claim online
- \* Send us an e-mail with health plan questions,
- \* View past year's claims and check status of recently submitted claims, and
- \* Obtain health information.

We are evaluating additional services for this site, with the intent of having them available in 2003, including:

- \* Eligibility status,
- \* Benefit plan summaries,
- \* Research physician rates
- \* Research provider volumes, and other quality data
- \* Fill out provider surveys
- \* Ability to research and save personalized health information.

Provider Site. We currently offer providers in The First Health[R] Network access to a customized provider Internet site. This site allows providers access to complete client listings, payor lists and referral directories, pre-certification submissions, demographic data updates and formularies. This site is being further developed in 2003. At that time, we plan to expand the provider Internet site to include the following:

- \* Online claims submission.

Client Site. Clients have access to customized information and applications including:

- \* Internet channeling tools (including electronic directory,

- directory maker and worksite poster applications),
- \* Bill review data analysis application,
- \* Claims inventory logs,
- \* Claims administration reports,
- \* Printing of temporary ID cards
- \* Access analysis
- \* Eligibility files, as well as the ability to make changes and updates,
- \* News and legislative updates

#### Stop-Loss Insurance

Our stop-loss insurance capabilities enable us to serve as an integrated single source for the managed care needs of our clients who are self-insured employers. Because our stop-loss rates are based on the savings and value generated through our various services, we are able to offer competitive rates and policies and multiple-year rate guarantees that include fixed-percent increases and are based upon loss results. Stop-loss policies are written through our wholly owned insurance subsidiaries and can be written for specific and/or aggregate stop-loss insurance. This is the only insurance product that is emphasized in our sales efforts.

#### Clients and Marketing

We primarily market our services to national, multi-site direct accounts, including self-insured employers, government employee groups and multi-employer trusts with greater than 1,000 employees or members. During 2002, one client (Mail Handlers Benefit Plan), for whom we provided PPO services and claims administration services, accounted for 21% of our total revenues. In addition, we market our services to and through group health and workers' compensation insurance carriers. The following are representative clients of First Health:

Agilent Technologies, Inc.	Liberty Mutual Insurance Company
Albertson's, Inc.	McDonald's Corporation
American International Group	Motorola, Inc.
Boilermakers National Health and Welfare Fund	National Association of Letter Carriers
Coach USA	Radio Shack Corporation
ConAgra Foods, Inc.	State Farm Mutual Automobile Insurance Company
Crawford and Company	The National Postal Mail Handlers Union
Eaton Corporation	The Sherwin-Williams Company
HCA Inc.	Travelers Property and Casualty
Hartford Financial Services, Inc	Watson Pharmaceuticals, Inc.

We presently have approximately 120 group health and workers' compensation insurance carrier clients. Typically, we enter into a master service agreement with an insurance carrier under which we agree to provide our cost management services to healthcare plans maintained by the carrier's policyholders. Our services are offered not only to new policyholders, but also to existing policyholders at the time their policies are renewed. The insurance carrier's sales and marketing staff ordinarily has the responsibility for offering our services to its policyholders, relieving us of a significant marketing expense.

In 2002, we also launched a national consumer advertising campaign to include print and television. It is expected that we will continue consumer advertising as a means of raising awareness with end-user buyers.

We typically enter into standardized service contracts with our direct accounts and master service agreements with our insurance carrier and third party administrator clients. These contracts and agreements have automatically renewable successive terms of between one and three years, and are generally terminable upon notice given one to six months prior to expiration. While these contracts are generally exclusive as to a client's ability to use other PPO companies in identified geographic areas, they are generally non-exclusive as to a client's right to provide in-house medical review services.

#### Change in Revenue Reporting.

Effective for the quarter ending March 31, 2003, the Company will report its revenue as follows:

- Group Health Revenue
- Workers' Compensation Revenue
- Public Sector Revenue

Additionally, its group health and workers' compensation revenue will be further broken down between PPO Services and PPO plus Administrative Services. The Company believes this revenue presentation represents how the Company currently sells its services. The Company is selling a predominance of its group health PPO services coupled with administrative services (especially claims administration) and, to a lesser extent, its workers' compensation PPO services are often coupled with fee schedule services. If the Company had used this presentation methodology for the years 2000

through 2002, its revenues would have been presented as follows (in thousands):

	Year ended December 31, 2000				
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Full Year
Group Health					
PPO	\$ 36,725	\$ 37,596	\$ 39,469	\$ 38,706	\$ 152,496
PPO plus Admin Services	35,305	34,176	34,327	36,768	140,576
Total Group Health	72,030	71,772	73,796	75,474	293,072
Workers' Compensation					
PPO	7,545	7,657	6,738	7,767	29,707
PPO plus Admin Services	18,502	19,719	19,698	19,187	77,106
Total Workers' Compensation	26,047	27,376	26,436	26,954	106,813
Public Sector	24,398	26,736	27,833	27,889	106,856
Total Revenue	\$ 122,475	\$ 125,884	\$ 128,065	\$ 130,317	\$ 506,741
EBITDA % *					
Commercial	43%	43%	42%	43%	43%
Public Sector	10%	13%	16%	12%	13%

	Year ended December 31, 2001				
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Full Year
Group Health					
PPO	\$ 42,684	\$ 43,605	\$ 53,642	\$ 60,566	\$ 200,497
PPO plus Admin Services	37,789	37,045	36,656	34,387	145,877
Total Group Health	80,473	80,650	90,298	94,953	346,374
Workers' Compensation					
PPO	8,108	8,280	10,571	13,470	40,429
PPO plus Admin Services	21,221	20,548	22,493	26,035	90,297
Total Workers' Compensation	29,329	28,828	33,064	39,505	130,726
Public Sector	27,182	29,471	28,845	30,510	116,008
Total Revenue	\$ 136,984	\$ 138,949	\$ 152,207	\$ 164,968	\$ 593,108
EBITDA % *					
Commercial	46%	46%	45%	41%	44%
Public Sector	8%	10%	4%	9%	8%

	Year ended December 31, 2002				
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Full Year
Group Health					
PPO	\$ 62,859	\$ 65,561	\$ 42,035	\$ 40,391	\$ 210,846
PPO plus Admin Services	38,002	36,322	88,831	92,186	255,341
Total Group Health	100,861	101,883	130,866	132,577	466,187
Workers' Compensation					
PPO	13,117	14,663	13,706	13,475	54,961
PPO plus Admin Services	26,083	27,206	27,132	25,942	106,363
Total Workers' Compensation	39,200	41,869	40,838	39,417	161,324
Public Sector	29,300	32,171	33,224	37,760	132,455
Total Revenue	\$ 169,361	\$ 175,923	\$ 204,928	\$ 209,754	\$ 759,966
EBITDA % *					
Commercial	44%	46%	39%	41%	42%
Public Sector	9%	4%	10%	7%	8%

\* EBITDA (in the preceding table) is defined as pretax income plus depreciation and amortization expense, plus interest expense, less interest income. EBITDA % is defined as EBITDA divided by revenues.

#### Competition

We compete in a highly fragmented market with national and local firms specializing in utilization review and PPO cost management services and with major insurance carriers and third party administrators that have implemented their own internal cost management services. In addition, other managed care programs, such as HMOs and group health insurers, compete for the enrollment of benefit plan participants. We are subject to intense competition in each market segment in which we compete and many of our competitors have greater financial and marketing resources than we do. We

distinguish ourselves on the basis of the quality and cost-effectiveness of our programs, our proprietary computer-based integrated information system, our emphasis on commitment to service with a high degree of physician involvement, the penetration of our network into secondary and tertiary markets and our role as an integrated provider of PBM services. Due to the quality of our services, we tend to charge more for our services than many of our competitors.

The insurer market for workers' compensation programs is somewhat concentrated with the top ten insurers controlling over 50% of the insured market. We have focused our efforts on the top tier of the workers' compensation market. Although we currently include several regional offices of six of the top ten workers' compensation insurers among our clients, we compete with a multitude of PPOs, technology companies that provide bill review services, clinical case management companies and rehabilitation companies for the business of these insurers. While experience differs with various clients, obtaining a workers' compensation insurer as a new client typically requires extended discussions and a significant investment of time. Given these characteristics of the competitive landscape, client relationships are critical to the success of our workers' compensation products.

#### Employees

As of December 31, 2002, we had approximately 5,500 employees, including approximately 2,000 employees involved in claims processing and related activities, 1,000 employees directly administering the Mail Handlers Benefit Plan, 800 employees in information systems, 500 employees in various clinical management and quality assessment activities, 500 employees in PPO development and operations, 500 employees in sales, account management and marketing and the remainder involved with accounting, legal, human resources, facilities, and other administrative, support and executive functions. We also have a nationwide network of conferring physicians in various specialties, most of whom are compensated on an hourly or per visit basis when they are requested to render consulting services on our behalf. None of our employees are presently covered by a collective bargaining agreement and we consider our relations with our employees to be good.

#### Information Systems

Our system and suite of integrated applications utilize centralized stores of corporate data. Our information technology consists of three layers. The first level consists of database servers located in a secure corporate center. We also have a backup data center in place for business continuity. The second level consists of integrated provider, plan participant and client corporate databases. Our suite of applications is the third level. The modular architecture of these applications is designed to provide flexible access to corporate databases, while maintaining tight control of our data assets.

#### Government Regulations and Risk Management

Federal-Level Regulation. Managed healthcare programs are subject to various federal laws and regulations. Both the nature and degree of applicable government regulation vary greatly depending upon the specific activities involved. Generally, parties that actually provide or arrange for the provision of healthcare services, assume financial risk related to the provision of those services, or undertake direct responsibility for making payment or payment decisions for those services, are subject to a number of complex regulatory schemes that govern many aspects of their conduct and operations.

While our management and information services typically have not been the subject of extensive regulation by the federal government, the last decade has witnessed increased regulation of our industry. In particular, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will impose obligations previously unknown to managed healthcare service providers. HIPAA is designed to reduce the amount of administrative waste in the healthcare industry and to protect the privacy of patients' medical information. Among other things, HIPAA establishes new requirements for the confidentiality of patient health information and standard formats for the secure transmission of healthcare data among healthcare providers, payors and plans. The regulations under HIPAA will require, among other things, that health plans give patients a clear written explanation of how they intend to use, keep and disclose patient health information, prohibit health plans from conditioning payment or coverage on a patient's agreement to disclose health information for other purposes, and create federal criminal penalties for health plans, providers and claims clearinghouses that knowingly and improperly disclose information or obtain information under false pretenses. The regulations regarding the standard formats for the secure transmission of healthcare information will become effective in October 2003 and the regulations regarding privacy issues will become effective in April 2003.

We have formed a corporate HIPAA Administrative Simplification Committee and Workgroup to identify processes, systems or policies that will require modification and to implement appropriate remediation and contingency plans to avoid any adverse impact on our ability to perform services in accordance with the applicable standards. We are communicating

with significant third-party business partners to assess their readiness and the extent to which we will need to modify our relationship with these third parties when conducting EDI or e-commerce.

The cost of this compliance effort is estimated to be approximately \$5 million and is already included in our EDI and E-Commerce initiatives. However, there can be no guarantee that the costs will not materially differ from those anticipated or that we will not be materially impacted. Additionally, we expect to receive reimbursement directly from a number of our clients due to the nature of the contractual arrangement with these entities.

**State-Level Regulation.** Our activities are subject to state regulations applicable to managed healthcare service providers. We believe that we are in compliance in all material respects with all current state regulatory requirements applicable to our business as it is presently conducted. However, changes in our business or in state regulations could affect the level of services that we are required to provide or could affect the rates we can charge for our healthcare products and services.

The workers' compensation segment of our business is more sensitive to state governmental regulation. Historically, governmental strategies to contain medical costs in the workers' compensation field have been limited to legislation on a state-by-state basis. For example, many states have implemented fee schedules that list maximum reimbursement levels for healthcare procedures. In certain states that have not authorized the use of a fee schedule, we adjust bills to the usual and customary levels authorized by the payor. Opportunities for our services could increase as more states legislate additional cost containment strategies. Conversely, we could be adversely affected if states elect to reduce the extent of medical cost containment strategies available to insurance carriers and other payors, or adopt other strategies for cost containment that would not support a demand for our services.

Item 2. Properties  
-----

We own seven office buildings consisting of an aggregate of approximately 670,000 square feet of space. Our headquarters are located in Downers Grove, Illinois and our other six offices are located in West Sacramento, California; San Diego, California; Houston, Texas; Pittsburgh, Pennsylvania; Tucson, Arizona; and Scottsdale, Arizona. Additionally, we lease significant office space in Salt Lake City, Utah; Rockville, Maryland; Milwaukee, Wisconsin; Richmond, Virginia; Tampa, Florida; and Boise, Idaho. We also have numerous smaller leased facilities throughout the nation.

All of our buildings and equipment are being utilized, have been maintained adequately and are in good operating condition. These assets, together with planned capital expenditures, are expected to meet our operating needs in the foreseeable future.

Item 3. Legal Proceedings  
-----

We are subject to various claims arising in the ordinary course of business and are parties to various legal proceedings that constitute litigation incidental to our business. Our wholly owned subsidiary, First Health Services Corporation, which we acquired in July 1997, continues to be subject to an investigation by the District of Columbia Office of Inspector General (OIG). In July 2000, the OIG issued a report evaluating the District of Columbia's Medicaid program and suggesting ways to improve the program. FH Services had acted as the program's fiscal agent intermediary for more than 20 years. The OIG report included allegations that, from 1993 to 1996, FH Services, in its role as fiscal agent intermediary, made erroneous Medicaid payments to providers on behalf of patients no longer eligible to receive Medicaid benefits. We do not believe that the outcome of the claim or the investigation will materially affect our business or financial position.

Item 4. Submission of Matters to a Vote of Security Holders  
-----

No matters were submitted to a vote of the Company's stockholders during the fourth quarter of the year ended December 31, 2002.

Executive Officers of the Company

Name	Age	Position
James C. Smith	62	Chairman of the Board Member of Board of Directors
Edward L. Wristen	51	President and Chief Executive Officer Member of Board of Directors
A. Lee Dickerson	53	Executive Vice President

Patrick G. Dills	49	Executive Vice President, Sales and President, CCN
Joseph E. Whitters	44	Vice President, Finance and Chief Financial Officer

James C. Smith has served as Chairman of the Board since January 2001. He had served as the Chief Executive Officer from January 1984 through December 2001.

Edward L. Wristen joined First Health in November 1990 as Director of Strategic Planning. He served in various senior and executive level positions from 1991 through August 1998. In September 1998, Mr. Wristen became Chief Operating Officer. In January 2001, Mr. Wristen became President of the Company. In January 2002, Mr. Wristen became Chief Executive Officer of the Company. Mr. Wristen has over 20 years experience in the health care industry.

A. Lee Dickerson joined First Health in 1988 as Regional Director, Hospital Contracting. Mr. Dickerson was promoted into his current position in November 1995. Previously he held various senior level positions in the Company's Provider Networks area. Mr. Dickerson has over 20 years experience in the health care industry.

Patrick G. Dills joined First Health in 1988 as Senior National Director, Sales and Marketing. Mr. Dills was promoted to Executive Vice President, Managed Care Sales in January 1994 and to Executive Vice President, Sales in 1998. He was appointed President of CCN in August 2001.

Joseph E. Whitters joined the Company as Controller in October 1986 and has served as its Vice President, Finance since August 1987 and its Chief Financial Officer since March 1988.

The Company's officers serve at the discretion of the Board of Directors.

PART II

Item 5. Market for Registrant's Common Equity and Related Stockholder Matters.  
-----

Our common stock has been quoted on the Nasdaq National Market under the symbol "FHCC" since our corporate name change on January 1, 1998 and prior to that was quoted under the symbol "HCCC". Information concerning the range of high and low sales prices of our common stock on the Nasdaq National Market and the approximate number of holders of record of our common stock is set forth under "Common Stock" in our 2002 Annual Report to Stockholders. Information concerning our dividend policy is set forth under "Dividend Policy" in our 2002 Annual Report to Stockholders. All such information is incorporated herein by reference.

Item 6. Selected Financial Data.  
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Selected financial data for each of our last five fiscal years is set forth under "Selected Financial Data" in our 2002 Annual Report to Stockholders. Such information is incorporated herein by reference.

Item 7. Management's Discussion and Analysis of Financial Condition and  
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Results of Operation.  
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The information required by this item is set forth under "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2002 Annual Report to Stockholders and is incorporated herein by reference.

Item 7a. Quantitative and Qualitative Disclosures About Market Risk.  
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The disclosures required by this item are contained in our 2002 Annual Report under the caption "Market Risk" and are incorporated herein by reference.

Item 8. Financial Statements and Supplementary Data.  
-----

The financial statements required by this item are contained in our 2002 Annual Report to Stockholders on the pages indicated below and are incorporated herein by reference.

Financial Statements: -----	Page No. -----
Report of Independent Auditors	35
Consolidated Balance Sheets as of December 31, 2001 and 2002	36-37
Consolidated Statements of Operations for the Years Ended December 31, 2000, 2001 and 2002	38
Consolidated Statements of Comprehensive Income for the Years Ended December 31, 2000, 2001 and 2002	39
Consolidated Statements of Cash Flows for the Years Ended December 31, 2000, 2001 and 2002	40-41
Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2000, 2001 and 2002	42-43
Notes to Consolidated Financial Statements	44-62

Item 9. Changes in and Disagreements with Accountants on Accounting and  
-----  
Financial Disclosure  
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Not applicable.

PART III

Item 10. Directors and Executive Officers of the Registrant.  
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Certain information regarding our executive officers is set forth under the caption "Executive Officers of the Company" in Part I. Other information regarding our executive officers, as well as certain information regarding First Health's directors, will be included in the Proxy Statement for our Annual Meeting of Stockholders to be held on May 13, 2003 (the "Proxy Statement"), and such information is incorporated herein by reference.

Item 11. Executive Compensation.  
-----

The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference. However, the Report of the Compensation Committee of the Board of Directors on Executive Compensation contained in the Proxy Statement is not incorporated by reference herein, in any of our previous filings under either the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, or in any of our future filings.

Item 12. Security Ownership of Certain Beneficial Owners and Management.  
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The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions.  
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The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference.

Item 14. Controls and Procedures  
-----

Within the 90 days prior to the filing date of this report, the Company carried out an evaluation, under the supervision and with the participation of the Company's management, including the Company's Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures pursuant to Rule 13a-15 under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Based upon that evaluation, the Company's Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures are effective. Disclosure controls and procedures are controls and procedures that are designed to ensure that information required to be disclosed in Company reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

There have been no significant changes in our internal controls or in other factors that could significantly affect internal controls subsequent to the date we carried out this evaluation.

PART IV

Item 15. Exhibits, Financial Statement Schedule, and Reports on Form 8-K.  
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(a) The following documents are filed as part of this report:

- (1) The Index to Financial Statements is set forth on pages 27 and 28 of this report.
- (2) Consolidated Financial Statements Schedules:  
Schedule II - Valuation and Qualifying Accounts and Reserves.  
Schedule IV - Reinsurance
- (3) Exhibits

(b) Reports on Form 8-K:

None

First Health Group Corp.  
Schedule II - Valuation and Qualifying Accounts and Reserves  
Years Ended December 31, 2002, 2001 and 2000

Description	Balance at Beginning of Period	Additions Charged to Revenues or Expenses	Adjustments and Charge-offs	Balance at End of Period
<u>Year Ended December 31, 2002</u>				
Allowance for Doubtful Accounts	\$14,327,000	\$ 600,000	\$ (145,000) (2)	\$14,782,000
Contractual Reserves (4)	\$18,152,000	\$23,893,000	\$ (818,000)	\$41,227,000
Accrued Restructuring Expenses	\$36,475,000	\$ 2,250,000 (1)	\$ (27,332,000) (3)	\$11,393,000
<u>Year Ended December 31, 2001:</u>				
Allowance for Doubtful Accounts	\$10,811,000	\$ 4,003,000 (2)	\$ (487,000)	\$14,327,000
Contractual Reserves (4)	\$23,401,000	\$ (4,435,000)	\$ (814,000)	\$18,152,000
Accrued Restructuring Expenses	\$ 4,249,000	\$41,113,000 (1)	\$ (8,887,000)	\$36,475,000
<u>Year Ended December 31, 2000:</u>				
Allowance for Doubtful Accounts	\$10,844,000	\$ --	\$ (33,000)	\$10,811,000
Contractual Reserves (4)	\$14,203,000	\$ 9,229,000	\$ (31,000)	\$23,401,000
Accrued Restructuring Expenses	\$ 5,149,000	\$ --	\$ (900,000)	\$ 4,249,000

- (1) Additions in 2001 represent accrued restructuring expenses that were included in the purchase accounting adjustments related to the acquisition of CCN Managed Care, Inc., not charged to expenses. In 2002, additions include accrued restructuring expenses that were included in the purchase accounting adjustments related to the CAC and HCVM acquisitions, not charged to expenses.
- (2) Additions in 2001 represent allowance for doubtful accounts that were included in the purchase accounting adjustments related to the acquisition of CCN Managed Care, Inc., not charged to expenses. In 2002, adjustments include a \$3 million reduction related to the true-up of the CCN allowance for doubtful accounts.
- (3) Amount includes a reclass of \$5.2 million of purchase accounting reserves to deferred income tax liability. Amount also includes a \$14.4 million reduction to the CCN restructuring reserve for a true-up of the liability amounts.
- (4) Contractual reserves represent reserves for items such as non-covered services, ineligible members, other insurance, performance guarantees, etc. These amounts are netted against gross accounts receivable in the consolidated balance sheets.

First Health Group Corp.  
Schedule IV - Reinsurance  
Years Ended December 31, 2002, 2001 and 2000

	Gross Amount	Ceded to Other Companies	Assumed from Other Companies	Net Amount	Percentage of Amount Assumed to Net
	-----	-----	-----	-----	---
Year ended 12/31/02: -----					
Life insurance in force:	\$157,963,000	\$ (150,501,000)	\$ 5,420,000	\$12,882,000	42%
	=====	=====	=====	=====	===
Premiums:					
Life insurance	1,813,000	(1,705,000)	32,000	140,000	23%
Accident and health insurance	18,986,000	(4,142,000)	557,000	15,401,000	4%
	-----	-----	-----	-----	---
Total premiums	\$ 20,799,000	\$ (5,847,000)	\$ 589,000	\$15,541,000	4%
	=====	=====	=====	=====	===
Year ended 12/31/01: -----					
Life insurance in force:	\$172,677,000	\$ (163,781,000)	\$ --	\$ 8,896,000	--%
	=====	=====	=====	=====	===
Premiums:					
Life insurance	2,129,000	(2,032,000)	37,000	134,000	28%
Accident and health insurance	16,491,000	(2,860,000)	907,000	14,538,000	6%
	-----	-----	-----	-----	---
Total premiums	\$ 18,620,000	\$ (4,892,000)	\$ 944,000	\$14,672,000	6%
	=====	=====	=====	=====	===
Year ended 12/31/00: -----					
Life insurance in force:	\$195,112,000	\$ (185,455,000)	\$ --	\$ 9,657,000	--%
	=====	=====	=====	=====	===
Premiums:					
Life insurance	4,064,000	(3,906,000)	42,000	200,000	21%
Accident and health insurance	13,614,000	(2,853,000)	1,214,000	11,975,000	10%
	-----	-----	-----	-----	---
Total premiums	\$ 17,678,000	\$ (6,759,000)	\$ 1,256,000	\$12,175,000	10%
	=====	=====	=====	=====	===

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

FIRST HEALTH GROUP CORP.

By: /s/Edward L. Wristen  
-----  
Edward L. Wristen, President  
and Chief Executive Officer

Date: March 24, 2003

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on March 24, 2003:

Signature	Title
----- /s/James C. Smith ----- James C. Smith	Chairman of the Board Director
----- /s/Edward L. Wristen ----- Edward L. Wristen	President and Chief Executive Officer Director (Principal Executive Officer)
----- /s/Joseph E. Whitters ----- Joseph E. Whitters	Vice President, Finance and Chief Financial Officer (Principal Financial and Accounting Officer)
----- /s/Michael J. Boskin ----- Michael J. Boskin	Director
----- /s/Daniel Brunner ----- Daniel Brunner	Director
----- /s/Raul Cesan ----- Raul Cesan	Director
----- /s/Robert S. Colman ----- Robert S. Colman	Director
----- /s/Ronald H. Galowich ----- Ronald H. Galowich	Director
----- /s/Harold S. Handelsman ----- Harold S. Handelsman	Director
----- /s/Don Logan ----- Don Logan	Director
----- /s/William Mayer ----- William Mayer	Director
----- /s/John C. Ryan ----- John C. Ryan	Director
----- /s/David Simon ----- David Simon	Director

CERTIFICATIONS

I, Edward L. Wristen, certify that:

1. I have reviewed this annual report on Form 10-K of First Health Group Corp.;
2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;
3. Based on my knowledge, the financial statements, and other financial information included in this annual report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this annual report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-14 and 15d-14) for the registrant and we have:
  - a) designed such disclosure controls and procedures to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report is being prepared;
  - b) evaluated the effectiveness of the registrant's disclosure controls and procedures as of a date within 90 days prior to the filing date of this annual report (the "Evaluation Date"); and
  - c) presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on our evaluation as of the Evaluation Date;
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
  - a) all significant deficiencies in the design or operation of internal controls which could adversely affect the registrant's ability to record, process, summarize and report financial data and have identified for the registrant's auditors any material weaknesses in internal controls; and
  - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal controls; and
6. The registrant's other certifying officer and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our most recent evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

Date: March 26, 2003

/s/ Edward L. Wristen  
President and Chief Executive Officer

I, Joseph E. Whitters, certify that:

1. I have reviewed this annual report on Form 10-K of First Health Group Corp.;
2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;
3. Based on my knowledge, the financial statements, and other financial information included in this annual report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this annual report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-14 and 15d-14) for the registrant and we have:
  - d) designed such disclosure controls and procedures to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report is being prepared;
  - e) evaluated the effectiveness of the registrant's disclosure controls and procedures as of a date within 90 days prior to the filing date of this annual report (the "Evaluation Date"); and
  - f) presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on our evaluation as of the Evaluation Date;
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
  - a) all significant deficiencies in the design or operation of internal controls which could adversely affect the registrant's ability to record, process, summarize and report financial data and have identified for the registrant's auditors any material weaknesses in internal controls; and
  - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal controls; and
6. The registrant's other certifying officer and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our most recent evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

Date: March 26, 2003

/s/ Joseph E. Whitters  
Vice President, Finance and Chief Financial Officer

INDEPENDENT AUDITORS' REPORT

Board of Directors and Stockholders  
First Health Group Corp.  
Downers Grove, IL 60515

We have audited the consolidated financial statements of First Health Group Corp. as of December 31, 2002 and 2001, and for each of the three years in the period ended December 31, 2002 and have issued our report thereon, dated February 14, 2003 (which expressed an unqualified opinion and included an explanatory paragraph related to the adoption of Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets"); such consolidated financial statements and report are included in the Company's 2002 Annual Report to Stockholders and are incorporated herein by reference. Our audits also included the consolidated financial statement schedules of First Health Group Corp. listed in Item 15. These consolidated financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion based upon our audits. In our opinion, such consolidated financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly in all material respects the information set forth therein.

DELOITTE & TOUCHE LLP

Chicago, Illinois  
February 14, 2003

INDEX TO EXHIBITS

Exhibit No.	Description
3.1.	Restated Certificate of Incorporation of the Company. {3.1} (1)
3.2.	Amendment to Restated Certificate of Incorporation of the Company. {3.2} (4)
3.3.	Restated Certificate of Designation of Preferences, Rights and Limitations. {3.3} (1)
3.4.	Amended and Restated By-Laws of the Company. {3.4} (1)
3.5.	Amendment, dated as of May 20, 1987, to Amended and Restated By-Laws of the Company {3. 5} (2)
3.6.	Amendment to Amended and Restated By-Laws of the Company.{3.6} (3)
3.7.	Amendment to Amended and Restated By-Laws of the Company.{3.7} (3)
4.	Specimen of Stock Certificate for Common Stock. {4} (2)
10.1.	Form of Consulting Physician Agreement, {10.1} (2)
10.2.	Form of Consulting Specialist Agreement. {10.2} (2)
10.3.	1995 Employee Stock Option Plan. (10.3) (5)
10.4.	Agreement dated as of September 1, 1995 between HealthCare COMPARE Corp. and Electronic Data Systems. {10.4} (6)
10.5.	Stock Purchase Agreement among HealthCare COMPARE Corp., First Financial Management Corporation and First Data Corporation dated as of May 22, 1997, incorporated by reference from the Company's Second Quarter 1997 Form 10-Q dated August 13, 1997. {10.5} (7)
10.6.	1998 Stock Option Plan {10.6} (8)
10.7.	1998 Directors Stock Option Plan {10.7} (9)
10.8.	Employment Agreement dated May 1, 1999 between First Health Group Corp. and Ed Wristen. {10.8} (10)
10.9.	Employment Agreement dated May 1, 1999 between First Health Group Corp. and Susan T. Smith. {10.9} (10)
10.10.	Employment Agreement dated May 1, 1999 between First Health Group Corp. and A. Lee Dickerson. {10.10} (10)

Exhibit No.	Description
10.11.	Employment Agreement dated May 1, 1999 between First Health Group Corp. and Joseph E. Whitters. {10.11} (10)
10.12.	Employment Agreement dated May 1, 1999 between First Health Group Corp. and Patrick G. Dills. {10.12} (10)
10.13.	Option Agreement dated as of May 18, 1999 by and between the Company and James C. Smith {10.13} (11)
10.14.	Option Agreement dated as of May 18, 1999 by and between the Company and James C. Smith {10.14} (11)
10.15.	2001 Stock Option Plan {10.15} (12)
10.16.	Option Agreements dated March 20, 2002 between First Health Group Corp. and Edward L. Wristen. {10.16} (13)
10.17.	Director's Stock Option Plan {10.17} (14)
10.18.	2002 Stock Option Plan {10.18} (15)
10.19.	Stock Purchase Agreement dated as of May 18, 2002, among the Company and HCA-the Healthcare Company and VH Holdings, Inc. {10.19} (16)
10.20.	Agreement and Acknowledgment with respect to the Stock Purchase Agreement, dated as of August 16, 2002, among the Company and HCA-the Healthcare Company and VH Holdings, Inc. {10.20} (16)
10.21.	Credit Agreement among the Company as borrower, Bank of America, N.A. as administrative agent, certain subsidiaries of the Company as guarantors; and other financial institutions party thereto as lenders {10.21} (17)
10.22.	Employment Agreement dated January 1, 2002, as amended on September 17, 2002 between First Health Group Corp. and James C. Smith
10.23.	2002 Restatement of the First Health Group Corp. Retirement Savings Plan.
10.24.	First Amendment to the 2002 Restatement of the First Health Group Corp. Retirement Savings Plan.
10.25.	Second Amendment to the 2002 Restatement of the First Health Group Corp. Retirement Savings Plan.
10.26.	Health Benefits Services Agreement dated as of January 1, 2003, among the National Postal Mail Handlers Union and First Health Group Corp.
10.27.	Agreement dated as of April 15, 2002, among the National Postal Mail Handlers Union, First Health Life and Health Insurance Company, Cambridge Life Insurance Company and Federal Employee Plans, Inc.
11.	Computation of Basic and Diluted Earnings Per Share.
13.	2002 Annual Report to Stockholders.
21.	Subsidiaries of the Company.
23.	Consent of Deloitte & Touche LLP
99.1.	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 - Edward L. Wristen
99.2.	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 - Joseph E. Whitters

Exhibit No.	Description
{ }	Exhibits so marked have been previously filed with the Securities and Exchange Commission as exhibits to the filings shown below under the exhibit number indicated following the respective document description and are incorporated herein by reference.
(1)	Registration Statement on Form S-1 ("Registration Statement"), as filed with the Securities and Exchange Commission on April 17, 1987.
(2)	Amendment No. 2 to Registration Statement, as filed with the Securities and Exchange Commission on May 22, 1987.
(3)	Registration Statement on Form S-1, as filed with the Securities and Exchange Commission on July 12, 1988.
(4)	Annual Report on Form 10-K for the year ended December 31, 1990, as filed with the Securities and Exchange Commission on March 30, 1991.
(5)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on September 20, 1995.
(6)	Annual Report on Form 10-K for the year ended December 31, 1996 as filed with the Securities and Exchange Commission on March 27, 1997.
(7)	Annual Report on Form 10-K for the year ended December 31, 1997 and filed with the Securities and Exchange Commission on March 25, 1998.
(8)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on December 15, 1998.
(9)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on December 15, 1998.
(10)	Annual Report on Form 10-K for the year ended December 31, 1999 and filed with the Securities and Exchange Commission on March 24, 2001.
(11)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on March 19, 2002
(12)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on March 19, 2002

Exhibit No.	Description
(13)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on August 15, 2002.
(14)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on August 15, 2002.
(15)	Registration Statement on Form S-8 as filed with the Securities and Exchange Commission on August 15, 2002.
(16)	Current Report on Form 8-K as filed with the Securities and Exchange Commission on August 27, 2002.
(17)	Quarterly Report on Form 10-Q as filed with the Securities and Exchange Commission on May 13, 2002.

## EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT is made and entered into as of the 1st day of January, 2002, by and between James C. Smith (the "Employee") and First Health Group Corp., a Delaware corporation (the "Company").

IN CONSIDERATION of the mutual promises set forth below, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. Employment. The Company hereby employs the Employee, and the Employee hereby accepts employment with the Company, upon the terms and subject to the conditions hereinafter set forth.

2. Duties. The Employee is hereby employed by the Company and shall render his services at the principal business offices of the Company in Downers Grove, Illinois, unless otherwise agreed by him and the Board of Directors of the Company or the Chief Executive Officer. The Employee shall have such authority and shall perform such duties as are customary for the office to which he has been appointed, including director and Chairman of the Board. Employee shall otherwise report to and receive direction from the Chief Executive Officer or Board of Directors and Employee shall report on his activities in the manner established between him and the Chief Executive Officer. He shall not otherwise devote time to the active pursuit of any other business enterprise, nor shall he have any interest in any business enterprise which is competitive with or adverse to the Company, whether as an employee, officer, director, consultant, creditor, security holder or otherwise (except to the extent permitted in Paragraph 8 hereof). The foregoing notwithstanding, the Employee shall be entitled to belong to and participate in professional organizations and to engage in professional activities in furtherance of the Company's business.

3. Term. The term of Employee's employment under this Agreement shall commence on January 1, 2002 and shall terminate on December 31, 2004 unless otherwise terminated in accordance with the terms hereof.

4. Compensation. As compensation for the services rendered hereunder, the Employee shall be entitled to receive the following:

a. Year 2002 Salary. Effective the date of this Agreement, Employee shall receive an annual salary of \$900,000.

b. Year 2003 Salary. Effective January 1, 2003, Employee shall receive an annual salary of \$700,000.

c. Year 2004 Salary. Effective January 1, 2004, Employee shall receive an annual salary of \$400,000. Salary will be payable in installments at such times and in such manner as may from time to time be in effect for executives of the Company, but not less often than monthly.

5. Benefits During the Term of this Agreement. In addition to the compensation to be paid to the Employee pursuant to Paragraph 4 hereof, the Employee shall be entitled to participate in all employee benefit programs currently maintained by the Company as such programs may be modified from time to time, including the health benefit, 401(k) and stock purchase programs and each such other program or policy established by the Company from time to time during the term of this Agreement for its employees and executives generally (to the extent that it is more favorable to the Employee than an existing program covering the same benefit). As part of Employees participation and subject to any necessary approvals, the Company shall grant to the Employee options to purchase shares of Common Stock of the Company, each such option to be on the terms and subject to the conditions of the respective stock option agreements to be entered into between the Company and the Employee. Such grants of options shall recognize Employee's responsibilities as Chairman of the Board.

6. Benefits After the Term of this Agreement. The Company hereby confirms the existence of the grant of health benefits to Employee after the term of this Agreement as first set forth in that certain Employment Agreement, dated as of July 1, 1993 between Employee and the Company (the "1993 Employment Agreement").

7. Reimbursement of Expenses. The Company, promptly upon receipt from the Employee of appropriate documentation, shall reimburse the Employee for all of his reasonable business expenses, including, without limitation, travel expenses, necessarily and appropriately incurred in the performance of his duties hereunder.

8. Confidentiality and Competition.

a. In consideration of the substantial benefits to be provided hereunder to the Employee by the Company, and in recognition of the fact

that the Employee occupies a position of trust and confidence with the Company, the Employee acknowledges that he has provided, created and acquired and hereafter will provide, create and acquire valuable and confidential information of a special and unique nature relating to such matters as the Company's trade secrets, systems, procedures, manuals, confidential reports, employee rosters, client lists, software systems, products, business and financial methods and practices, plans, pricing, selling techniques, special methods and processes involved in designing, assembling and operating computer programs previously and currently used by the Company and the application thereof to managed care programs and other related electronic data processing information respecting the Company's existing businesses and services and those developed during the term of this Agreement, as well as credit and financial data relative to the Company and its clients, and the particular business requirements of the Company's clients, including the methods used and preferred by the Company's clients and fees paid by such clients. In addition, the Employee has developed and may further develop on behalf of the Company a personal acquaintance with the Company's clients, which acquaintances may constitute the Company's only contact with such clients. For purposes of this Paragraph 8, the term "Company" shall mean First Health Group Corp. and each company which is a subsidiary thereof and any partnership or joint venture in which the Company or any such subsidiary owns an equity interest at any time during the term of this Agreement. In view of the foregoing and in consideration of the remuneration to be paid to the Employee hereunder, the Employee acknowledges and agrees that it is reasonable and necessary for the protection of the goodwill and business of the Company that he make the covenants contained herein regarding his conduct during and subsequent to his employment by the Company and that the Company will suffer irreparable injury if the Employee were to engage in any conduct prohibited hereby. The Employee represents that his experience and/or abilities are such that the observance of the aforementioned covenants will not cause the Employee any undue hardship, nor will it unreasonably interfere with the Employee's ability to earn a livelihood. The Employee and the Company further agree that the covenants contained in this Paragraph 8 shall each be construed as a separate agreement independent of any other provisions of this Agreement, and that the existence of any claim or cause of action by the Employee against the Company, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement by the Company of any of these covenants. In the event a court of competent jurisdiction determines that any provision of this Paragraph 8 is unreasonable as to duration, substantive extent or geographic scope, the provision will nonetheless be enforced to the fullest extent reasonable.

b. The Employee, while in the employ of the Company or at any time thereafter, will not directly or indirectly communicate or divulge, or use for the benefit of himself or of any other person, firm, association or corporation, any of the Company's trade secrets or other confidential information, including, without limitation, the information described in Paragraph 8a, which trade secrets and confidential information were or will be communicated to or otherwise learned or acquired by the Employee in the course of his employment with the Company, except that the Employee may disclose such matters to the extent that the disclosure thereof is required: (i) in the course of his employment with the Company, provided such disclosure is made exclusively for the benefit of the Company, or (ii) by a court, governmental agency of competent jurisdiction or grand jury.

c. During the term of his employment with the Company and for a period of three years thereafter, the Employee will not contact, directly or indirectly, with a view towards selling any product or service competitive with any product or service sold (or proposed to be sold) by the Company during the Employee's employment, any person, firm association or corporation (i) to which the Company has provided its services, or (ii) which the Employee or, to his knowledge, any other employee or representative of the Company has solicited, contacted or otherwise dealt with on behalf of the Company, nor will he directly or indirectly make any such contact, for the benefit or on behalf of any other person, firm, association or corporation or in any manner assist any person, firm, association or corporation to make any such contact.

d. During the term of his employment by the Company and for a period of three years thereafter, the Employee will not directly or indirectly acquire any interest in any corporation, firm or business (other than the Company) which is engaged in any business in the United States the same as, similar to or competitive with the business of the Company as conducted at any time during the Employee's employment, whether as an employee, sole proprietor, director, officer, consultant, equity security holder or otherwise (except that he may own up to 2% of the outstanding shares of capital stock of any corporation whose stock is listed on a national securities exchange or is traded in the over-the-counter market), nor will the Employee directly or indirectly have any interest in any corporation, firm or business which is engaged in a business adverse to the Company's business (except that he may own up to 2% of the outstanding shares of capital stock of any corporation whose stock is listed on a national securities exchange or is traded in the over-the-counter market).

e. During the term of his employment by the Company and for a period of three years thereafter, neither the Employee nor any entity by which the Employee is employed or otherwise associated with will directly or indirectly employ, retain the services of or induce or attempt to induce, in

any manner whatsoever, any present or future employee of the Company to leave the employ of the Company and/or to seek or accept employment with the Employee or any other person, firm, association or corporation.

f. In the event of a breach or threatened or intended breach of this Agreement and the foregoing covenants by the Employee, the Employee acknowledges that the Company will suffer irreparable injury and that determination of the exact amount of the Company's damages will be difficult, if not impossible, and agrees that the Company shall be entitled, in addition to remedies otherwise available to it at law or in equity, to injunctions, both preliminary and permanent and without bond therefor, enjoining or restraining such breach or threatened or intended breach, and the Employee hereby consents to the issuance thereof forthwith by any court of competent jurisdiction.

#### 9. Termination of Employment.

a. Incapacity. If, during the term of this Agreement, the Employee should be prevented from performing his duties by reason of illness or physical or mental disability (hereinafter referred to collectively as "Incapacity") for a continuous period of between 90 and 180 days, the Employee shall receive one-half his per diem Base Salary for each day during such time period that he fails, due to his Incapacity, to render the services contemplated hereunder. If during the term of this Agreement, the Employee should be prevented from performing his duties by reason of Incapacity for a continuous period greater than 180 days, the Company may terminate the Employee's employment hereunder by giving written notice thereof to the Employee, effective on the date set forth in the notice (which date shall be not less than 15 business days after the notice is given).

For purposes hereof, a continuous period of Incapacity shall not be deemed interrupted until the Employee returns to substantially full time work for a period of at least 30 days.

b. Death. In the event of the Employee's death during the term of this Agreement, the Employee's employment hereunder shall be deemed terminated as of the date of the Employee's death.

c. Cause. This Agreement and the Employee's employment hereunder may be terminated at any time by the Company for cause. As used herein "cause" shall mean (i) theft, embezzlement or fraud by the Employee or the Employee's involvement in any other scheme or conspiracy pursuant to which the Company has lost or could reasonably be expected to lose assets to the Employee or to others calculated by the Employee to receive such assets, (ii) incapacity on the job by reason of the use or abuse of alcohol or drugs, (iii) commission of a felony or a crime involving moral turpitude, (iv) gross insubordination, (v) unexplained and continuous absences from work, (vi) material breach of the Employee of any of the provisions of this Agreement which is not cured within 30 business days after the Company gives written notice thereof to the Employee specifying the nature of such breach, (vii) refusal to act in accordance with a lawful and duly adopted resolution of the Board of Directors, (viii) intentional, knowing, or grossly negligent violation of the Federal Securities laws, Delaware law or any other law or regulation applicable to the Company or the Board of Directors.

d. Termination of Employment by the Company. The Company may terminate the Employee's employment for any reason deemed sufficient by the Company.

As used in this Paragraph 9, unless otherwise specified, the term "days" refers to calendar days.

#### 10. Effect of Termination of Employment.

a. Incapacity. If termination of employment results or occurs due to Incapacity under Paragraph 9a, the Company shall pay or cause to be paid in a lump sum (i) such amounts, if any, as the Employee shall be entitled to under the Company's disability policy and program applicable to the Employee, (ii) subject to the limitations set forth in the last sentence of Paragraph 6a hereof, payment in respect of all unused Flexible Time Off (FTO), to the extent the Employee has not prior thereto received compensation in lieu thereof, (iii) the Employee's interest in all Company retirement and investment plans, to the extent such plans permit such interest to be distributed and (iv) payment in respect of all compensation earned to date but not theretofore paid.

b. Death. If termination of employment occurs as a result of the Employee's death, the Company shall pay to the Employee's estate a lump sum payment equal to (i) such amounts as the Employee's estate shall be entitled to receive under the terms of retirement and investment plans of the Company, to the extent such plans permit such amounts to be paid, (ii) subject to the limitation set forth in the last sentence of Paragraph 6a hereof, payment in respect of all unused FTO, to the extent the Employee has not prior thereto received compensation in lieu thereof, and (iii) payment in respect of all compensation earned to date but not theretofore paid.

c. Cause. If the Employee's employment is terminated by the Company for cause, Employee shall be entitled to all earned but unpaid

compensation, provided, however, the Company shall be entitled to offset therefrom any amounts lost by the Company as a result of Employee's action giving rise to such cause.

d. Voluntary Termination. If the Employee shall voluntarily terminate his employment hereunder, the Company shall be obligated to pay or cause to be paid in a lump sum (i) payment in respect of the Employee's interest in all Company retirement and investment plans, to the extent such plans permit such payment to be made, (ii) subject to the limitations set forth in the last sentence of Paragraph 6a hereof, payment in respect of all unused paid vacation time, to the extent the Employee has not prior thereto received compensation in lieu thereof.

e. Termination of Employment Pursuant to Paragraphs 9d. In the event that this Agreement is terminated by the Company pursuant to Paragraph 9d hereof, the Company shall be obligated to pay or cause to be paid to the Employee (i) the balance of the Salary payments required to be paid during the remaining term of this Agreement, which payments shall be made at regular intervals in accordance with the Company's regular pay periods, (ii) payment in respect of the Employee's interest in all Company retirement and investment plans, to the extent that such plans permit such payment to be made, and (iii) subject to the limitations set forth in the last sentence of Paragraph 6a hereof, payment in respect of all unused FTO, to the extent Employee has not prior thereto received compensation in lieu thereof. Payments pursuant to subsections (ii) and (iii) shall be paid in a lump sum.

f. Effect of Termination of Employment: Survival. In the event that the Employee's employment with the Company terminates, this Agreement shall be deemed terminated, provided, however, that the terms and conditions of Paragraphs 6 (to the extent provided therein), 8, 9 and 10 shall survive such termination and be fully binding and enforceable.

11. Return of Documents. Upon termination of this Agreement for any reason, the Employee shall deliver to the Company any property then in his possession belonging to the Company. For purposes of this Agreement, the parties hereto do hereby agree that any original or copies of any books, papers, customer lists, files, books of accounts, summaries, notes and other documents and data or other writings, tapes or records, relating to the company or prepared in connection with the Employee's performance of his duties hereunder, are owned by and are the property of the Company.

12. Best Efforts. The Company and the Employee each agree to use its or his best efforts to operate the business of the Company in a manner designed to maximize the revenues and net income of the Company and to preserve and enhance its goodwill and other assets.

13. Termination of Prior Employment Agreement. All prior employment agreements between Company and Employee are hereby terminated.

14. Notices. Any notices to be given hereunder by either party to the other may be effected either by personal delivery in writing or by mail, registered or certified, postage prepaid, with return receipt requested. Mailed notices shall be addressed to the respective addresses shown below. Either party may change its address for notice by giving written notice in accordance with the terms of this Paragraph 14.

a. If to the Employee:

James C. Smith  
First Health Group Corp.  
3200 Highland Avenue  
Downers Grove, Illinois 60515

b. If to the Company:

Susan T. Smith  
General Counsel  
First Health Group Corp.  
3200 Highland Avenue  
Downers Grove, Illinois 60515

with a copy to:

Chairman of the Compensation Committee  
of the First Health Group Corp. Board of Directors

15. Acknowledgment of Reading. The Employee acknowledges, represents and warrants to the Company that he has received a copy of this Agreement, that he has read and understands this Agreement, that he has had the opportunity to seek the advice of legal counsel before signing this Agreement and that he has either sought such counsel or has voluntarily decided not to do so.

16. General Provisions.

a. Governing Law. This Agreement shall be governed and construed in accordance with the law of the State of Illinois.

b. Invalid Provisions. If any provision of this Agreement is

held to be illegal, invalid, or unenforceable under present or future laws effective during the term hereof, such provisions shall be fully severable and this Agreement shall be construed and enforced as if such illegal, invalid or unenforceable provisions had never comprised a part hereof; and the remaining provisions hereof shall remain in full force and effect and shall not be affected by the illegal, invalid or unenforceable provisions or by its severance herefrom. Furthermore, in lieu of such illegal, invalid or unenforceable provision as similar in terms to the illegal, invalid or unenforceable provision as may be possible and still be legal, valid or enforceable.

c. Entire Agreement. This Agreement and the Option Agreements set forth the entire understanding of the parties with respect to the matters specified herein. No other terms, conditions or warranties, and no amendments or modifications hereto, shall be binding unless made in writing and signed by the parties hereto.

d. Binding Effect: Assignment and Assumption of Agreement. This Agreement shall be binding upon the parties hereto and inure to the benefit of such parties, their respective heirs, representatives, successors and permitted assigns. This Agreement may not be assigned by the Employee nor may it be assigned by the Company without the Employee's consent.

e. Waiver. The waiver by either party hereto of any breach of any term or condition of this Agreement shall not be deemed to constitute the waiver of any other breach of the same or any other term or condition hereof.

f. Titles. Title of the paragraphs herein are used for convenience only and shall not be used for interpretation or construction of any word, clause, paragraph, or provision of this Agreement.

g. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but which together shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Company and the Employee have executed this Agreement as of the date and year first written above.

COMPANY:

FIRST HEALTH GROUP CORP.

By:

-----  
Edward L. Wristen  
President and Chief Executive Officer

EMPLOYEE:

-----  
JAMES C. SMITH

FIRST AMENDMENT TO THE  
EMPLOYMENT AGREEMENT  
DATED AS OF JANUARY 1, 2002, BETWEEN  
FIRST HEALTH GROUP CORP. AND JAMES C. SMITH

THIS AMENDMENT is effective as of the 17th day of September, 2002, by and between First Health Group Corp. ("First Health") and James C. Smith (the "Employee").

WHEREAS, First Health and Employee have previously entered into a certain EMPLOYMENT AGREEMENT, dated as of January 1, 2002, under which First Health will employ Employee (the "Agreement"); and

WHEREAS, First Health and Employee desire to amend the Agreement to memorialize the parties' agreement to extend the term of the Agreement from December 31, 2004 until December 31, 2007 at the annual salary of \$500,000 for the additional three year period.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein and in the Agreement, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Paragraph 3 of the Agreement will be deleted and replace in its entirety by the following:

The term of Employee's employment under this Agreement shall commence on January 1, 2002 and shall terminate on December 31, 2007 unless otherwise terminated in accordance with the terms hereof.

2. Paragraph 4 of the Agreement will have the following, additional subparagraph:

d. Years 2005 through 2007 Salary. Effective January 1, 2005, Employee shall receive an annual salary of \$500,000. Salary will be payable in installments at such times and in such manner as may from time to time be in effect for executives of the Company, but less often than monthly.

3. The parties ratify and affirm the Agreement and agree that it is valid as amended herein. This Amendment will prevail over any conflict with the Agreement.

IN WITNESS WHEREOF the duly authorized representatives of the parties have executed this Amendment effective on the day and year first written above.

Employee:	First Health Group Corp.
_____	By: _____
Name: James C. Smith	Chief Executive Officer and President
Date: _____	Date: _____

2002 RESTATEMENT OF THE  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN  
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ARTICLE I.  
INTRODUCTION

- 1.01 History of the Plan. Effective September 1, 1986, HealthCare COMPARE Corp. established the HealthCare COMPARE Corp. Retirement Savings (the "Plan") in order to provide benefits for eligible employees. Effective September 1, 1987, the Plan has been subsequently amended and restated to comply with various changes in the tax laws and to reflect plan mergers. HealthCare COMPARE Corp. changed its name to First Health Group Corp. (the "Company") and changed the name of the Plan to the First Health Group Corp. Retirement Savings Plan.

In order to comply with the amendments to the Internal Revenue Code mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994, the Uruguay Round Agreements Act (GATT), the Small Business Job Protection Act of 1996, the Taxpayer Relief Act of 1997, the IRS Restructuring and Reform Act of 1998, and the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), as well as reflect certain plan mergers, and make certain other administrative changes, the Plan is hereby amended and restated, effective as provided herein or otherwise required by law.

- 1.02 Former Participants. Except as otherwise specifically provided herein or required by the Code, the provisions of this amended and restated Plan relating to eligibility for participation, eligibility for benefits, amount of benefits, manner of benefit payments and timing of benefit payments shall only apply to an Employee who terminates employment on or after the Effective Date. An Employee who terminated employment prior to the Effective Date shall have his eligibility for benefits, and the amount and form of benefits, if any, determined in accordance with the provisions of the Plan, as applicable, in effect on the date his employment terminated.

ARTICLE II.  
DEFINITIONS

Unless otherwise required by the context, the following terms and phrases as used in the Plan shall have the meanings set forth in this Article II.

- 2.01 Accounts means the following Accounts which may be maintained under this Plan for Participants, adjusted in each case for such Account's share in the increase or decrease in the net worth of the Trust:
- (a) Matching Account means the separate account maintained for each Participant to which his allocable share of Matching Contributions, if any, made pursuant to Section 4.02(a) shall be credited.
  - (b) 401(k) Account means the separate account maintained for each Participant to which such Participant's Salary Reduction Contribution, if any, made pursuant to Section 4.01(a) shall be credited. A Participant's interest in his 401(k) Account shall be 100% fully vested at all times.
  - (c) Rollover Account means the separate account maintained for each Employee or Participant to which such Employee's or Participant's Rollover Contributions, if any, made pursuant to Section 4.07 shall be credited. An Employee's or Participant's interest in his Rollover Account shall be 100% fully vested at all times.

In addition, such other Accounts may be established and maintained as the Plan Administrator may deem appropriate, such as, but not limited to, Forfeiture accounts, etc.

- 2.02 Actual Contribution Percentage means the percentage of which the Company Matching Contributions allocated to a Participant's Matching Account are of a Participant's Compensation. A Participant's Actual Contribution Percentage shall be determined in accordance with Treas. Reg. Sec. 1.401(m)-1.
- 2.03 Actual Deferral Percentage means the percentage of which the Salary Reduction Contributions allocated to a Participant's 401(k) Account are of a Participant's Compensation. A Participant's Actual Deferral Percentage shall be determined in accordance with Treas. Reg. Sec. 1.401(k)-1.
- 2.04 Beneficiary.
- (a) Definition. Beneficiary means any person or entity designated by a Participant, in the manner directed by the Plan Administrator, to receive benefits payable upon the Participant's death as a result of the Participant's participation in the Plan.
  - (b) Special Rule for Married Participants. Each married Participant will be deemed to have selected his Spouse as his Beneficiary unless the Participant's Spouse has given his written notarized consent on the form provided by the Plan Administrator. Spousal

consent will not be required if the Participant states on the applicable form provided for such purpose by the Plan Administrator and notarized that:

- (i) the Participant is able to establish to the satisfaction of the Plan Administrator that he has no Spouse; or
- (ii) the Participant's Spouse cannot be located; or
- (iii) there are other circumstances under which consent of the Spouse is not required in accordance with applicable U.S. Treasury or Department of Labor regulations.

Upon the death of a Spouse or divorce from the Participant any prior designation of the Spouse as the Participant's Beneficiary shall automatically become void as to that Spouse.

- (c) Special Rule if No Designation in Effect. If no valid Beneficiary designation is in effect upon the death of the Participant, the Beneficiary shall be the person or persons who shall survive the Participant in the first of the following classes:

- (i) the Participant's Spouse;
- (ii) his children in equal shares and their descendants, per stirpes; or
- (iii) his estate.

- 2.05 Board means the Board of Directors of the Company or other person or governing body having authority to bind the Company.
- 2.06 Break in Service means a twelve consecutive month period commencing on the date of the Employee's termination of employment with the Participating Employer and all Related Entities, or any anniversary thereof, if such Employee is not then reemployed by a Participating Employer or a Related Entity within that period. If an Employee is no longer performing services because of a maternity or paternity absence, then the Employee shall be considered to have terminated employment on the second anniversary of the first date of such absence. A maternity or paternity absence is an absence on account of the birth of a child of the Employee, the placement of a child with the Employee in connection with the adoption of such child by such Employee, or the caring for such child for a period beginning immediately following such birth or placement.
- 2.07 Code means the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder. Reference to any Section of the Code includes any successor provision thereto.
- 2.08 Company means First Health Group, Inc., a Delaware corporation, and any organization with which the Company shall be merged or consolidated, or any organization resulting in any manner from a reorganization of the Company, or any individual, firm or corporation which shall assume the obligations of the Company with respect to the Plan.
- 2.09 Compensation for any period means all compensation paid by a Participating Employer for services rendered, including commissions, amounts contributed as Salary Reduction Contributions to the Plan, any amounts contributed by the Participant pursuant to a salary reduction agreement for a cafeteria plan under Section 125 of the Code, overtime pay, bonuses, and commissions, but excludes any Participant's share in any Company contributions hereto, and to any other employee benefit or insurance program, imputed income or reimbursement of relocation expenses. Compensation in excess of the applicable dollar limitation set forth in Code Section 401(a)(17) (as adjusted for cost of living increases) each Plan Year shall be disregarded for all Plan purposes.
- 2.10 Contribution Period means the regular and recurring established payroll periods for payment of Compensation to Employees.
- 2.11 Determination Year means the Plan Year.
- 2.12 Disability means any physical or mental incapacity which, in the opinion of a physician approved by the Plan Administrator, renders or will render an Active or Inactive Participant incapable of performing the duties customarily performed by him for his Participating Employer immediately preceding such incapacity for a period of one year or more.
- 2.13 Early Retirement Date means the date the Participant attains age 55 and completes ten (10) Years of Service.
- 2.14 Effective Date means January 1, 1997, except as provided herein or as otherwise required by law.
- 2.15 Eligible Employee means an Employee of a Participating Employer, other than

- (a) an Employee who is classified by the Company as a "registry"

employee (a "Registry Employee") unless; such Registry Employee either (i) was an Active Participant in the Plan immediately prior to January 1, 1993, or (ii) becomes an Active Participant in the Plan due to employment in a capacity other than as a Registry Employee and changes the terms of his employment to become a Registry Employee;

- (b) any Employee the terms of whose employment are governed by the provisions of a collective bargaining agreement with respect to which retirement benefits were the subject of good faith negotiations unless such agreement specifically provides for his coverage hereunder;
- (c) any Leased Employee (unless the provisions of Section 414(n) of the Code require participation in the Plan by Leased Employees, in which case Leased Employees shall be Eligible Employees; and
- (d) any individual whose services with a Participating Employer are performed pursuant to a contract which purports to treat the individual as an independent contractor, even if such individual is later determined (by judicial action or otherwise) to have been a common law employee of the Participating Employer rather than an independent contractor.

2.16 Eligible Retirement Plan means an individual retirement account (described in Code Section 408(a)), an individual retirement annuity (described in Code Section 408(b)), an annuity plan (described in Code Section 403(a)), or a qualified trust (described in Code Section 401(a)). Effective January 1, 2002 an Eligible Retirement Plan shall also include an annuity contract under Code Section 403(b) and an eligible plan under Code Section 457(b) which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state. However, prior to January 1, 2002 in the case of a direct rollover by a surviving Spouse, an "Eligible Retirement Plan" shall mean only an individual retirement account or an individual retirement annuity.

2.17 Employee means a person who is an employee, as the term is defined in Code Section 3121(d), of a Related Entity.

2.18 Entry Date means January 1, April 1, July 1 and October 1 of each Plan Year.

2.19 ERISA means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder. Reference to any Section of ERISA includes any successor provision thereto.

2.20 Five Percent Owner means any Employee, who at any time during the Plan Year, owned (or is considered as owning within the meaning of Code Section 318) more than 5 percent of the outstanding stock of the Company or stock possessing more than 5 percent of the total combined voting power of all stock of the Company.

2.21 Forfeiture means the portion of a Participant's Matching Account which is not vested upon his termination of employment with all related entities in accordance with Section 6.03 and is forfeited under Section 6.04.

2.22 Highly Compensated Group includes every "Highly Compensated Employee." Effective January 1, 1998, for any current Plan Year, a "Highly Compensated Employee" is an Employee who:

- (a) was a Five Percent Owner of a Related Entity at any time during the prior or current Plan Year; or
- (b) during the prior Plan Year received Compensation in excess of \$80,000 (as adjusted) from a Related Entity and was in the group consisting of the top twenty percent of Employees when ranked by Compensation for the Plan Year in question (determined after excluding the Employees described in Code Sections 414(q)(5) and 414(q)(8)); or
- (c) was a former Employee, who during the Plan Year in which he separated from Service or during any Plan Year ending on or after his fifty-fifth (55) birthday, was a highly compensated employee, as defined in Code Section 414(q).

2.23 Hour of Service means:

- (a) each hour for which an Employee (or Leased Employee) is paid or entitled to payment by the Company or a Related Entity for the performance of services.
- (b) Each hour in or attributable to a period of time during which he or she performs no duties due to a vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or a leave of absence for which he or she is so paid or so entitled to payment by the Company or a Related Entity, whether direct or indirect; provided, however, that no more than five

hundred and one Hours of Service shall be credited under this paragraph to an Employee on account of any such period, and no such hours shall be credited to an Employee if attributable to payments made or due under a plan maintained solely for the purpose of complying with applicable workers' compensation, unemployment compensation or disability insurance laws or to a payment which solely reimburses the Employee for medical or medically related expenses incurred by him.

- (c) Each hour for which he or she is entitled to back pay, irrespective of mitigation of damages, whether awarded or agreed to by the Company or a Related Entity.
  - (d) Hours of Service under subsections (b) and (c) shall be calculated in accordance with 29 C.F.R. S2530.200b-2(b). Each Hour of Service shall be attributed to the Plan Year or initial eligibility year in which it occurs except to the extent that the Company, in accordance with 29 C.F.R. S 2530.200b-2(c), credits such Hour to another computation period under a reasonable method consistently applied.
- 2.24 Leased Employee means any individual who is not an employee of a Participating Employer and who provides services to the Participating Employer if (a) such services are provided pursuant to an agreement between the Participating Employer and any other person, (b) such individual has performed such services for the Participating Employer (or for the Participating Employer and Related Entities) on a substantially full-time basis for the period of at least 1 year, and (c) such services are performed under primary direction of control by the Participating Employer.
- 2.25 Merged Plan means a plan set forth on an Appendix hereto which merged into the Plan effective as of the date set forth on such Appendix. Appendices may be added to the Plan from time to time by the Plan Administrator without formally amending the Plan.
- 2.26 NonHighly Compensated Group includes every Employee who is not a Highly Compensated Employee. Every member of the NonHighly Compensated Group is a "NonHighly Compensated Employee".
- 2.27 Normal Retirement Date means the Participant's 65th birthday. If the Participant does not retire from the service of any and all Related Entities on his Normal Retirement Date, then the Participant's retirement date shall be the date of his actual retirement after attaining age 65.
- 2.28 Participant means an Employee or former Employee of a Participating Employer who is or has been a Participant in the Plan pursuant to Article III hereof. All Participants shall be further classified as follows:
- (a) Active Participant means an Employee who meets the requirements of Section 3.01 or Section 3.04.
  - (b) Inactive Participant means an Employee of a Related Entity who meets the requirements of Section 3.02 and who still has an Account in the Plan.
  - (c) Former Participant means a person who meets the requirements of Section 3.03 and who still has an Account in the Plan.
- 2.29 Participating Employer means collectively or individually, as the context indicates, the Company and each Related Entity which has, with the consent of the Company, adopted this Plan and is named on Schedule A, attached to and made a part of this Plan.
- 2.30 Plan means this 2002 Restatement of the First Health Group, Inc. Retirement Savings Plan as set forth in this document, as it may be amended from time to time.
- 2.31 Plan Administrator means the Company or the administrative committee appointed by the Company to administer the Plan.
- 2.32 Plan Year means the calendar year.
- 2.33 Qualified Domestic Relations Order means any judgment, decree, or order (including approval of a property settlement agreement) which:
- (a) relates to the provision of child support, alimony payments, or marital property rights to a spouse, child or other dependent of a Participant,
  - (b) is made pursuant to a state domestic relations law (including a community property law),
  - (c) creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to, receive all or a portion of the benefits payable with respect to the Participant,

- (d) clearly specifies the name and last known mailing address, if any, of the Participant and the name and mailing address of each Alternate Payee covered by the Order, the amount and percentage of the Participant's benefits to be paid by the Plan to each Alternate Payee, or the manner in which such amount or percentage is to be determined, the number of payments or period to which order applies and each plan to which such order applies, and
- (e) does not require the Plan to provide (i) any form or type of benefit, or any option, not otherwise provided under the Plan, (ii) increased benefits, or (iii) benefits to an Alternate Payee which are required to be paid to another payee under another order previously determined by the Plan Administrator to be a Qualified Domestic Relations Order.

The term "Alternate Payee" means any spouse, former spouse, child or other dependent of a Participant who is recognized by a Qualified Domestic Relations Order as having a right to receive all, or a portion of, the benefits payable under the Plan with respect to the Participant.

- 2.34 Related Entity means a Participating Employer and any other corporation, firm or other enterprise on or after the date that such corporation or business, along with the Company, is a member of a controlled group of corporations as defined in Section 414 (b) of the Code, is a member of a group of trades or businesses under common control as defined in Section 414 (c) of the Code, is a member of an affiliated service group as defined in Section 414 (m) of the Code, or is otherwise required to be treated as a single employer pursuant to regulations promulgated under Section 414(o) of the Code.
- 2.35 Spouse means the individual to whom, under the laws of the Participant's domicile, a Participant is legally married as of the later of the date on which the first payment of his retirement benefit is to be made or the date of his death. A former Spouse shall be treated as a Spouse to the extent provided under a Qualified Domestic Relations Order.
- 2.36 Trust means the First Health Group Corp. Retirement Savings Trust, the fund established to hold and invest the assets accumulated under this Plan, which is maintained in accordance with the terms of this Plan and the Trust Agreement.
- 2.37 Trust Agreement means any one or all trust agreements entered into between the Company and the Trustee to carry out the purposes of the Plan, which trust agreement(s) shall constitute a part of the Plan.
- 2.38 Trustee means any individual or corporate fiduciary and any duly appointed successors functioning in that capacity in accordance with the Trust Agreement.
- 2.39 Valuation Date means each day on which the New York Stock Exchange is open for trading and such other times as the Company may elect.
- 2.40 Year of Service means, each Year of Service credited under the terms of the Plan prior to January 1, 1993, and thereafter the number of years, including fractional periods thereof, elapsed from the Employee's date of hire until his date of termination of employment with all Related Entities, subject to the provisions of Section 3.04. If an Employee is absent from employment with the Company and all Related Entities for any reason other than resignation, dismissal, retirement or death, the Employee will be considered to have terminated employment on the earlier of the date he resigns or is dismissed or the first anniversary of the first date of such absence.

### ARTICLE III. ELIGIBILITY AND PARTICIPATION

- 3.01 Active Participant Eligibility Requirements. Each Eligible Employee shall become an Active Participant on the first Entry Date after, or on which, the Eligible Employee attains age 21 and completes the following service:
  - (a) if the Eligible Employee is classified as a full-time Employee, one Year of Service, or
  - (b) if the Eligible Employee is classified as a part-time Employee, 1,000 Hours of Service during any Plan Year, or the 12-consecutive month period commencing on the part-time Employee's date of hire;provided he is still an Eligible Employee on such date. Each Participant in the Plan immediately prior to the Effective Date shall continue to be a Participant in the Plan on and after the Effective Date subject to the limitations of the Plan.
- 3.02 Inactive Participant Eligibility Requirements. An Active Participant who ceases to be an Eligible Employee but who remains an Employee shall automatically become an Inactive Participant as of the date he ceases

to be an Eligible Employee. An Inactive Participant shall continue to be treated the same as an Active Participant in every respect except that no Matching Contributions or Forfeitures shall be allocated to his Accounts, with the exception of those to which he may be entitled for the Plan Year in which he ceases to be an Active Participant as required by Section 4.02. In addition, an Inactive Participant shall not be permitted to make any Salary Reduction or Rollover Contributions unless and until he again becomes an Active Participant. An Inactive Participant will become an Active Participant on the date he is reclassified as an Eligible Employee.

3.03 Former Participant Eligibility Requirements. An Active Participant or an Inactive Participant shall automatically become a Former Participant as of the date he is no longer employed by any Related Entity, provided he retains an Account balance under the Plan. A Former Participant shall cease being a Participant on the date he no longer retains an Account balance under the Plan.

3.04 Effect of Reemployment on Participation and Service.

- (a) A Former Participant who is reemployed as an Employee prior to incurring a Break in Service shall resume active participation in the Plan on the date of his return to employment as an Employee. As of the date he again becomes an Active Participant, such Participant's Years of Service as of the date of his prior termination of employment shall be restored.
- (b) A Former Participant who is reemployed as an Employee after having incurred a Break in Service shall be eligible to resume participation in the Plan as an Active Participant on the date of his return to employment as an Employee provided (i) such Participant's vested percentage as determined under Section 6.03 is more than 0%; or (ii) he has not incurred five or more consecutive one year Breaks in Service. As of the date he again becomes an Active Participant, such Participant's Years of Service as of the date of his prior termination of employment shall be restored, provided such Participant completes a Year of Service after his reemployment.
- (c) In the event a Former Participant does not have any vested percentage as determined under Section 6.03 and the number of his consecutive one year Breaks in Service equals or exceeds five, then his Years of Service, if any, completed prior to such period of such one year Breaks in Service shall be disregarded and he shall become an Active Participant on the date he again satisfies the requirements set forth in Section 3.01.

3.05 Reemployment Rights after Qualified Military Service. Effective October 13, 1996:

- (a) Solely for the purposes of this Section, the following definitions shall apply:
  - (i) "Qualified Military Service" shall mean any service in the uniformed services (as defined in chapter 43 of title 38, United States Code) by any individual if such individual is entitled to reemployment rights under such chapter with respect to such service.
  - (ii) "Compensation" shall mean
    - (A) Compensation the Employee would have received during his period of Qualified Military Service if the Employee were not in Qualified Military Service, determined based on the rate of pay the Employee would have received from the Participating Employer but for the absence during his period of Qualified Military Service, or
    - (B) if the Compensation the Employee would have received during his period of Qualified Military Service was not reasonably certain, the Employee's average Compensation from the Participating Employer during the 12-month period immediately preceding the Qualified Military Service (or, if less, the period of employment immediately preceding the Qualified Military Service).
- (b) A Participant who leaves a Participating Employer as a result of Qualified Military Service and returns to employment with a Participating Employer may elect during the period described in subsection (c) to make additional deferrals to his 401(k) Account under the Plan in the amount determined under subsection (d) or such lesser amount, as elected by the Participant.
- (c) The period determined under this subsection shall be the period which begins on the date of the Employee's reemployment with the Participating Employer after his Qualified Military Service and extends to the lesser of
  - (i) the product of 3 and the period of Qualified Military

Service, and

(ii) 5 years.

- (d) The amount described in this subsection is the maximum amount of deferrals to the Participant's 401(k) Account that the Participant would have been permitted to make in accordance with the limitations described in subsection (f) (i) during the Participant's period of Qualified Military Service if the Participant had continued to be employed by the Participating Employer during such period and received Compensation. Proper adjustment shall be made for any contributions actually made during the Participant's period of Qualified Military Service.
- (e) If the Participant elects to make deferrals to his 401(k) Account under subsection (b), the Participating Employer shall make such matching contributions to his Matching Account with respect to such deferrals as would have been required under the Plan had such deferrals actually been made during the period of such Qualified Military Service.
- (f) If any deferral or contribution is made by a Participant or the Company pursuant to this Section,
  - (i) such deferral or contribution shall not be subject to any otherwise applicable limitation contained in Code Section 402(g), 404(a), or 415 and shall not be taken into account in applying such limitations to other deferrals, contributions or benefits under the Plan or any other plan, with respect to the Plan Year in which deferral or contribution is made,
  - (ii) such deferral or contribution shall be subject to the limitations described in paragraph (i) with respect to the Plan Year to which the deferral or contributions relates in accordance with the rules prescribed by the Secretary of the Treasury,
  - (iii) the Plan shall not be treated as failing to meet the requirements of Code Section 401(a) (4), 401(k) (3), 401(k) (11), 401(k) (12), 401(m), 410(b) or 416 by reason of the making of (or the right to make) such deferral or contribution.
- (g) The Company shall not credit earnings on any deferral or contribution made under this Section before such deferral or contribution is actually made.
- (h) A Participant reemployed under subsection (b) shall be treated as not incurring a Break in Service by reason of his period of Qualified Military Service. For purposes of calculating the Participant's Years of Service, the Participant will be credited with service for the period of his Qualified Military Service.

ARTICLE IV.  
CONTRIBUTIONS

4.01 Participant Contributions.

- (a) Salary Reduction Contributions.
  - (i) Subject to the limitations of this Article IV, each Active Participant shall be eligible to elect to have a portion of Compensation that would otherwise be payable to him during a Contribution Period reduced and contributed to the Plan as a Salary Reduction Contribution. Such Salary Reduction Contributions shall be not less than 1% of the Participant's Compensation and shall be in whole percentages thereof, as elected by the Participant on a payroll reduction agreement. Prior to January 1, 2002, a Participant's Salary Reduction Contributions shall not exceed 15% of his Compensation. Except as provided in Section 4.08, no Participant may make Salary Reduction Contributions under this Plan and any other qualified plan maintained by a Related Entity during the Plan Year in excess of dollar limitation contained in Code Section 402(g) (i) for such year.
  - (ii) If the Salary Reduction Contributions made on behalf of a Participant to this Plan and all other retirement plans with elective deferrals (as described in Section 402(g) (3) of the Code) for any calendar year exceeds the limit set forth in Section 402(g) (1) (as adjusted for each calendar year by the Secretary of the Treasury or his delegate as provided in Section 402(g) (4) for years after December 31, 2001 and 402(g) (5) for years prior to January 1, 2002), such excess shall be treated as "excess deferrals." No later than the April 15 following the close of the calendar year, the Plan will distribute to the Participant any excess deferrals and any income or losses attributable thereto for the Plan Year. Such

distributions will not require the consent of the Participant's Spouse, will not violate any outstanding Qualified Domestic Relations Orders and will not be subject to any restrictions on distribution of Salary Reduction Contributions set forth in Section 6.09.

- (b) Changes and Discontinuance of Salary Reduction Contributions.
  - (i) An Active Participant may increase or decrease his Salary Reduction Contributions effective as of the Contribution Period which contains the first day of the next calendar quarter by filing a written notice with the Plan Administrator.
  - (ii) An Active Participant may discontinue his Salary Reduction Contributions as of any Contribution Period in the manner prescribed by the Plan Administrator. An Active Participant who has discontinued his Salary Reduction Contributions may recommence them as of the Contribution Period which contains the first day of the next calendar quarter in the manner prescribed by the Plan Administrator provided he is an Active Participant and has executed a payroll reduction agreement.
  - (iii) Salary Reduction Contributions of an Active Participant shall cease automatically as of the last day of the last Contribution Period which coincides with or immediately follows the date on which such Participant ceases to be an Active Participant.
- (c) Payment to Trustee. The Company shall pay to the Trustee the Participant's Salary Reduction Contributions as soon as practicable but in no event later than 15 business days after the end of the month in which such amounts would otherwise have been payable to the Participant in cash.
- (d) Allocation of Salary Reduction Contributions. Each Active Participant's Salary Reduction Contributions shall be credited to his 401(k) Account in accordance with Section 5.01(a). A Participant shall always be 100% nonforfeitably vested in his 401(k) Account.

#### 4.02 Participating Employer Contributions.

- (a) Matching Contribution. For each Plan Year, each Participating Employer may contribute to the Trust on behalf of each eligible Participant, as a Matching Contribution, an amount (which includes Forfeitures) which shall be a percentage, as may be determined in the sole discretion of the Company at the beginning of such Plan Year, of each eligible Participant's Salary Reduction Contributions for each Contribution Period.
- (b) Eligibility and Allocation of Matching Contributions. Each Active Participant who has completed one Year of Service shall be eligible to receive a Matching Contribution. Matching Contributions will be made starting with the first Contribution Period which contains the first day of the calendar quarter after the Participant has completed one Year of Service. Matching Contributions shall be allocated as of the last day of each Contribution Period to the Matching Account of each Participant who makes Salary Reduction Contributions during such Contribution Period.
- (c) Form and Timing of Contribution. Matching Contributions shall be made in cash. Matching Contributions for a Plan Year shall be delivered to the Trustee either in a single payment, or in installments, within the time permitted by the Code. For purposes of this Section 4.02, Matching Contributions for any Plan Year will be considered to have been made on the last day of that Plan Year, but only if paid to the Trustee prior to the Participating Employer's federal income tax due date, including extensions.
- (d) Disposition of Forfeitures. Forfeitures are first to be used to the extent necessary to restore a Participant's Accounts as provided in Section 6.04. The remaining balance of Forfeitures, if any, may in the discretion of the Plan Administrator be credited towards and used to reduce a Participating Employer's Matching Contribution for the Plan Year and/or used to pay the reasonable expenses of the Plan.
- (e) Irrevocability of Matching Contribution. Except as provided herein, no contributions to the Trust and no part of the corpus or income of the Trust shall revert to a Participating Employer or shall be used for or diverted to any purpose other than for the exclusive benefit of persons covered by the Plan. However, a contribution which was made by a mistake of fact or conditioned upon the deductibility of the contribution under Section 404 of the Code, shall be returned to a Participating Employer within one year after payment of the contribution or the disallowance of the deduction (to the extent disallowed), whichever is applicable, at

the request of the Company.

#### 4.03 Limitation on Allocations.

- (a) Basic Limitation on Allocations to Participants. Except to the extent permitted by Section 4.08, there shall not be allocated to the Accounts of any Participant under the Plan and any other defined contribution plan of a Related Entity for any Limitation Year an amount which would cause his Annual Addition to exceed the lesser of:
- (i) the amount set forth in Section 415(c)(1)(A) of the Code as adjusted for cost of living increases under Code Section 415(d), or
  - (ii) the percentage limitation of the Participant's Total Compensation for such Limitation Year, set forth in Section 415(c)(1)(B).

If the Annual Addition for a Participant exceeds either of the limitations in subsection (a) as a result of the allocation of Forfeitures, a reasonable error in estimating a participant's Total Compensation, a reasonable error in determining the amount of elective deferrals (within the meaning of Code Section 402(g)(3)) that may be made under the limits of Code Section 415 or other limited facts and circumstances found justifiable by the Commissioner of Internal Revenue, the Plan Administrator shall, to the extent necessary to eliminate such excess (and in the following order):

- (A) return to the Participant any Salary Reduction Contributions which otherwise would not be eligible for a Matching Contribution under Section 4.02;
  - (B) return to the Participant any Salary Reduction Contributions which otherwise would be allocable to his 401(k) Account and which would be eligible for a Matching Contribution under Section 4.02; and
  - (C) reduce the Company Matching Contribution which otherwise would be allocable to the Matching Account of the Participant pursuant to Section 4.02(c).
- (b) Special Definitions for Section 4.03.
- (i) Limitation Year. For the purposes of the Plan the Limitation Year shall be the Plan Year.
  - (ii) Annual Addition. Annual Addition means, with respect to any Limitation Year, the sum of:
    - (A) all Participating Employer contributions allocable to the Participant under the Plan and under all other defined contribution plans maintained by all Related Entities;
    - (B) forfeitures allocable to the Participant under such plans, if any;
    - (C) all Participant's contributions to such plans for such Limitation Year;
    - (D) amounts allocated to an individual medical account, as defined in Section 415(c)(2) of the Code, which is part of a defined benefit pension plan maintained by a Related Entity; and
    - (E) amounts derived from contributions which are attributable to post-retirement medical benefits allocated to the separate account of a key employee under a welfare benefit plan maintained by the Company or a Related Entity ("key employee" and "welfare benefit plan" being defined in Sections 419A(d)(3) and 419(e) of the Code, respectively).
  - (iii) Total Compensation. For the purpose of determining the maximum allocation permitted by Section 4.03(a) (and notwithstanding the definition of Compensation used elsewhere in this Plan) Total Compensation shall mean, with respect to any Limitation Year, the Employee's wages, salaries for professional services, other amounts paid over the entire Plan Year for personal services actually rendered (including, but not limited to, commissions paid salesmen, compensation for services on the basis of percentage of profits, commissions on insurance premiums, tips and bonuses), and effective for Plan Years beginning on or after January 1, 1998, elective deferrals as defined in Code Section 402(g)(3). Total Compensation does not include:

- (A) deferred compensation, including contributions by a Participating Employer to a deferred compensation plan or a simplified employee pension plan and any distribution from a deferred compensation plan,
- (B) amounts realized from the exercise of non-qualified stock options and amounts realized from the sale, exchange or other disposition of stock acquired under a qualified stock option,
- (C) other distributions which receive special tax benefits, and
- (D) any amounts in excess of the applicable dollar limitation in effect under Code Section 401(a)(17) for such Limitation Year.

4.04 Nondiscrimination in Salary Reduction Contributions. Each Plan Year the Plan must satisfy the requirements of this Section and Sections 4.05 and 4.06. The Plan Administrator shall determine if these requirements are satisfied pursuant to Treas. Reg. Sec. 1.401(k)-1, the provisions of which are incorporated by reference.

- (a) For each Plan Year, the Deferral Percentage of the Highly Compensated Group shall be:
  - (i) not more than 125 percent of, or
  - (ii) not more than two percentage points higher than, and not more than twice,

the Deferral Percentage for such Plan Year of the NonHighly Compensated Group for the preceding Plan Year (using the definition of such term that was in effect during such preceding Plan Year) for Plan Years commencing prior to January 1, 2002, or such other amount as may be required by Treasury regulations under Code Section 401(m)(9). The Deferral Percentage for the Highly Compensated Group or the NonHighly Compensated Group for a Plan Year is the average of the Actual Deferral Percentage of each Participant in such group.

- (b) If the amount of Salary Reduction Contributions to be credited to the 401(k) Accounts of Highly Compensated Group for any Plan Year does not satisfy the above test, then the amount of excess contributions (as defined below) made on behalf of any Highly Compensated Employee (and any income or loss attributable thereto as of the earlier of the date of distribution or the last day of the Plan Year in which such excess contribution was made) shall, before the last day of the following Plan Year, be distributed to such Highly Compensated Employee until the above test is satisfied. An "excess contribution" for any Plan Year is the excess of the amount of Salary Reduction Contributions actually paid over to the Plan on behalf of such Highly Compensated Employee for the Plan Year over the maximum amount permitted by the limitations of this Section determined by reducing the Salary Reduction Contributions made on behalf of each Highly Compensated Employee in order of the dollar amount of their Salary Reduction Contributions beginning with the largest of such dollar amounts. Distribution of excess contributions under this Section will not require the consent of the Participant or his Spouse and will not violate any outstanding Qualified Domestic Relations Orders.

4.05 Nondiscrimination in Matching Contributions. Each Plan Year must satisfy the requirements of this Section and Sections 4.04 and 4.06. The Administrator shall determine if these requirements are satisfied pursuant to Treas. Reg. Sec. 1.401(m)-1, the provisions of which are incorporated by reference.

- (a) For each Plan Year, the Contribution Percentage of the Highly Compensated Group, shall be
  - (i) not more than 125 percent of, or
  - (ii) not more than two percentage points higher than, and not more than twice,

the Contribution Percentage for such Plan Year of the Non-Highly Compensated Group for the preceding Plan Year, or for Plan Years commencing prior to January 1, 2002 such other amount as may be required by Treasury Regulations under Code Section 401(m)(9).

The Contribution Percentage for the Highly Compensated Group or the Non-Highly Compensated Group, as the case may be, for a Plan Year is the average of the Actual Contribution Percentages for each Participant in such group.

- (b) The Trustee shall distribute to such Highly Compensated Employees the amount of actual excess aggregate contributions (as defined below) (and any income or losses allocable thereto as of the earlier of the date of distribution or the last day of the Plan

Year in which such excess aggregate contribution was made) for any Plan Year not later than the last day of the next following Plan Year, on the basis of the respective portions of the excess aggregate contributions attributable to each such Highly Compensated Employee. Excess aggregate contributions will be distributed by reducing Matching Contributions made on behalf of Highly Compensated Employees in order of the dollar amount of such Matching Contributions beginning with the largest of such dollar amounts. The term "excess aggregate contributions" means, with respect to any Plan Year, the excess of:

- (i) the aggregate amount of Matching contributions made on behalf of Highly Compensated Employees for such Plan Year, over
- (ii) the maximum amount of such contributions permitted under the foregoing provisions of this Section 4.05.

4.06 Alternative Limitation Test. In addition to the requirements of Sections 4.04 and 4.05 for any Plan Year commencing prior to January 1, 2002, the Plan must satisfy the requirements of this Section. The Plan Administrator shall determine if these requirements are satisfied pursuant to Treas. Reg. Sec. 1.401(m)-2, the provisions of which are incorporated by reference.

(a) Multiple Use Test. The sum of the Actual Deferral Percentage and the Actual Contribution Percentage of the Highly Compensated Group for the current Plan Year may not exceed the greater of:

(i) The sum of:

(A) 1.25 times the greater of:

- (1) the Actual Deferral Percentage of the Non-Highly Compensated Group for the preceding Plan Year; or
- (2) the Actual Contribution Percentage of the Non-Highly Compensated Group for the preceding Plan Year; and

(B) two percentage points plus the lesser of (1) or (2) next above, but in no event in excess of twice the lesser of (1) or (2) above; or

(ii) The sum of:

(A) 1.25 times the lesser of:

- (1) the Actual Deferral Percentage of the Non-Highly Compensated Group for the preceding Plan Year; or
- (2) the Actual Contribution Percentage of the Non-Highly Compensated Group for the Preceding Plan Year; and

(B) two percentage points plus the greater of (1) or (2) next above, but in no event in excess of twice the greater of (1) or (2) above.

(b) Adjustments. If the requirements of subsection (a) are not satisfied, the amount of such excess will be an excess contribution or excess aggregate contribution, as determined at the discretion of the Plan Administrator, and the corresponding contribution will be reduced and distributed to Highly Compensated Employees in the manner described in the applicable provisions of Sections 4.04 and 4.05. The Deferral Percentage and the Contribution Percentage of the Highly Compensated Group will be determined after any corrective distributions of excess deferrals or contributions under Sections 4.04 and 4.05.

4.07 Rollover Contribution. With the consent of the Plan Administrator, an Employee or Participant may make a Rollover Contribution to the Plan. The term "Rollover Contribution" means an eligible rollover distribution (as described in Code Section 402(c)) from an Eligible Retirement Plan or a tax-free rollover distribution from an individual retirement account or an individual retirement annuity which in turn consisted entirely of an eligible rollover distribution (as described in Code Section 402(c)(4)) from an Eligible Retirement Plan.

4.08 Catch-Up Contributions. Effective for Plan Years commencing after December 31, 2001, all Participants who are eligible to make elective deferrals under this Plan and who have attained age 50 before the close of the Plan Year shall be eligible to make Catch-up Contributions in accordance with, and subject to the limitations of, section 414(v) of the Code. Such Catch-up Contributions shall not be taken into account for purposes of the provisions of the Plan implementing the required limitations of sections 402(g) and 415 of the Code. The Plan shall not be treated as failing to satisfy the provisions of the Plan implementing the requirements of section 401(k)(3), 401(k)(11), 401(k)(12), 410(b), or 416 of the Code, as applicable, by reason of the

making of such catch up contributions. Catch-up Contributions will not be subject to and, no Matching Contributions will be made on, such Catch-Up Contributions under Section 4.02 of the Plan.

ARTICLE V.  
ACCOUNTS

5.01 Account Values. As of each Valuation Date, the value of each of a Participant's Accounts shall be determined as follows:

(a) 401(k) Accounts:

- (i) the value of such Account as of the preceding Valuation Date,
- (ii) plus any Salary Reduction Contributions, Catch-Up Contributions and any loan repayments credited to such Account for such period,
- (iii) minus the amount of any distributions or withdrawals made from such Account during such period, and
- (iv) plus or minus such Account's share of the net income, loss, appreciation and/or depreciation in the value of that portion of the Trust allocable to 401(k) Accounts, as determined under Section 5.02 during such period.

(b) Matching Accounts:

- (i) the value of such Account as of the preceding Valuation Date,
- (ii) minus the amount of any distributions or withdrawals made from such Account during such period,
- (iii) plus or minus such Account's share of the net income, loss, appreciation and/or depreciation in the value of that portion of the Trust allocable to Matching Accounts, as determined in Section 5.02 during such period, and
- (iv) plus any Matching Contributions (including Forfeitures) allocated and any loan repayments credited to such Account during such period.

(c) Rollover Accounts:

- (i) the value of such Account as of the preceding Valuation Date,
- (ii) minus the amount of any distributions or withdrawals made from such Account during such period,
- (iii) plus or minus such Account's share of the net income, loss, appreciation and/or depreciation in the value of that portion of the Trust allocable to Rollover Accounts, as determined in Section 5.02 during such period, and
- (iv) plus any Rollover Contributions or transfers made to and any loan repayments credited to such Account during such period.

5.02 Allocation of Investment Income. As of each Valuation Date, before the allocation of the Matching Contributions (including Forfeitures as set forth in Section 4.02(d)) as of that date, any net appreciation or net depreciation in the value of each Investment Fund shall be allocated among the Accounts of Participants in the same proportion that the value of such portion of each of the Participant's Account as is invested in such Investment Fund bears to the total value of the portions of the Accounts of all Participants as are invested in such Investment Fund, determined as of the immediately preceding Valuation Date, reduced in each case by the amount of any distributions, loans, withdrawals, Forfeitures and transfers from such Accounts allocable to such Investment Fund for the benefit of such Participant since the immediately preceding Valuation Date and increased in each case by the aggregate Salary Reduction Contributions, Rollover Contributions and loan repayments credited to such Investment Fund since the immediately preceding Valuation Date. All determinations made by the Trustee with respect to the value of Participants' Accounts shall be made in accordance with generally accepted principles of trust accounting, and such determinations made by the Trustee and any determinations made by the Plan Administrator based thereon, shall be conclusive and binding upon any person having an interest under the Plan.

ARTICLE VI.  
DISTRIBUTIONS

6.01 Termination Dates. A Participant's "Termination Date" will be the date on which his employment with the Participating Employers and the Related Entities is terminated because of the first to occur of the following events:

- (a) his Normal Retirement Date or Early Retirement Date;
- (b) his Disability;
- (c) his death; or
- (d) his resignation or dismissal from the employ of all Related Entities before retirement in accordance with (a) or (b) next above.

6.02 Fully Vested Accounts. A Participant shall at all times be fully vested in his 401(k) Account. If a Participant

- (a) retires or is retired under subsection 6.01(a) or (b),
- (b) dies while in the employ of an Employer or a Related Entity, or
- (c) completes at least five Years of Service,

then he shall become fully vested in the balance of his Accounts. The entire balance in his Accounts, if any, as of any Valuation Date coincident with or next following his Termination Date (after all adjustments then required under the Plan have been made), may then become distributable to or for his benefit or, in the event of his death, to or for the benefit of his Beneficiary, in accordance with the applicable provisions of this Article VI.

6.03 Partially Vested Accounts. A Participant shall become vested in the balances in his Matching Account, in accordance with the following schedule:

Number of Completed Years of Service	Vested Percentage
-----	-----
Less than 2 years	0%
2 years but less than 3 years	25%
3 years but less than 4 years	50%
4 years but less than 5 years	75%
5 years or more	100%

The vested balances of his Matching Account, if any, and the balances in his 401(k) Account and Rollover Account, if any, as of any Valuation Date coincident with or next following his Termination Date (after all adjustments then required under the Plan have been made), may become distributable in accordance with the applicable provisions of this Article VI. The unvested portion of a Participant's Matching Account on his Termination Date shall be forfeited in accordance with the provisions of Section 6.04.

6.04 Forfeiture Accounts and Forfeitures. The portion of a Participant's Matching Account that is not distributable to him by reason of the provisions of Section 6.03 shall be credited to a Forfeiture Account established and caused to be maintained by the Plan Administrator in the Participant's name as of the Valuation Date coincident with or next following his Termination Date (before adjustments then required under the Plan have been made). If the Participant does not return to employment with a Participating Employer or a Related Entity prior to incurring a one year Break in Service or, if earlier, after he receives a complete distribution of his Accounts, the balance in his Forfeiture Account, determined as of the Valuation Date coincident with or next following such date (after all adjustments then required under the Plan have been made) will be a "Forfeiture" and will be allocated in accordance with Section 4.02 until exhausted. If the Participant returns to employment with a Participating Employer or a Related Entity prior to incurring five consecutive One Year Breaks in Service and:

- (a) subsequently becomes eligible for Plan benefits in accordance with the provisions of Section 6.02, the balance of his Forfeiture Account as of the next following Valuation Date (after all adjustments then required under the Plan have been made) will be distributable to or for his benefit or, in the event of his death, to or for the benefit of his Beneficiary in accordance with the provisions of Section 6.05; or
- (b) again resigns or is dismissed prior to completing 5 Years of Service, then, as of the Valuation Date coincident with or next following the date on which the Participant first incurs a one year Break in Service after such subsequent resignation or dismissal (after all adjustments then required under the Plan have been made), the balance in his Forfeiture Account shall be determined by multiplying that balance by the following fraction:

$$\frac{x-y}{100\%-y}$$

For purposes of the above formula, x equals the Participant's vested percentage on the date of his subsequent termination of employment and y equals the Participant's vested percentage on

the date of his prior termination of employment.

The balance in the Participant's Forfeiture Account after the calculation described in subsection (b) next above will be nonforfeitable and will be distributable to or for his benefit or, in the event of his death, to or for the benefit of his Beneficiary in accordance with the applicable provisions of this Article VI. The amount by which a Participant's Forfeiture Account is reduced under this Section 6.04 will, if the Participant does not return to employment with the Related Entities prior to incurring a One Year Break in Service or, if earlier, after he receives a complete distribution of his Accounts, be a Forfeiture and will be allocated and used in accordance with Section 4.02(d) until exhausted. If a Participant returns to employment with one of the Related Entities after incurring a one year Break in Service but before incurring five consecutive one year Breaks in Service, the amount forfeited from the Forfeiture Account by reason of such one year Break in Service will be restored to his Forfeiture Account, first, out of Forfeitures occurring in the year of restoration, second, out of contributions by the Participating Employer. Upon such Participant's subsequent Termination Date, his Forfeiture Account will be paid in accordance with either subsection (a) or (b) of this Section, as applicable.

#### 6.05 Distribution of Accounts.

- (a) Form of Distribution. Subject to the following provisions of this Article VI, the vested balances of a Participant's Plan Accounts will be distributable to or for his benefit by payment in either:
  - (i) a lump sum; or
  - (ii) by direct rollover in compliance with Section 401(a)(31) of the Code to an Eligible Retirement Plan:
- (b) In addition to the distribution options available under Section 6.05(a), prior to March 31, 2002, a Participant can, in his discretion, elect payment of the vested balances of his Plan Accounts in the form of substantially equal annual or more frequent installments over a period not exceeding the greater of:
  - (i) the Participant's life expectancy, or
  - (ii) the joint and last survivor life expectancy of the Participant and a Designated Beneficiary.

For purposes of this subsection, the life expectancy of the Participant and the joint and last survivor life of a Participant and his Spouse, may be redetermined annually as elected by the Participant.

- (c) Rules Regarding Distribution.
  - (i) The Trustee may make distribution in cash or property, or partly in each, provided property is distributed at its fair market value as at the date of distribution, as determined by the Trustee.
  - (ii) Where distribution has commenced pursuant to (b) of this Section and prior to the Participant's death, the remaining portions of the Participant's Accounts shall be distributed to the Participant's Beneficiary at least as rapidly as the installment payments otherwise selected by the Participant prior to death. Such distribution will normally be completed within 5 years after the Participant's death, except that:
    - (A) if the distribution is payable to a Beneficiary who is not the Participant's surviving Spouse, it may be payable over a period not extending beyond the life expectancy of such person, and it may commence not later than one year after the date of the Participant's death, or
    - (B) if the distribution is payable to a Beneficiary who is the surviving Spouse of the Participant, it may be payable over a period not extending beyond the life expectancy of such surviving Spouse, and it may commence not later than the date of the Participant's death or, if later, the date the Participant would have attained age 70/ years had he or she lived.
  - (iii) Under regulations prescribed by the Secretary of the Treasury pursuant to Section 401(a)(9) of the Code, any amount paid to a child of a deceased Participant shall be treated as if it has been paid to the surviving spouse of the Participant if such amount will become payable to the surviving spouse upon such child reaching the age of majority (or other designated event permitted under said regulations).
- (d) Election of Distribution. The Participant shall select the method

by which his vested Accounts will be distributed to him. A Participant, if he so desires, may direct how his vested Accounts are to be paid to his Beneficiary. If the deceased Participant did not file a valid direction with the Plan Administrator, then his Beneficiary shall select the method by which the Participant's vested Accounts will be distributed.

- (e) Small Distributions. Notwithstanding anything contained in the Plan to the contrary, if the distributable balance of the Participant's Accounts is \$5,000 or less for Plan Years beginning on or after January 1, 1998, (or \$3,500 or less for Plan Years beginning prior to January 1, 1998) then the Trustee shall distribute the Participant's vested Accounts in a lump sum, and the Participant shall have no right to select the manner in which he will receive his distribution from the Plan. For Plan Years beginning on and after January 1, 2002, for purposes of this Section 6.05(e) and Section 6.06, the vested balances of a Participant's Accounts shall be determined without regard to the balance of the Participant's Rollover Account.

6.06 Time for Distribution. Distribution of a Participant's vested Accounts will normally be made or commenced as soon as practicable following the Valuation Date next following the Participant's Termination Date, but not later than the 60th day next following the close of the Plan Year during which the Participant attains age 65 years or, if later, during which his Termination Date occurs, except as otherwise permitted under circumstances described in Treas. Reg. 51.401(a)-14(d). If the vested value of the Participant's Accounts at the time of any distribution is over \$5,000 for Plan Years beginning on or after January 1, 1998, (or \$3,500 or less for Plan Years beginning prior to January 1, 1998) the Participant (but not his Beneficiary in the event of the Participant's death) must consent in writing to receive the distribution. However, a Participant may not elect to defer distribution beyond the date described above.

6.07 Required Minimum Distributions. Distribution of a Participant's vested Plan Accounts must comply with the requirements of Section 401(a)(9) of the Code.

- (a) A Participant who is a Five Percent Owner in the calendar year in which the Employee attains age 70/ shall receive or commence the receipt of the entire amount credited to his Accounts on the April 1 following the end of the calendar year in which he attains age 70/.
- (b) A Participant (other than a Five Percent Owner) who attains age 70/ after December 31, 1995 and before January 1, 1999, and did not incur a Termination Date prior to or during that calendar year may elect:
  - (i) to commence distribution no later than the April 1 of the calendar year following the year he attains age 70/, or
  - (ii) to defer such distributions until the April 1 following the calendar year in which his Termination Date occurs.
- (c) A Participant (other than a Five Percent Owner) who attained age 70/ prior to January 1, 1996 and was required to receive one or more distributions of his Accounts by December 31, 1996 because he had reached his "required beginning date," as the term was defined under Code Section 401(a)(9) prior to January 1, 1997, may elect to defer such distributions until the April 1 following the calendar year in which his Termination Date occurs.
- (d) The Administrator may permit, any Participant (other than a Five Percent Owner) who attained age 70/ prior to January 1, 1997, was receiving minimum distributions and retires on or after January 1, 1997 to elect that such distributions cease until resumption is otherwise required under the Plan.
- (e) Effective January 1, 2001 for a Participant who is not a Five Percent Owner in the calendar year in which he attains age 70/ distributions shall be made or commence not later than the later of:
  - (i) the April 1 following the calendar year in which his Termination Date occurs, or
  - (ii) the April 1 following the calendar year in which he attains age 70/.

6.08 Facility of Payment. Notwithstanding any provision of this Article VI to the contrary, if, in the Plan Administrator's opinion, a Participant or other person entitled to benefits under the Plan is under a legal disability or is in any way incapacitated so as to be unable to manage his financial affairs, the Plan Administrator may, until claim is made by a conservator or other person legally charged with the care of his person or of his estate, direct the Trustee to make payment to a relative or friend of such person for his benefit. Thereafter, any

benefits under the Plan to which such Participant or other person is entitled shall be paid to such conservator or other person legally charged with the care of his person or his estate.

6.09 Restrictions on Distribution of Salary Reduction Contributions.

Except as provided in Section 7.02, no Participant shall receive a distribution of his 401(k) Account earlier than his separation from service within the meaning of Section 401(k)(2)(B) of the Code, his death or disability, or upon any of the events described in Section 401(k)(10) of the Code and the regulations thereunder. Effective January 1, 2002, no Participant shall receive a distribution of his 401(k) Account earlier than his severance from employment within the meaning of Code Section 401(k)(2)(B), his death or disability or upon any of the events described in Section 401(k)(10) of the Code and the regulations thereunder.

ARTICLE VII.  
LOANS AND WITHDRAWALS

7.01 Loans to Participants. While the primary purpose of the Plan is to accumulate funds for the Participants when they retire, it is recognized that under some circumstances it is in the best interests of Participants to permit loans to be made to them while they continue in the employ of one of the Related Entities. Accordingly, the Plan Administrator, in its sole discretion and upon written request by an Active or Inactive Participant, may make a loan from the Trust Fund to the Participant in accordance with the terms of a loan policy adopted by the Plan Administrator. The amount of such loan together with the accrued interest under this Plan and all other qualified employer plans shall be within the following limits:

- (a) If the vested balance of the Participant's Accounts is between \$0 and \$99,999, the Participant may borrow up to one-half the nonforfeitable balance of his Accounts;
- (b) If the vested balance of the Participant's Accounts is \$100,000 or more, the Participant may borrow up to lesser of:
  - (i) one-half the nonforfeitable balance of his Accounts; or
  - (ii) \$50,000, reduced by the excess (if any) of:
    - (A) the highest outstanding balance of loans under the Plan and all other qualified plans maintained by the Related Entities during the 1 year period ending on the day before the date on which such loan was made, over
    - (B) the outstanding balance of such outstanding loans on the date on which such loan was made.
- (c) USERRA. A Participant with an outstanding Plan loan who leaves the employ of the Related Entities as a result of Qualified Military Service may suspend his installment payments on any loan under the Plan during any part of such service and such suspension shall not be taken into account for purposes of Code Section 72(p), 401(a), or 4975(d)(1).

7.02 Severe Hardship Withdrawals.

- (a) In the sole discretion of the Plan Administrator, a Participant may withdraw all or a portion of the Salary Reduction Contributions made to his 401(k) Account (but not any earnings on such Salary Reduction Contributions) the balance of his Matching Accounts and/or Rollover Accounts if the Plan Administrator, in accordance with the Plan and regulations issued by the Internal Revenue Service, determines that such a withdrawal will alleviate a condition of "severe financial hardship" of a Participant, as defined in subsection 7.02(b) below. Withdrawals from the 401(k) Account shall be limited to the lesser of (1) the amount necessary to satisfy the Participant's severe financial hardship or (2) the amount of the Participant's contributions to such Account at the time of the withdrawal. A Participant may take only one severe hardship withdrawal a Plan Year. A Participant seeking such a withdrawal must apply in writing to the Plan Administrator within such time frame as the Plan Administrator shall require and provide the Plan Administrator with such evidence as it requires to make its determination. The Plan Administrator will respond to each such request in writing as to its approval or denial as soon as practical after receipt of all requested information from the Participant.
- (b) Severe financial hardship withdrawals may be made for the following specified purposes:
  - (i) purchase of the Participant's principal residence;
  - (ii) payment of tuition and educational fees for the next twelve months of post-secondary education of the Participant or

members of his immediate family;

(iii) unreimbursed or anticipated expenses for medical care described in Code Section 213(d) of the Participant or members of his immediate family;

(iv) expenses to prevent the eviction of the Participant from his principal residence or the foreclosure on a mortgage on his principal residence; or

(v) funeral expenses for an immediate family member of the Participant.

(c) In determining the amount required to meet a severe financial hardship, the Plan Administrator may take into account the anticipated federal and state income and excise taxes with respect to the withdrawal.

7.03 Age 59/ or Disability Withdrawal. A Participant who is at least age 59/ or has a Disability may withdraw all or a portion of his 401(k) Account for any reason. To obtain an age 59/ or disability withdrawal, the Participant must submit a written request to the Plan Administrator in such form and at such time as the Plan Administrator shall require. A Participant may take only one age 59/ or Disability withdrawal each year.

7.04 Rollover Contributions. A Participant may withdraw all or a portion of his Rollover Account for any reason upon submission of a written request to the Plan Administrator in such form and at such time as the Plan Administrator shall require.

7.05 Minimum Withdrawal. Notwithstanding any other provision of Article VII, withdrawals may not be made in amounts of less than \$200 unless the amount which may be withdrawn is less than \$200.

ARTICLE VIII.  
ADMINISTRATION OF THE PLAN

8.01 Plan Administrator and Named Fiduciary. The authority and responsibility to control and manage the operations and administration of the Plan shall reside in the Plan Administrator. For purposes of ERISA, the Plan Administrator shall be the "named fiduciary" with respect to this Plan. The Company shall have the sole authority to appoint and remove the Trustee, and the investment manager, if any, provided for under the Trust. The Plan Administrator shall be responsible for the day-to-day administration of the Plan. The Trustee shall have the sole responsibility for the administration of the Trust and the management of the assets held under the Trust, all as specifically provided in the Trust. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan or the Trust, as the case may be, authorizing or providing for such direction, information or action. The Plan Administrator and Company and the Participating Employers do not guarantee the Trust in any manner against investment loss or depreciation in asset value.

8.02 Claim Procedure. Claims for benefits under this Plan shall be filed with the Plan Administrator in writing by the claimant. Written notice of the disposition of a claim shall be furnished the claimant, by the Plan Administrator, within 90 days after the application therefor is filed, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90 day period. Such notice shall specify the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision on such claim. In the event the claim is denied, the Plan Administrator shall specifically set forth:

(a) The specific reason or reasons for the denial;

(b) A specific reference to the pertinent Plan provision on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and any explanation why such material or information is necessary; and

(d) An explanation of the Plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse decision upon review.

If the Plan Administrator shall fail to act within the initial 90 day period without furnishing notice to the claimant of an extension of time for processing the claim, the claimant's application shall be deemed to be denied.

8.03 Request for Review (Claim Review Procedure). Any Participant or Beneficiary of a deceased Participant shall be entitled, upon request to the Plan Administrator, to appeal the denial of his claim. Such appeal shall be submitted to the Plan Administrator, along with a written statement of the claimant's position, no later than 60 days after receipt of the denial, as provided in Section 8.02 above. The claimant, or his duly authorized representative may request review upon written application to the Plan Administrator; to review and/or copy free of charge, pertinent Plan documents, records, and other information relevant to the claimant's claim; submit issues and ; and submit documents, records and other information relating to the claim. The decision on review shall be made by the Plan Administrator, who may, in its discretion, hold a hearing on the denied claim. The review shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator shall make an independent determination of the issue(s) raised by the claimant within the following 60 days and shall given written notice to the applicant of its determination. However, if there are special circumstances requiring an extension of time for processing, a decision shall be rendered within 120 days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. Such notice of extension shall indicate the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render the determination on review. All decisions on review shall be in writing and shall be delivered to the claimant as soon as possible, but not later than 5 days after the claim determination is made. Such notice shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with the specific reason or reasons for the denial of the claim, specific references to the pertinent Plan provisions on which the decision is based and a statement that the claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits, as well as a statement of the claimant's right to bring an action under Section 502(a) of ERISA. In the event that the decision on review is not furnished within the time period set forth above, the claim shall be deemed denied on review. Unless a court of competent jurisdiction determines otherwise, the decision of the Plan Administrator on any appeal shall be final and conclusive.

8.04 Records and Reports. The Plan Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with ERISA and governmental regulations issued thereunder relating to records of Participants' eligibility, notifications to Participants, annual reports to the Internal Revenue Service, and necessary filings with the Department of Labor and the Internal Revenue Service.

8.05 Other Powers and Duties. The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

- (a) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder;
- (b) to prescribe the uniform procedures to be followed by Participants or Beneficiaries filing applications for benefits, loans or withdrawals;
- (c) to prepare and distribute, in such manner as it determines to be appropriate, information explaining the Plan;
- (d) to receive from the Participating Employers and from Participants such information as shall be necessary for the proper administration of the Plan;
- (e) to furnish the Company, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
- (f) to receive, review and keep on file (as deemed convenient and proper) reports of benefit payments by the Trustee and reports of disbursements for administrative expenses; and
- (g) to appoint or employ individuals to assist in the administration of the Plan and any other agents deemed advisable, including legal and actuarial counsel.

Except by formal amendment, the Plan Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or to add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

8.06 Rules and Decisions. The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All such rules and

decisions shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant or Beneficiary, the Company, the legal counsel of the Company, or the Trustee.

- 8.07 Authorization of Benefit Payments. The Plan Administrator shall issue directions to the Trustee concerning all benefits which are to be paid from the Trust pursuant to the provisions of the Plan and warrants that all such directions are in accordance with this Plan.
- 8.08 Application Forms for Benefits. The Plan Administrator may require a Participant to complete and file an application for benefits and all other forms approved by the Plan Administrator, and to furnish all pertinent information requested by the Plan Administrator. The Plan Administrator may rely upon all such information furnished to it, including the Participant's current mailing address.
- 8.09 Indemnification by the Company. To the extent any individuals acting hereunder as either a Plan Administrator, named fiduciary, Trustee, or as members of any advisory committee, if applicable, are not indemnified or saved harmless under any liability insurance contracts, the Company does hereby agree to and does hereby indemnify and agree to defend said persons and to hold them harmless from and against any and all liabilities, losses, costs or expenses including reasonable attorneys' fees and court costs, of whatsoever kind and nature which may be imposed upon, incurred by or asserted against, said persons at any time by reason of any such persons, services hereunder or to the Plan, provided, however, the foregoing shall not apply to a particular person if he should be guilty of willful misconduct or gross negligence, or of a willful violation of the law or regulation under which such liability, loss, or expense arises.

ARTICLE IX.  
INVESTMENT FUNDS

- 9.01 Investment Funds. The Trustee shall invest all or a portion of the Participant's Accounts among such Investment Funds in the Trust as may be approved by the Plan Administrator from time to time in the amounts and manner set forth in this Article IX.
- 9.02 Participant's Choice of Investment Funds.
- (a) Each Participant shall have the right to direct in writing to the Plan Administrator, that the value of his existing Accounts be invested among the various Investment Funds from time to time offered by the Plan Administrator. The Plan Administrator shall establish such rules and procedures as it may deem desirable for the administration of such elections.
- (b) All contributions made pursuant to Article IV shall be invested in accordance with the most recent investment election made by the Participant.
- (c) The Trustee shall comply with such investment directions of Participants, Accounts made in accordance with this Section until such persons give timely investment direction to the Administrator. Notwithstanding any provision in this Section, a Participant's investment direction shall be subject to any transfer restrictions imposed by an Investment Fund, the Plan Administrator or the Trustee. All transfers among the Investment Funds shall be effectuated as soon as may be practicable under the then circumstances and neither the Trustee, the Plan Administrator nor any investment manager shall be liable for any loss that may be incurred by any Participant as a result of any delay in transferring Accounts among the Investment Funds.
- (d) The Plan is a plan which is described in ERISA Section 404(c) under which each Participant or Beneficiary shall exercise control over the assets in his or her Accounts and shall be provided the opportunity to choose, from a broad range of investments, the manner in which the assets in his or her Accounts are invested. The Participant or Beneficiary shall not be deemed to be a fiduciary by reason of his or her exercise of control and no person who is otherwise a fiduciary shall be liable for any loss or by reason of any breach which results from such exercise of control, whether by the Participant's or Beneficiary's affirmative direction or failure to direct an investment. In addition, no account shall bear any loss or have any responsibility or liability for any investment directed by any other Participant or Beneficiary with respect to his or her Accounts.

ARTICLE X.  
GENERAL PROVISIONS

- 10.01 Inalienability. Except with respect to any indebtedness owing to the Trust, if any, or as provided in Section 10.11 or Section 10.12, no

benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge prior to actual receipt thereof by the payee; and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge prior to such receipt shall be void; nor shall the Trust be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any person entitled to any benefit hereunder.

- 10.02 Unclaimed Benefits. If all or any part of the Accounts of any Participant, Former Participant or Beneficiary becomes distributable hereunder and the address of the person entitled thereto is unknown, and the Plan Administrator, after making a reasonable effort to locate all persons entitled to benefits under the Plan, fails to receive a claim for such distribution from the person entitled thereto or from any other person validly acting in his behalf, then such distribution may, on the direction of the Plan Administrator, be disposed of as follows:
- (a) The Plan Administrator shall first send a certified letter to any person entitled to such Accounts at their last known address advising them that their interest in such Accounts shall be suspended unless the Plan Administrator is contacted within 3 months of receipt.
  - (b) If within 3 months after such mailing such person has not made a claim, then the Plan Administrator may direct that the Participant's unclaimed Accounts be cancelled on the records of the Plan and the amount thereof used to reduce the Company Matching Contribution for the Plan Year in which such cancellation occurs.
  - (c) If the person entitled to the Participant's cancelled Accounts subsequently makes a valid claim with respect to such reallocated amounts, the Participating Employer shall make a contribution to the Plan in an amount necessary to restore the Participant's Accounts. Any application of payments made in accordance with this Section shall fully acquit and discharge the Company, the Plan Administrator and the Trustee from all further liability on account thereof.
- 10.03 Non-Guarantee of Employment. Nothing contained in this Plan shall be construed as a contract of employment between any Related Entity and any individual, or as a right of any individual to be continued in the employment of the Company, or as a limitation of the right of the Related Entities to discharge any individual with or without cause.
- 10.04 No Right to Trust Fund. No Employee shall have any right to, or interest in, any part of the Trust upon termination of his employment or otherwise except as provided from time to time under this Plan, and then only to the extent of the benefits payable to such Employee out of the assets in the Trust. All payments of benefits as provided for in this Plan shall be made solely out of the assets in the Trust and neither the Company nor the Trustee shall be liable therefor in any manner.
- 10.05 Non-Liability Provisions. Subject to any limitation on the application of this Section 10.05 pursuant to ERISA, neither the Company, Plan Administrator or the Trustee guarantee the Trust in any manner against loss or depreciation, and none of them shall be liable for any act or failure to act which is made in good faith pursuant to the provisions of the Plan. The Company shall not be responsible for any act or failure to act of the Trustee. The Plan Administrator shall not be responsible for any act or failure to act of the Company or the Trustee. The Plan Administrator shall be indemnified by the Company against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.
- 10.06 Applicable Law. Except as otherwise provided for under ERISA, all questions pertaining to the construction of the Plan shall be determined in accordance with the laws of the State of Illinois.
- 10.07 Litigation by Participants. If any person beneficially interested in the Trust shall bring any suit or proceeding against the Trustee or the Trust, or if any dispute shall arise as to the person or persons to whom payment or delivery of any funds shall be made by the Trustee, the cost to the Trustee of defending the action, where the result is adverse to the complainant or pursuant to the court authorization, shall be charged to the Accounts of the Participant whose interest is at issue, and only the excess, if any, shall be included in the expenses of the Trust.
- 10.08 Tax Releases. Prior to making any payment or distribution hereunder to any person, the Trustee may require such releases, documentation or such other indemnity from the payee or distributee as the Trustee shall reasonably deem necessary for its protection, and may deduct from the amount to which such person may be entitled, such amount as, in its discretion, the Trustee deems proper to protect

the Trustee and the Trust against liability on account of death, succession, estate, inheritance, income or other taxes and out of the money so deducted may discharge any such liability and pay the balance to the person or persons entitled thereto.

- 10.09 Inspection of Records. No person shall have any right to inspect any records of the Company or to inspect any records of the Trustee with respect to any person's rights hereunder.
- 10.10 Pronouns. Masculine pronouns used herein shall refer to men or women or both and nouns and pronouns when stated in the singular shall include the plural and when stated in the plural shall include the singular wherever appropriate.
- 10.11 Qualified Domestic Relations Order. In addition to payments made under Article VI on account of a Participant's termination of employment, payments may be made to an Alternate Payee (as defined below) prior to, coincident with, or after Participant's termination of employment if made pursuant to a Qualified Domestic Relations Order. In any event, however, payments to an Alternate Payee pursuant to a Qualified Domestic Relations Order may not commence prior to the earlier of (a) the date on which the Participant corresponding to the Qualified Domestic Relations Order is entitled to a distribution under the Plan; or (b) the later of (i) the date on which such Participant attains age 50 or (ii) the earliest date on which such Participant could begin receiving benefits under the Plan if the Participant had separated from service. In addition, this Plan specifically authorizes distributions to an Alternate Payee under a Qualified Domestic Relations Order regardless of whether the Participant has attained the earliest retirement age (as defined above and in Section 414(p) of the Code) only if: (A) the order specifies distribution at the earlier date or permits an agreement between the Plan and (B) the Alternate Payee consents to a distribution prior to the Participant's earliest retirement age if the present value of the Alternate Payee benefits under the Plan exceeds \$5,000. Nothing in this Section 10.11 shall permit a Participant a right to receive distribution at a time otherwise not permitted under the Plan, nor shall it permit the Alternate Payee to receive a form of payment not permitted under the Plan.

The Plan Administrator shall establish reasonable procedures to determine the qualified status of domestic relations orders and to administer distributions under such qualified orders, including, in its sole discretion, the establishment of segregated accounts for Alternate Payees. All expenses incurred by the Plan Administrator in determining the qualified status of a domestic relations order or in administering a qualified order may be charged to the Accounts of the Participant to whom such order relates.

- 10.12 Certain Offsets of a Participant's Accounts.
- (a) Notwithstanding Section 10.01 or any other provision of the Plan to the contrary, upon receipt by the Plan Administrator of a judgment, order, decree or settlement agreement that was entered into on or after August 5, 1997, described in subsection (b) which expressly provides for an offset against all or part of an amount ordered or required to be paid to the Plan against a Participant's Accounts under the Plan, such Participant's Accounts shall be reduced or offset by the amount specified in such judgment, order, decree or settlement agreement and such amount shall promptly be paid to the Plan.
- (b) The judgment, order, decree or settlement agreement described in subsection (a) must arise from
- (i) a judgment of conviction for a crime involving the Plan,
- (ii) a civil judgment (including a consent order or decree) entered by a court in an action brought in connection with a violation (or alleged violation) of Part 4 of ERISA, or
- (iii) a settlement agreement between the Secretary of Labor or the Pension Benefit Guaranty Corporation and the Participant in connection with a violation (or alleged violation) of Part 4 of ERISA by a fiduciary or any other person.

#### ARTICLE XI. AMENDMENTS

- 11.01 Amendments. The Company, reserves the right to amend this Plan at any time and from time to time by resolution adopted by it, and all persons claiming any interest hereunder shall be bound thereby; provided, that no amendment shall have the effect of prejudicing the interest of any Participant or Beneficiary in his Accounts as of the date of such amendment or of changing the rights, duties, or responsibilities of the Trustee without its written consent. No amendment making the vesting provisions more restrictive shall apply to a Participant having at least 3 years of service as defined in Section

411(a)(5) of the Code using a Plan Year 12 month period as of the date such amendment becomes effective. It is the intention of the Company that all amounts transferred to the Trustee hereunder are irrevocably set aside for the benefit of Participants and Beneficiaries, and the Company does not reserve any right, title or interest in any funds transferred to the Trustee except as provided in Section 4.02(e). No amendment to the Plan shall decrease a Participant's Accounts or, unless otherwise permitted by the Secretary of the Treasury, Code Regulation's and/or rulings, eliminate an optional form of distribution.

ARTICLE XII.  
TERMINATION

- 12.01 Right to Terminate Plan. The Company contemplates that the Plan shall be permanent and that it shall be able to make contributions to the Plan. Nevertheless, in recognition of the fact that future conditions and circumstances cannot now be entirely foreseen, the Company reserves the right to terminate either the Plan or both the Plan and the Trust.
- 12.02 Merger or Consolidation of Plan and Trust. Neither the Plan nor the Trust may be merged or consolidated with, nor may its assets or liabilities be transferred to, any other plan or trust, unless each Participant would, if the Plan then terminated receive a benefit immediately after the merger, consolidation, or transfer which is equal to or greater than the benefit he would have been entitled to receive immediately before the merger, consolidation, or transfer, if the Plan had then terminated.
- 12.03 Discontinuance of Contributions. Whenever a Participating Employer determines that it is impossible or inadvisable for it to make further contributions as provided in the Plan, the Participating Employer may adopt an appropriate resolution permanently discontinuing all further contributions without terminating the Plan and/or Trust. A certified copy of such resolution or similar document shall be delivered to the Trustee, and the Plan Administrator. Thereafter, the Trustee shall continue to administer all the provisions of the Plan which are necessary and remain in force, other than the provisions relating to contributions by the Participating Employer. However, the Trust shall remain in existence with respect to the Company and all of the provisions of the Trust Agreement shall remain in force except as provided in Section 12.05.
- 12.04 Termination of Plan and Trust. If the Company decides to terminate the Plan and Trust partially or completely they shall be terminated insofar as they are applicable to such affected Participants as of the date specified by resolution of the Company, delivered to the Trustee. Upon such partial or complete termination of the Plan and Trust, the Trust may continue to be held by the Trustee for the benefit of the Participants and Beneficiaries to be distributed in accordance with Article VI until all assets have been completely paid out.
- 12.05 Effect of Discontinuance or Termination on Vesting. In the event of a discontinuance of contributions as provided in Section 12.03 or a "complete" or "partial" termination of the Plan, as those terms are defined in the Code and/or rulings, such affected Employees shall, notwithstanding any other provision of the Plan, be 100% nonforfeitably vested as of the effective date of such discontinuance or termination, respectively, in the value of their Accounts after adjustments for related expenses and/or unallocated Trust profits, losses or contributions have been made.

ARTICLE XIII.  
TOP HEAVY PLANS

- 13.01 Top Heavy Plan Requirements. Notwithstanding anything hereinabove to the contrary, if the Plan is a Top Heavy Plan as determined pursuant to this Article XIII for any Plan Year then the Plan shall meet the requirements of this Article XIII for any such Plan Year.
- 13.02 Top Heavy Plan Definitions:
- (a) Aggregation Group means:
- (i) Mandatory Aggregation Group. Each plan of any Related Entity in which a Key Employee is a participant, and each other plan of any Related Entity which enables any plan of a Related Entity in which a Key Employee is a participant to meet the nondiscrimination and participation requirements of Sections 401(a)(4) or 410 of the Code.
- (ii) Permissive Aggregation Group. All plans of a Related Entity included in the Mandatory Aggregation Group and any other plan sponsored by a Related Entity which the Company elects to include as part of the group and which continues to satisfy the nondiscrimination and participation requirements

of Sections 401(a)(4) and 410 of the Code.

In determining which plans of a Related Entity are part of an Aggregation Group, only plan years with Determination Dates which fall within the same calendar year shall be aggregated.

- (b) Determination Date means, as to any Plan Year, the last day of the preceding Plan Year.
- (c) Key Employee means any Employee or former Employee, who during the Plan Year or during any of the preceding 4 Plan Years is any of the following:
  - (i) An officer of any Related Entity having compensation (as determined applying the definition of compensation set forth in Section 415(c)(3) of the Code) equal to 1.5 times the Code Section 415 dollar limit for defined contribution plans, or for Determination Dates occurring on and after January 1, 2002 compensation greater than \$130,000 (as adjusted under Code Section 416(i)(1)). The number of persons to be considered officers in any Plan Year and the identity of the person to be so considered shall be determined pursuant to the provisions of Section 416(i) of the Code;
  - (ii) For Determination Dates occurring prior to January 1, 2002, one of the 10 Employees who:
    - (A) owns or who is considered to own under the attribution rules set forth in Section 318 of the Code both more than a 1/2% interest and the largest interest in a Related Entity; and
    - (B) has, during the Plan Year of ownership, annual Plan Year compensation from a Related Entity more than the compensation which is set forth in Section 415(c)(1)(A) of the Code for the calendar year in which such Plan Year ends;
    - (C) a person who is both an Employee and the owner of a greater than 5% capital or profits interest in the Company, and any person who owns, or who, under Section 318 of the Code, is considered as owning more than 5% of the outstanding stock of the Company or of stock possessing more than 5% of the total combined voting power of all stock of such entity.
  - (iii) A person who is both an Employee whose annual compensation (as determined applying the definition of compensation set forth in Section 415(c)(3) of the Code) from all Related Entities exceeds \$150,000 and who is a greater than 1% owner of the Company, with ownership determined pursuant to Section 13.02(c)(iii) by substituting "1%" for "5%" at each place where "5%" is set forth therein.
  - (iv) For purposes of this Section 13.02(c) , when applying the constructive ownership rules under Section 318 of the Code, "5%," shall be substituted for "50%" in Section 318(a)(2)(C) of the Code. The determination of who is a Key Employee will be made in accordance with Section 416(i)(1) of the Code and the Code regulations.

The Beneficiary of any deceased Participant who was a Key Employee shall be considered a Key Employee for the same period as the deceased Participant would have been so considered.

- (d) Key Employee Ratio means the ratio for any Plan Year, as of the Determination Date with respect to such Plan Year, determined by comparing the amount described in Section 13.02(d)(i) with the amount described in Section 13.02(d)(ii) after deduction from both such amounts the amount described in Section 13.02(d)(iii) .
  - (i) The amount described in this Section 13.02(d)(i) is the sum of:
    - (A) the aggregate of the present value of all accrued benefits of Key Employees under all qualified defined benefit plans included in the Aggregation Group;
    - (B) the aggregate of the balances in all of the accounts standing to the credit of Key Employees under all qualified defined contribution plans included in the Aggregation Group; and
    - (C) the aggregate amount distributed from all plans in such Aggregation Group to or on behalf of any Key Employee during the period of 5 Plan Years ending on the Determination Date (effective January 1, 2002, such period shall be the 1 year period ending on the Determination Date in the case of distributions

made on account of separation from service, death or disability).

- (ii) The amount described in this Section 13.02(d) (ii) is the sum of:
  - (A) the aggregate of the present value of all accrued benefits of all Participants under all qualified defined benefit plans included in the Aggregation Group.
  - (B) the aggregate of all balances in all of the accounts standing to the credit of all Participants under all qualified defined contribution plans included in the Aggregation Group; and
  - (C) the aggregate amount distributed from all plans in such Aggregation Group to or on behalf of any Participant during the period of 5 Plan Years ending on the Determination Date (effective January 1, 2002, such period shall be the 1 year period ending on the Determination Date in the case of distributions made on account of separation from service, death or disability).
- (iii) The amount described in 13.02(d) (iii) is the sum of:
  - (A) all rollover contributions and trustee transfers which are initiated by an Employee and made from a plan maintained by one unrelated employer to a plan maintained by another unrelated employer to the Plan; and
  - (B) any amount that is included in Section 13.02(d) (ii) hereof for, on behalf of, or on account of, a person who is a Non-Key Employee as to the Plan Year of reference but who was a Key Employee as to any earlier Plan Year.

For purposes of determining the Key Employee Ratio, accrued benefits and account balances attributable to employee contributions, other than amounts attributable to deductible Employee contributions, shall be taken into consideration. The account balances and accrued benefits of a Participant who has not performed any services for a Related Entity at any time during the 5 year period ending on the Determination Date will be disregarded (effective January 1, 2002 such period shall be the 1 year period ending on the Determination Date).

- (e) Non-Key Employee means any Participant in the Plan (including a Beneficiary of such Participant) who is not a Key Employee.
- (f) Super Top Heavy means this Plan for any Plan Year in which this Plan would be deemed a "Top Heavy Plan" if "90%" were substituted for "60%" wherever it appears in Section 13.02(g) .
- (g) Top Heavy Plan. This Plan shall be deemed "Top Heavy" as to any applicable Plan Year if, as of the Determination Date with respect to such Plan Year, any of the following conditions are met:
  - (i) The Plan is not part of an Aggregation Group and the Key Employee Ratio under the Plan exceeds 60%.
  - (ii) The Plan is part of an Aggregation Group, there is no Permissive Aggregation Group of which the Plan is a part, and the Key Employee Ratio of the Mandatory Aggregation Group of which the Plan is a part exceeds 60%.
  - (iii) The Plan is part of an Aggregation Group, there is a Permissive Aggregation Group of which the Plan is a part, and the Key Employee Ratio of the Permissive Aggregation Group of which the Plan is a part exceeds 60%.

13.03 Right to Participate in Allocation of Company Contributions. Notwithstanding any other provision of this Plan, any person who was a Participant at any time during a Plan Year in which this Plan was a Top Heavy Plan shall share in the allocations of Company contributions provided for in this Plan for such Plan Year if he remained in the employ of a Related Entity through the end of the Plan Year with respect to which such allocation applies.

13.04 Minimum Company Contribution Allocation. The allocation made under this Plan to the Account of each Participant who is entitled to an allocation pursuant to the provisions of Section 13.03 and who is a Non-Key Employee for any Plan Year in which this Plan is a Top Heavy Plan or a Super Top Heavy Plan shall not be less than the lesser of:

- (a) 3% of the total compensation as defined in Section 415 of the Code but limited to \$200,000 of such compensation adjusted as provided in Code Section 416(d) (2) by the Secretary of the Treasury of each such Participant for such computation period; or

- (b) The percentage of compensation so allocated under this Plan to the Account of the Key Employee for whom such percentage is the highest for such Plan Year.

This Section 13.04 shall not apply to any Participant to the extent the Participant is covered under any other plan sponsored by a Related Entity provided the minimum allocation or benefit requirement applicable to Top Heavy Plans will be met in the other plan or plans. For the purposes of determining whether or not the provisions of this Section 13.04 have been satisfied:

- (i) contributions or benefits under Chapter 2 of the Code (relating to tax on self-employment income), Chapter 21 of the Code (relating to Federal Insurance Contributions Act), Title 11 of the Social Security Act, or any other Federal or state laws are disregarded;
- (ii) Company contributions made under any salary reduction or similar arrangement shall be disregarded; and
- (iii) Effective January 1, 2002, Matching Contributions under this Plan and any other plan of a Related Entity shall be taken into account for purposes of satisfying the minimum contribution requirements of Code Section 416(c)(2) and this Section 13.04.

IN WITNESS WHEREOF, the Company has caused these presents to be executed by its duly authorized officers on this \_\_\_\_ day of \_\_\_\_\_, 2002.

FIRST HEALTH GROUP CORP.

By: \_\_\_\_\_  
Edward L. Wristen  
President and Chief Executive Officer

By: \_\_\_\_\_  
Joseph E. Whitters  
Vice President, Finance and Chief Financial Officer

2002 AMENDMENT AND RESTATEMENT OF  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN

APPENDIX A

This Appendix A contains provisions which modify and supplement the Plan with respect to individuals who became Participants in the Plan ("CCN Participants") upon the merger of the CCN, Inc. 401(k) Plan (the "CCN Plan") with the Plan on January 1, 2002.

Section AII - Definitions

A2.1 Accounts. CCN Participants shall have the following additional Accounts maintained under the Plan adjusted in each case for such Account's share in the increase or decrease in the net worth of the Trust and withdrawals as provided in Article V:

After-Tax Contribution Account means the separate account maintained for each CCN Participant to which his after-tax contributions made under the CCN Plan are credited. A CCN Participant shall be fully vested in his After-Tax Contribution Account at all times.

CCN Matching Contribution Account means the sub-account of a CCN Participant's Matching Contribution Account which reflects the matching contributions credited to such CCN Participant under the CCN Plan and the earnings and losses thereon.

Employer Contribution Account means the separate account maintained for each CCN Participant to which employer contributions made under the CCN Plan on behalf of the CCN Participant and earnings and losses thereon are credited. A CCN Participant shall be fully vested in his Employer Contribution Account at all times.

A2.2 CCN Participant means each participant in the CCN Plan on December 31, 2001, whose accounts under the CCN Plan were transferred to and merged into the Plan on January 1, 2002.

A2.3 CCN Plan means the CCN, Inc. 401(k) Plan as in existence on December 31, 2001, which merged with and into the Plan on January 1, 2002.

A2.4 Year of Service with respect to each CCN Participant includes each Year of Service credited under the CCN Plan prior to December 31, 2001.

Section A-VI - Distributions

A6.1 Partially Vested Accounts. A CCN Participant shall vest in the balance of his CCN Matching Contribution Account in accordance with the following schedule:

Number of Completed Years of Service	Vested Percentage
Less than 1 year	0%
1 year but less than 2 years	33 1/3%
2 years but less than 3 years	66 2/3%
3 years or more	100%

The vested balances of a CCN Participant's Matching Account, if any, and the balances of his 401(k) Account, After Tax Account, Employer Contribution Account and Rollover Account as of any Valuation Date

coincident with or next following his Termination Date (after all adjustments then required under the Plan have been made may become distributable in accordance with the applicable provisions of this Article VI. The unvested portion of a Participant's Matching Account on his Termination Date shall be forfeited in accordance with the provisions of Section 6.04 of the Plan.

A6.2 Form of Distribution. The provisions of this Section A6.2 shall only apply to distributions to CCN Participants made prior to March 31, 2002.

- (a) Distributions to Unmarried Participants. Upon termination of employment by an unmarried Participant, the Participant shall be paid his Account balances in cash under any one or more of the options described in Section 6.05(a) or (b) or in the form of a single life annuity, as determined by the Participant. If the Participant fails to elect the form of distribution, then such distribution will be made in the form of a single life annuity.
- (b) Distributions to Married Participants. When a married Participant becomes entitled to a distribution from his Accounts and the balance in his Accounts (excluding his Rollover Account) exceeds \$5,000, the distribution will

be made in accordance with the following requirements:

- (i) Unless the married Participant makes a Qualified Election (as defined in paragraph (c) below) to receive payment of his Accounts in a manner described in Section 6.05, his Accounts will be paid in the form of a Joint and Survivor Annuity. A Joint and Survivor Annuity is an annuity for the life of the Participant with a survivor annuity for the life of the spouse equal to 50 percent of the amount of the annuity which is payable during the joint lives of the Participant and the spouse. The actuarial value of the Joint and Survivor Annuity will equal the value of the Participant's Accounts.
- (ii) To assist a married Participant in determining whether to make a Qualified Election, the Plan Administrator shall provide the Participant with a written explanation of the following within a reasonable period of time prior to commencement of the payment of his Accounts.
  - (a) the terms and conditions of a Joint and Survivor Annuity,
  - (b) the Participant's right to make, and the effect of, a Qualified Election to waive the Joint and Survivor Annuity form of benefit,
  - (c) the rights of a Participant's Spouse, and
  - (d) the right to make, and the effect of, a revocation of a previous Qualified Election to waive the Joint and Survivor Annuity.
- (c) For an election to waive a Joint and Survivor Annuity to be effective, it must meet the requirements of this paragraph (c) (a "Qualified Election"). A Qualified Election must be consented to in writing by the Participant's spouse. The spouse's consent must acknowledge the effect of the Qualified Election and be witnessed by a Plan representative or a notary public. The consent will be effective only as to the non-spouse Beneficiary or form of benefit named therein. A new consent must be obtained if the non-spouse Beneficiary or form of benefit is changed. A spouse's consent will not be required, however, if the Participant establishes to the satisfaction of the Committee that the consent may not be obtained because there is no spouse, the spouse cannot be found or another reasonable excuse. A Qualified Election to waive a Joint and Survivor Annuity must be made within the 90 day period ending on the date payment of the Participant's Accounts would commence. If a Participant makes a Qualified Election to waive the Joint and Survivor Annuity, his Accounts will be paid in the manner elected by the Participant under Section 6.05.

#### AVII- Loans and Withdrawals

A7.1 Spousal Consent to Loan. A married CCN Participant receiving a loan from the Plan prior to March 31, 2002 must obtain the consent of his spouse to use his Accounts as security for the loan. The spousal consent must be obtained within the 90-day period prior to the date on which the loan is made (or renegotiated, extended, renewed or revised). Furthermore, the spousal consent must be in writing, acknowledge the effect of the loan and be witnessed by a Plan representative or notary public. A spousal consent, however, will not be required if the Participant establishes to the satisfaction of the Plan Administrator that the consent may not be obtained because there is no spouse, the spouse cannot be found or another reasonable excuse.

A7.2 Spousal Consent - Withdrawals. A married CCN Participant making a withdrawal under Section 7.02, 7.03, 7.04 or A7.3 prior to March 31, 2002 must obtain the consent of his spouse to the withdrawal. The spousal consent must be obtained within the 90-day period prior to the date on which the withdrawal is made. The Participant receiving a withdrawal from the Plan must obtain the consent of his spouse to use his Accounts as security for the withdrawal. The spousal consent must be obtained within the 90- day period prior to the date on which withdrawal is made (or renegotiated, extended, renewed or revised). Furthermore, the spousal consent must be in writing, acknowledge the effect of the withdrawal and be witnessed by a Plan representative or notary public. A spousal consent, however, will not be required if the Participant establishes to the satisfaction of the Plan Administrator that the consent may not be obtained because there is no spouse, the spouse cannot be found or another reasonable excuse.

A7.3 Withdrawal of After-Tax and Employer Contribution Accounts. A CCN Participant may withdraw all or any portion of the balance of his After-Tax Account and/or Employer Contribution Account at any time for any reason upon written request to the Plan Administrator in such form and at

such time as the Plan Administrator shall require.

FIRST AMENDMENT TO  
2002 RESTATEMENT OF THE  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN

Effective September 1, 1986, HealthCare COMPARE Corp. established the HealthCare COMPARE Corp. Retirement Savings (the "Plan") in order to provide benefits for eligible employees. Effective September 1, 1987, the Plan was amended and restated to comply with various changes in the tax laws and to reflect plan mergers. HealthCare COMPARE Corp. changed its name to First Health Group Corp. (the "Company") and changed the name of the Plan to the First Health Group Corp. Retirement Savings Plan. The Plan has been amended from time to time.

In order to make certain administrative changes to the Plan, the Plan is hereby amended, effective as set forth below.

1. Effective as of January 1, 2001, Section 2.09 of the Plan is hereby amended to read in its entirety as follows:

2.09 Compensation for any period means all compensation paid by a Participating Employer for services rendered, including commissions, amounts contributed as Salary Reduction Contributions to the Plan, any amounts contributed by the Participant pursuant to a salary reduction agreement for a cafeteria plan under Section 125 of the Code or qualified transportation fringe benefits under Code Section 132(f)(4), overtime pay, bonuses, and commissions, but excludes any Participant's share in any Company contributions hereto, and to any other employee benefit or insurance program, imputed income or reimbursement of relocation expenses. Compensation in excess of the applicable dollar limitation set forth in Code Section 401(a)(17) (as adjusted for cost of living increases) each Plan Year shall be disregarded for all Plan purposes.

2. Effective as of January 1, 2002, Section 2.12 of the Plan is hereby amended to read in its entirety as follows:

2.12 Disability means an Active or Inactive Participant's termination of employment with a Participating Employer and Related Entities as a result of a mental or physical disease or condition which entitles such a Participant (or would entitle, after expiration of applicable waiting periods) to long term disability benefits under the long term disability plan offered to its Employees by the Company or, if such Participant does not participate in such plan, would be so entitled if he did participate.

3. Effective as of April 1, 2002, Section 2.15 of the Plan is hereby amended to read in its entirety as follows:

2.15 Eligible Employee means an Employee of a Participating Employer, other than

- (a) any Employee the terms of whose employment are governed by the provisions of a collective bargaining agreement with respect to which retirement benefits were the subject of good faith negotiations unless such agreement specifically provides for his coverage hereunder;
- (b) any Leased Employee (unless the provisions of Section 414(n) of the Code require participation in the Plan by Leased Employees, in which case Leased Employees shall be Eligible Employees); and
- (c) any individual whose services with a Participating Employer are performed pursuant to a contract which purports to treat the individual as an independent contractor, even if such individual is later determined (by judicial action or otherwise) to have been a common law employee of the Participating Employer rather than an independent contractor.

4. Effective as of April 1, 2002, Section 2.18 of the Plan is hereby amended to read in its entirety as follows:

2.18 Entry Date means the first full payroll period of the calendar month coincident with or next following the Eligible Employee's completion of the requirements set forth in Section 3.01.

5. Effective as of April 1, 2002, Section 3.01 of the Plan is hereby amended to read in its entirety as follows:

3.01 Active Participant Eligibility Requirements. Each Eligible Employee shall become an Active Participant on the first Entry Date after, or on which, the Eligible Employee attains age 21 and completes the following service:

- (a) if the Eligible Employee is classified as a full-time Employee, three consecutive months of service with a Participating Employer, or
- (b) if the Eligible Employee is not classified as described in subsection (a), 1,000 Hours of Service during any one of the following periods of service with a Participating Employer, whichever occurs first:
  - (i) the 12-consecutive month period beginning on his hire date, or
  - (ii) any Plan Year beginning with the Plan Year which includes the first anniversary of his hire date;

provided that he is still an Eligible Employee on such date. Each Participant in the Plan immediately prior to the Effective Date shall continue to be a Participant in the Plan on and after the Effective Date subject to the limitations of the Plan.

6. Effective as of April 1, 2002, Section 3.04 of the Plan is hereby amended to read in its entirety as follows:

3.04 Effect of Reemployment on Participation and Service.

- (a) A Former Participant who is reemployed as an Eligible Employee, prior to incurring a Break in Service shall resume active participation in the Plan on the date of his return to employment as an Eligible Employee. As of the date he again becomes an Active Participant, such Participant's Years of Service as of the date of his prior termination of employment shall be restored.
- (b) A Former Participant who is reemployed as an Eligible Employee after having incurred a Break in Service shall be eligible to resume participation in the Plan as an Active Participant on the date of his return to employment as an Eligible Employee provided (i) such Participant's vested percentage as determined under Section 6.03 is more than 0%; or (ii) he has not incurred five or more consecutive one year Breaks in Service. As of the date he again becomes an Active Participant, such Participant's Years of Service (or consecutive months of service, as applicable) as of the date of his prior termination of employment shall be restored, provided such Participant completes a Year of Service after his reemployment.
- (c) In the event a Former Participant does not have any vested percentage as determined under Section 6.03 and the number of his consecutive one year Breaks in Service equals or exceeds five, then his Years of Service (or consecutive months of service, as applicable), if any, completed prior to such period of such one year Breaks in Service shall be disregarded and he shall become an Active Participant on the date he again satisfies the requirements set forth in Section 3.01.

7. Effective as of January 1, 1997, the last sentence of Section 4.01(a)(i) of the Plan is hereby amended to read in its entirety as follows:

Except as provided in Section 4.08, no Participant may make Salary Reduction Contributions under this Plan and any other qualified plan maintained by a Related Entity during the Plan Year in excess of dollar limitation contained in Code Section 402(g)(1) for such year.

8. Effective as of April 1, 2002, Section 4.02(b) of the Plan is hereby amended to read in its entirety as follows:

- (b) Eligibility and Allocation of Matching Contributions. Each Active Participant who has completed one Year of Service shall be eligible to receive a Matching Contribution. Matching Contributions will be made starting with the first full payroll period of the calendar month coincident with or next following the Eligible Employee's completion of one Year of Service. Matching Contributions shall be allocated as of the last day of each Contribution Period to the Matching Account of each Participant who makes Salary Reduction Contributions during such Contribution Period.

9. Effective as of the dates set forth below, the first sentence of Section 4.03(b)(iii) of the Plan is hereby amended to read in its entirety as follows:

For the purpose of determining the maximum allocation permitted by Section 4.03(a) (and notwithstanding the definition of Compensation used elsewhere in this Plan) Total Compensation shall mean, with respect to any Limitation Year, the Employee's wages, salaries for professional services, other amounts paid over the entire Plan Year

for personal services actually rendered (including, but not limited to, commissions paid salesmen, compensation for services on the basis of percentage of profits, commissions on insurance premiums, tips and bonuses) and, effective as of January 1, 1998, including any elective deferral as defined in Code Section 402(g)(3) and any amounts not includable in gross income by reason of Code Section 125 (cafeteria plan) or Code Section 457 (deferred compensation plan of state and local governments and tax-exempt organizations) and, effective as of January 1, 2001, Code Section 132(f)(4) (qualified transportation fringe).

IN WITNESS WHEREOF, the Company has caused these presents to be executed by its duly authorized officers on this \_\_\_\_ date of \_\_\_\_\_, 2002.

FIRST HEALTH GROUP CORP.

By \_\_\_\_\_  
Edward L. Wristen  
President and Chief Executive Officer

By: \_\_\_\_\_  
Joseph E. Whitters  
Vice President and Chief Financial Officer

SECOND AMENDMENT TO  
2002 RESTATEMENT OF THE  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN

Effective September 1, 1986, HealthCare COMPARE Corp. established the HealthCare COMPARE Corp. Retirement Savings (the "Plan") in order to provide benefits for eligible employees. Effective September 1, 1987, the Plan was amended and restated to comply with various changes in the tax laws and to reflect plan mergers. HealthCare COMPARE Corp. changed its name to First Health Group Corp. (the "Company") and changed the name of the Plan to the First Health Group Corp. Retirement Savings Plan. The Plan has been amended from time to time.

In order to (1) provide for the merger of the Healthcare Value Management, Inc. Profit Sharing Plan and the Claims Administration Corporation Employees' Savings Plan into the Plan, and (2) amend the Plan in certain other respects, the Plan is hereby amended, effective as of the dates provided below.

1. Effective as of \_\_\_\_\_, Section 2.08 of the Plan is hereby amended to read in its entirety as follows:

2.08 Company means First Health Group Corp., a Delaware corporation, and any organization with which the Company shall be merged or consolidated, or any organization resulting of the Company, or any individual, firm or corporation which shall assume the obligations of the Company with respect to the Plan.

2. Effective as of January 1, 1998, Section 2.09 of the Plan is hereby amended to read in its entirety as follows:

2.09 Compensation for any period means all compensation paid by a Participating Employer for services rendered, including commissions, amounts contributed as Salary Reduction Contributions to the Plan, any amounts contributed by the Participant pursuant to a salary reduction agreement for a cafeteria plan under Section 125 of the Code (whether or not such amount is "deemed Section 125 compensation" within the meaning of Revenue Ruling 2002-27) or qualified transportation fringe benefits under Code Section 132(f)(4), overtime pay, bonuses, and commissions, but excludes any Participant's share in any Company contributions hereto, and to any other employee benefit or insurance program, imputed income or reimbursement of relocation expenses. Compensation in excess of the applicable dollar limitation set forth in Code Section 401(a)(17) (as adjusted for cost of living increases) each Plan Year shall be disregarded for all Plan purposes.

3. Effective as of January 1, 1998, Section 4.03(b)(iii) of the Plan is hereby amended to read in its entirety as follows:

(iii) Total Compensation. For the purpose of determining the maximum allocation permitted by Section 4.03(a) (and notwithstanding the definition of Compensation used elsewhere in this Plan) Total Compensation shall mean, with respect to any Limitation Year, the Employee's wages, salaries for professional services, other amounts paid over the entire Plan Year for personal services actually rendered (including, but not limited to, commissions paid salesmen, compensation for services on the basis of percentage of profits, commissions on insurance premiums, tips and bonuses) and, effective as of January 1, 1998, including any elective deferral as defined in Code Section 402(g)(3) and any amounts not includable in gross income by reason of Code Section 125 (cafeteria plan) (whether or not such amount is "deemed Section 125 compensation" within the meaning of Revenue Ruling 2002-27) or Code Section 457 (deferred compensation plan of state and local governments and tax-exempt organizations) and, effective as of January 1, 2001, Code Section 132(f)(4) (qualified transportation fringe). Total Compensation does not include:

(A) deferred compensation, including contributions by a Participating Employer to a deferred compensation plan or a simplified employee pension plan and any distribution from a deferred compensation plan,

(B) amounts realized from the exercise of non-qualified stock options and amounts realized from the sale, exchange or other disposition of stock acquired under a qualified stock option,

(C) other amounts which receive special tax benefits such as premiums for group-term insurance (but only to the extent that the premiums are not includible

in the gross income of the Employee except as otherwise provided herein), and

(D) any amounts in excess of the applicable dollar limitation in effect under Code Section 401(a)(17) for such Limitation Year.

4. Effective as of December 31, 2002, the Plan is hereby amended by the addition of Appendices B and C which are attached hereto and incorporated in the Plan by this reference.

IN WITNESS WHEREOF, the Company has caused these presents to be executed by its duly authorized officers on this \_\_\_\_ date of December, 2002.

FIRST HEALTH GROUP CORP.

By \_\_\_\_\_  
Edward L. Wristen  
President and Chief Executive Officer

By: \_\_\_\_\_  
Joseph E. Whitters  
Vice President and Chief Financial Officer

2002 AMENDMENT AND RESTATEMENT OF  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN

APPENDIX B

This Appendix B contains provisions which modify and supplement the Plan with respect to individuals who became Participants in the Plan ("HCVM Participants") prior to the merger of the HealthCare Value Management, Inc. Profit Sharing Plan (the "HCVM Plan") with the Plan on December 31, 2002. HCVM Participants became eligible to participate in the Plan effective as of September 1, 2002.

Article BII - Definitions

B2.01 Accounts. HCVM Participants shall have the following additional HCVM Accounts maintained under the Plan adjusted in each case for such Account's share in the increase or decrease in the net worth of the Trust and withdrawals as provided in Article V:

- (a) HCVM Elective Deferral Account means the sub-account of a HCVM Participant's 401(k) Account which reflects the elective deferral contributions credited to such Participant under the HCVM Plan and the earnings and losses thereon.
- (b) HCVM Matching Contribution Account means the sub-account of a HCVM Participant's Matching Account which reflects the matching contributions credited to such HCVM Participant under the HCVM Plan and the earnings and losses thereon.
- (c) HCVM Discretionary Contribution Account means the separate account maintained for each HCVM Participant to which discretionary employer contributions made under the HCVM Plan on behalf of the HCVM Participant and earnings and losses thereon are credited.
- (d) HCVM Rollover Contribution Account means the sub-account of a HCVM Participant's Rollover Account which reflects the rollover contributions credited to such HCVM Participant under the HCVM Plan on behalf of the HCVM Participant and earnings and losses thereon are credited.

B2.02 Annuity Elimination Date means the date which is 90 days following the date HCVM Participants and Beneficiaries receiving benefits from HCVM Accounts have been furnished a summary that reflects the elimination of the Qualified Joint and Survivor Annuity, life annuity, Optional Forms and Qualified Preretirement Survivor Annuity and that satisfies the requirements of 29 CFR 2520.104b-3 (relating to a summary of material modifications).

B2.03 Distribution Date means the date that a HCVM Participant receives or begins to receive his HCVM Accounts under the Plan as described in Section 6.06 of the Plan; provided, however, that if his total Account balance exceeds \$5,000, a HCVM Participant may elect to receive (or begin to receive) his HCVM Accounts on his Normal Retirement Date even if he continues as an Employee on or after such date.

B2.04 Early Retirement Date means, with respect to the HCVM Accounts of a HCVM Participants, the date that the HCVM Participant attains age 55 and completes 6 Years of Service.

B2.05 HCVM Participant means each participant in the HCVM Plan on December 31, 2002 whose accounts under the HCVM Plan were transferred to and merged into the Plan on December 31, 2002.

B2.06 HCVM Plan means the HealthCare Value Management, Inc. Profit Sharing Plan as in existence on December 31, 2002, which merged with and into the Plan on December 31, 2002.

B2.07 Optional Form means the forms of payment described in Section B6.02(d) that a HCVM Participant may elect prior to the Annuity Elimination Date provided if the HCVM Participant is married, he makes a Qualified Election and provided further that the HCVM Participant's total vested Account balance is greater than \$5,000.

B2.08 Qualified Joint and Survivor Annuity means an annuity for the life of the HCVM Participant with a survivor annuity with installment refund for the life of his surviving spouse for 50 % of the amount of the annuity which is payable during the joint lives of the HCVM Participant and his Spouse. The actuarial value of the Qualified Joint and Survivor Annuity will equal the value of the HCVM Participant's HCVM Accounts.

B2.09 Qualified Preretirement Survivor Annuity means a life annuity with installment refund payable to the HCVM Participant's surviving Spouse. The actuarial value of the Qualified Preretirement Survivor Annuity will equal the value of the HCVM Participant's HCVM Accounts.

B2.10 Year of Service with respect to each HCVM Participant shall include each Year of Service credited under the HCVM Plan as of December 31, 2002.

#### Article BVI - Distributions

B6.01 Partially Vested Accounts. Each HCVM Participant shall become vested in the balance of his HCVM Matching Contribution Account and HCVM Discretionary Contribution Account in accordance with the schedule described in Section 6.03 of the Plan.

B6.02 Form of Distribution. The provisions of this Section B6.02 shall apply only to distributions to HCVM Participants made prior to the Annuity Elimination Date. After the Annuity Elimination Date, Section 6.05 shall apply to HCVM Participants.

- (a) Distributions to Unmarried HCVM Participants. Subject to Section 6.05(e) of the Plan, on an unmarried HCVM Participant's Distribution Date, such HCVM Participant shall receive his vested HCVM Account balance in cash under any one or more of the options described in Section 6.05(a), in the form of a single life annuity or in any one of the Optional Forms described in subsection (c), as determined by the Participant. If the Participant fails to elect the form of distribution, then such distribution will be made in the form of a single life annuity.
- (b) Distributions to Married HCVM Participants. Subject to Section 6.05(e), on a married HCVM Participant's Distribution Date, his HCVM Accounts shall be distributed in accordance with the following requirements:
  - (i) Unless the married HCVM Participant makes a Qualified Election (as defined in paragraph (c) below) to receive payment of his HCVM Accounts in a manner described in Section 6.05 or in an Optional Form, his HCVM Accounts will be paid in the form of a Qualified Joint and Survivor Annuity.
  - (ii) To assist a married HCVM Participant in determining whether to make a Qualified Election, the Plan Administrator shall provide the HCVM Participant with a written explanation of the following within a reasonable period of time prior to commencement of the payment of his HCVM Accounts.
    - (A) the terms and conditions of a Qualified Joint and Survivor Annuity,
    - (B) the HCVM Participant's right to make, and the effect of, a Qualified Election to waive the Qualified Joint and Survivor Annuity form of benefit,
    - (C) the rights of an HCVM Participant's Spouse, and
    - (D) the right to make, and the effect of, a revocation of a previous Qualified Election to waive the Qualified Joint and Survivor Annuity.
- (c) For an election to waive the Qualified Joint and Survivor Annuity or the Qualified Preretirement Survivor Annuity (described in subsection (e)) to be effective, it must meet the requirements of this subsection (c) (a "Qualified Election"). A Qualified Election must be consented to in writing by the HCVM Participant's Spouse. The Spouse's consent must acknowledge the effect of the Qualified Election and be witnessed by a Plan representative or a notary public. The consent will be effective only as to the non-spouse Beneficiary or form of benefit named therein. A new consent must be obtained if the non-spouse Beneficiary or form of benefit is changed. A Spouse's consent will not be required, however, if the HCVM Participant establishes to the satisfaction of the Plan Administrator that the consent may not be obtained because there is no Spouse, the Spouse cannot be found or another reasonable excuse. A Qualified Election to waive a Qualified Joint and Survivor Annuity must be made within the 90 day period ending on the date payment of the HCVM Participant's HCVM Accounts would commence. A Qualified Election to waive the Qualified Preretirement Survivor Annuity may be made by an HCVM Participant who has had a termination of employment, during the period that begins on his termination of employment and ends on the date of his death, or, otherwise during the period which begins on the first day of the Plan Year in which the HCVM Participant attains age 35 and ends on his death. If a HCVM Participant makes a Qualified Election to waive the Qualified Joint and Survivor Annuity, his HCVM Accounts will be paid in the manner elected by the HCVM Participant under subsection (d)

or Section 6.05. If a HCVM Participant makes a Qualified Election to waive the Qualified Preretirement Survivor Annuity, his HCVM Accounts will be paid in the manner elected by the HCVM Participant or the HCVM Participant's Beneficiary in any one of the forms described in subsection (d) or Section 6.05.

- payment:
- (d) Optional Forms shall include the following annuity forms of
    - (i) straight life annuity;
    - (ii) single life annuity with 5, 10 or 15 period certain;
    - (iii) a single life annuity with installment refund;
    - (iv) joint and 50% 66 2/3% and 100% survivor annuity with installment refund;
    - (v) fixed period annuities for any period of whole months which is not less than 60 and does not exceed the life expectancy of the HCVM Participant; and
    - (vi) a full flexibility option.
  - (e) (i) Distributions upon Death of a HCVM Participant. If a HCVM Participant dies before distribution of his HCVM Accounts has been made or commenced and was married on the date of his death and his total Account balance exceeds \$5,000, the entire amount credited to his HCVM Accounts shall be applied to purchase a Qualified Preretirement Survivor Annuity for the benefit of the HCVM Participant's surviving Spouse which shall commence on a date specified by the Spouse which is not later than the later of
    - (A) the first anniversary of the HCVM Participant's death, or
    - (B) the date on which the HCVM Participant would have attained age 70/.
  - (ii) Notwithstanding paragraph (e) (i),
    - (A) if such HCVM Participant made a Qualified Election to waive the Qualified Preretirement Survivor Annuity in accordance with the Rules of Plan, or
    - (B) if such Spouse, after the HCVM Participant's death, elects in accordance with the Rules of the Plan to waive the Qualified Preretirement Survivor Annuity to which such Spouse is otherwise entitled,the entire amount credited to his HCVM Accounts shall be paid to the surviving Spouse in one lump sum in cash not later than the first anniversary of the HCVM Participant's death, or in any one Optional Form within the limits described in Code Section 401(a) (9) or as described in Section 6.05.
  - (iii) Upon the death of a HCVM Participant
    - (A) who was not married on the date of his death, or
    - (B) who was married on the date of his death but made a Qualified Election to waive the Qualified Preretirement Survivor Annuity and properly designated another Beneficiary,the entire amount credited to his HCVM Accounts shall be paid in any Optional Form except the option described in (d) (vi) or as described in Section 6.05, to the Participant's Beneficiary, as elected by the HCVM Participant or the HCVM Participant's Beneficiary, all within the limits described in Code Section 401(a) (9).
  - (iv) To assist a married HCVM Participant in determining whether to make a Qualified Election to waive the Qualified Preretirement Survivor Annuity, the Plan Administrator shall provide the HCVM Participant with a written explanation of the following within the period described in paragraph (v):
    - (A) the terms and conditions of a Qualified Preretirement Survivor annuity,
    - (B) the HCVM Participant's right to make, and the effect of, a Qualified Election to waive the Qualified Preretirement Survivor Annuity form of benefit,

- (C) the rights of an HCVM Participant's Spouse, and
  - (D) the right to make, and the effect of, a revocation of a previous Qualified Election to waive the Qualified Preretirement Survivor Annuity.
- (v) The Administrator shall provide a written explanation of the Qualified Preretirement Survivor Annuity described in paragraph (iv):
- (A) to a HCVM Participant who is such a Participant on his thirty-second birthday, within the three Plan Year period commencing with the Plan Year in which his thirty-second birthday occurs;
  - (B) to a HCVM Participant who becomes such a Participant after his thirty-second birthday, within the three Plan Year period commencing with the Plan Year in which he becomes a HCVM Participant; and
  - (C) to a HCVM Participant who has a Termination Date prior to his thirty-second birthday, within one year of his Termination Date,
- or such longer period as is allowed under Code Section 417(a)(3).
- (f) Notwithstanding any other provision of this Plan, if the vested amount credited to an HCVM Participant's Accounts do not exceed \$5,000, his HCVM Accounts will be distributed in one lump sum without consent as soon as administratively feasible following the HCVM Participant's Termination Date.

#### Article BVII- Loans and Withdrawals

B7.1 Spousal Consent to Loan. A married HCVM Participant receiving a loan from his HCVM Accounts under the Plan prior to the Annuity Elimination Date must obtain the consent of his spouse to use his Accounts as security for the loan. The spousal consent must be obtained within the 90-day period prior to the date on which the loan is made (or renegotiated, extended, renewed or revised). Furthermore, the spousal consent must be in writing, acknowledge the effect of the loan and be witnessed by a Plan representative or notary public. A spousal consent, however, will not be required if the Participant establishes to the satisfaction of the Plan Administrator that the consent may not be obtained because there is no spouse, the spouse cannot be found or another reasonable excuse.

B7.2 Spousal Consent - Withdrawals. A married HCVM Participant making a withdrawal of any portion of his HCVM Accounts under Section 7.02, 7.03, 7.04 or B7.3 or B7.4 prior to the Annuity Elimination Date must obtain the consent of his spouse to the withdrawal. The spousal consent must be obtained within the 90-day period prior to the date on which the withdrawal is made. The spousal consent must be obtained within the 90-day period prior to the date on which withdrawal is made (or renegotiated, extended, renewed or revised). Furthermore, the spousal consent must be in writing, acknowledge the effect of the withdrawal and be witnessed by a Plan representative or notary public. A spousal consent, however, will not be required if the Participant establishes to the satisfaction of the Plan Administrator that the co-sent may not be obtained because there is no spouse, the spouse cannot be found or another reasonable excuse.

B7.3 Age 59 / Withdrawal. A HCVM Participant who has attained age 59 / may withdraw all or any portion of the vested balance of his HCVM Accounts at any time for any reason upon written request to the Plan Administrator in such form and at such time as the Plan Administrator shall require. An HCVM Participant may take only two age 59 / withdrawals from his HCVM Accounts in any 12-month period.

B7.4 Withdrawal of HCVM Matching Contribution Account and HCVM Discretionary Contribution Account After Five Years of Participation. A HCVM Participant who has been an Active Participant in the HCVM Plan and the Plan for at least 5 years may withdraw any part of his vested HCVM Matching Contribution Account and HCVM Discretionary Contribution Account at any time. An HCVM Participant may take only two such withdrawals in any 12-month period.

2002 AMENDMENT AND RESTATEMENT OF  
FIRST HEALTH GROUP CORP.  
RETIREMENT SAVINGS PLAN

APPENDIX C

This Appendix C contains provisions which modify and supplement the Plan with respect to individuals who became Participants in the Plan ("CAC Participants") upon the merger of the Claims Administration Corporation Employees' Savings Plan (the "CAC Plan") with the Plan on December 31, 2002. CAC Participants shall be eligible to participate in the Plan effective as of January 1, 2003.

Article CII - Definitions

C2.01 Accounts. CAC Participants shall have the following additional CAC Accounts maintained under the Plan adjusted in each case for such Account's share in the increase or decrease in the net worth of the Trust and withdrawals as provided in Article V:

- (a) CAC 401(k) Account means the sub-account of a CAC Participant's 401(k) Account which reflects the elective deferral contributions credited to such Participant under the CAC Plan and the earnings and losses thereon.
- (b) CAC After-Tax Account means the separate account maintained for each CAC Participant to which after-tax contributions made under the CAC Plan by the CAC Participant and earnings and losses thereon are credited. A CAC Participant shall be fully vested in his CAC After-Tax Account at all times.
- (c) CAC Matching Account means the sub-account of a CAC Participant's Matching Account which reflects the matching contributions credited to such CAC Participant under the CAC Plan and the earnings and losses thereon.
- (d) CAC Rollover Account means the sub-account of a CAC Participant's Rollover Account which reflects the rollover contributions credited to such CAC Participant under the CAC Plan and earnings and losses thereon.

C2.02 CAC Employee means an employee of Claims Administration Corporation.

C2.03 CAC Participant means each participant in the CAC Plan on December 31, 2002 whose accounts under the CAC Plan were transferred to and merged into the Plan on December 31, 2002.

C2.04 CAC Plan means the Claims Administration Corporation Employees' Savings Plan as in existence on December 31, 2002, which merged with and into the Plan on December 31, 2002.

C2.05 Entry Date means with respect to a CAC Employee or CAC Participant who is hired on or before December 31, 2002 and is a full-time Employee, the first payroll period after 31 days of employment. With respect to a CAC Employee or CAC Participant who is a part-time Employee, the first day of the first payroll period immediately following his completion of the service requirement described in Section C3.01(b).

C2.6 Year of Service with respect to each CAC Participant shall include each Year of Service credited under the CAC Plan as of December 31, 2002.

ARTICLE CIII  
ELIGIBILITY AND PARTICIPATION

C3.01 Active Participant Eligibility Requirements.

Each Eligible Employee hired on or before December 31, 2002 who is a CAC Employee shall become an Active Participant on the first Entry Date after, or on which, the Eligible Employee completes the following service:

- (a) if the Eligible Employee is classified as a full-time Employee, on his first Hour of Service, or
- (b) if the Eligible Employee is classified as a part-time Employee, 1,000 Hours of Service during any one of the following periods of service with a Participating Employer, whichever occurs first:
  - (i) the 12-consecutive month period beginning on his hire date, or
  - (ii) any Plan Year beginning with the Plan Year which includes the first anniversary of his hire date;

provided he is still an Eligible Employee on such date. Each CAC Participant immediately prior to December 31, 2002 shall continue to be a Participant in the Plan on and after December 31, 2002, subject to the limitations of the Plan.

#### Section CVI - Distributions

C6.1 Partially Vested Accounts. A CAC Participant shall vest in the balance of his CAC Matching Contribution Account in accordance with the following schedule:

Number of Completed Years of Service	Vested Percentage
Less than 1	0%
1 but less than 2	20%
2 but less than 3	40%
3 but less than 4	60%
4 but less than 5	80%
5 years or more	100%

The vested balances of a CAC Participant's CAC Matching Account, if any, and the balances of his CAC 401(k) Account, CAC After-Tax Account and CAC Rollover Account as of any Valuation Date coincident with or next following his Termination Date (after all adjustments then required under the Plan have been made) may become distributable in accordance with the applicable provisions of this Article VI. The unvested portion of a CAC Participant's CAC Matching Account on his Termination Date shall be forfeited in accordance with the provisions of Section 6.04 of the Plan.

#### Article CVII- Loans and Withdrawals

C7.3 Age 59 / Withdrawal. A CAC Participant who has attained age 59 / may withdraw all or any portion of the vested balance of his CAC Matching Account, CAC 401(k) Account and CAC After-Tax Account at any time for any reason upon written request to the Plan Administrator in such form and at such time as the Plan Administrator shall require. A CAC Participant may take only two such age 59 / withdrawals in any Plan Year. The minimum amount of any such withdrawal is \$1,000.

C7.4 Withdrawal of CAC Matching Account. A CAC Participant who has been an Active Participant in the CAC Plan and the Plan for at least 5 years may withdrawal any part of his vested CAC Matching Account at any time. A CAC Participant who has fewer than 5 years of participation, may withdrawal any portion of his CAC Matching Account that has been in the CAC Plan and the Plan for at least two years. An CAC Participant may take only two such withdrawals in any Plan Year. The minimum amount of any such withdrawal is \$1,000.

C7.5 Withdrawal of CAC After-Tax Account. A CAC Participant who has a CAC After-Tax Account may withdraw all or any portion of such Account at any time for any reason upon written request to the Plan Administrator in such form and at such time as the Plan Administrator shall require. A CAC Participant may take only two such withdrawals from his CAC After-Tax Account in any Plan Year. The minimum amount of any such withdrawal is \$1,000.

## HEALTH BENEFITS SERVICES AGREEMENT

THIS HEALTH BENEFITS SERVICES AGREEMENT, including all attachments and exhibits hereto (the "Agreement"), is entered into as of January 1, 2003, by and between the National Postal Mail Handlers Union, a Division of the Laborers International Union of North America, AFL-CIO (the "Mail Handlers Union") and First Health Group Corp. ("First Health"). The Mail Handlers Union and First Health may be individually referred to herein as a "party" or collectively referred to herein as the "parties."

## RECITALS

WHEREAS, certain federal government employees and annuitants and former spouses of such employees and annuitants are enrolled in a Federal Employees Health Benefits plan known as the Mail Handlers Benefit Plan ("MHBP" or "Plan"), which is established by federal government procurement Contract No. CS 1146 between the National Postal Mail Handlers Union, a Division of the Laborers International Union of North America, AFL-CIO, an unincorporated association, and the United States Office of Personnel Management; and

WHEREAS, First Health Life and Health Insurance Company and Cambridge Life Insurance Company (collectively, the "Underwriter") underwrite and Federal Employee Plans, Inc. ("FEPI") administers the MHBP pursuant to Prime Subcontract No. L-35489 between the Underwriter, FEPI and the Mail Handlers Union (the "Prime Subcontract"); and

WHEREAS, it is in the MHBP's best interest for the Mail Handlers Union to procure cost containment services to manage medical costs; and

WHEREAS, so long as the Underwriter is performing underwriting services and FEPI is performing administrative services to the Mail Handlers Union, the Mail Handlers Union desires First Health to provide cost containment programs; and

WHEREAS, First Health is a recognized leader in the business of establishing, administering, and maintaining cost containment services.

NOW THEREFORE, in consideration of the mutual covenants herein contained, and for other good and valuable consideration, receipt of which is hereby acknowledged, First Health and the Mail Handlers Union agree as follows:

## ARTICLE 1 DEFINITIONS

- 1.1 Agreement Year means each calendar year, beginning January 1st and ending December 31st.
- 1.2 Area Network Rate means the average of the Contract Rates for a Covered Service based upon all of the Contract Providers' Contract Rates for that Covered Service in the Market Area in which the claim was incurred. This rate is also known as the "blended" rate as defined on page 70 of the Plan in effect for 2002.
- 1.3 Authorized Designee means the entity or person, including but not limited to, the Mail Handlers Union, its health benefits service providers, brokers and consultants which are authorized by the Mail Handlers Union to have access to Confidential Medical Information as defined in Section 10.2.
- 1.4 Claims Administrator means FEPI, or its designee (as approved by the Mail Handlers Union).
- 1.5 Contract Provider means a provider of medical services that has entered into an agreement with First Health to provide medical services to Members at negotiated rates.
- 1.6 Contract Rates means the negotiated rates for medical services specified in the respective agreements between First Health and the Contract Providers.
- 1.7 Covered Service means a medical service provided to a Member which is eligible for payment under the provisions of the Plan.
- 1.8 Enrollee means each covered active member and any other person covered under a Plan in his or her own right (such as former members or others electing temporary continuation of coverage) and not by reason of status as a dependent or spouse.
- 1.9 The First Health[R] Network (the "Network") is a provider network of Contract Providers, including hospitals, physicians and ancillary service providers and a specially credentialed network of transplant providers.
- 1.10 Geographic Areas means the states listed in Exhibit II of this Agreement.
- 1.11 Market Area means an area identified by First Health as a market area

with a sufficient number of Contract Providers located in such area so that First Health can develop the Area Network Rates.

1.12 Member means a person entitled to benefits for medical services under the Plan.

1.13 Non-Network Claim means a non-hospital medical claim for Covered Services from a medical provider which is not a member of The First HealthO Network.

1.14 OPM means the United States Office of Personnel Management.

1.15 Plan means the benefits brochure for the current year authorized for distribution by OPM entitled "Mail Handlers Benefit Plan, RI 71-07".

1.16 PPO means a network of medical providers.

1.17 Prime Contract means the Contract for Federal Employees Health Benefits No. CS 1146, as amended, between the Mail Handlers Union, as Carrier of the Plan, and OPM.

1.18 Savings means the difference between billed charges (net of: (1) charges that are excluded from coverage under the terms of the Plan; (2) payments made to over 65 annuitants that are limited to Medicare allowable or approved amounts; and (3) payments due from other third party payors (including Medicare)) and the negotiated rates. Negotiated rates on bills incurred in the Network equal the Contract Rates and on non-network bills equal the negotiated discounts as specified in Section 2.2. Savings does not include claim reductions taken in accordance with Section 2.3.

## ARTICLE 2 NETWORK AND CLINICAL SERVICES

2.1 The First Health[R] Network. First Health will provide the Mail Handlers Union with access to the Network for Members in the Geographic Areas. First Health will provide notice to Contract Providers regarding the Mail Handlers Union's selection of the Network in conjunction with its quarterly Contract Provider bulletin, or earlier as determined practical by First Health. Subject to Section 2.6 below regarding certain Network changes, First Health may at any time, and in its sole discretion, add or delete any Contract Provider from the Network.

2.2 Non-Network Negotiation Services. First Health will review large dollar claims, at the then-current threshold as established by First Health, that have not been repriced pursuant to Section 2.3 below, from non-network medical providers prior to claims payment and attempt to negotiate a discount from billed charges for prompt payment where feasible. In addition, First Health will evaluate claims for audit potential, make recommendations to the Claims Administrator and coordinate on-site audits as necessary. Such on-site audits will be conducted under terms and conditions mutually acceptable to First Health and the Claims Administrator.

2.3 Market Area Network Services. First Health will provide the Mail Handlers Union with access to the Market Area Network Services in the Geographic Areas.

2.3.1 Non-Network Claims. First Health will review Non-Network Claims incurred by Members that are submitted to First Health. First Health will reprice the claim to the Area Network Rate, in accordance with Section 2.3.2 below.

2.3.2 Area Network Rate Repricing. For each Non-Network Claim received by First Health, First Health will identify whether the Non-Network Claim was incurred in a Market Area. If the Non-Network Claim was incurred in a Market Area, First Health will reprice the claim to the Area Network Rate. The Mail Handlers Union acknowledges that the Market Areas are subject to change by First Health from time to time.

2.4 Clinical Software and Medical Consulting. First Health will provide access to software designed to identify opportunities for utilization review and medical case management intervention. In addition, First Health will provide access to physicians for the purpose of providing medical consulting services. First Health will provide the clinical software and physician access consistent with the provision of such services by the previous vendor and/or administrator of the Mail Handlers Union, and the fee for such access is included in the Network access fee.

2.5 Information Provided by First Health. First Health will provide Members with information regarding Contract Providers and will provide the Claims Administrator with a camera-ready hard copy listing of Contract Providers, including annual updates, for each Geographic Area for the Mail Handlers Union or its designee to reproduce and distribute at the Claims Administrator's expense. Printed Contract Provider directories may be purchased by the Claims Administrator from First Health at the then-current rates.

2.6 Network Improvement. First Health agrees to improve and expand the Network during the Term, and will establish a joint task force made up of

representatives from both First Health and the Mail Handlers Union. When requested by the Mail Handlers Union, the task force will meet promptly to identify areas of the Network which need improvement and expansion, and to monitor progress of existing improvement and expansion efforts. In addition, First Health will maintain a toll free number for the nomination and recruitment of providers, and, if First Health intends to make major changes (either additions or deletions) in the composition of Contract Providers in any Geographic Area, First Health will notify and consult with the Mail Handlers Union regarding the substance and timing of such changes prior to taking any such action.

### ARTICLE 3 OBLIGATIONS OF THE MAIL HANDLERS UNION OR ITS DESIGNEES

3.1 Eligibility Verification. The Claims Administrator will maintain a procedure for prompt verification during normal business hours of a Member's enrollment in the Plan.

3.2 Communication to Members.

3.2.1 The Claims Administrator will identify all Contract Providers as the exclusive PPO providers of Covered Services and will advise Members as to the identity of all such Contract Providers.

3.2.2 The Claims Administrator will advise Members that the list of Contract Providers may change from time to time, with or without notice, and the Member is obligated to confirm with the Contract Provider the Contract Provider's status.

3.2.3 The Claims Administrator will provide Members with a First Health-approved Plan identification card which prominently displays The First Health[R] Network logo and the toll-free number. The Mail Handlers Union and its designees agree not to alter or attach any information to the identification cards which materially changes any of the information contained on the identification cards, including, but not limited to, stickers and card sleeves.

3.2.4 Upon implementation, and at least twice annually, the Claims Administrator will provide Members with information regarding the services provided pursuant to this Agreement, including the following: (a) instructions about how to use the services; (b) information on the toll-free number; (c) information on the obligations of the Member and of any benefits and penalties, including benefit differentials, under the Plan for use of or failure to use the services made available pursuant to this Agreement; and (d) information about incentives to encourage Members to use the services of Contract Providers through the distribution of communication materials on the Network, provision of directories or other means agreed to by the Claims Administrator and First Health.

3.2.5 The Claims Administrator will indicate on the explanation of payment to a Contract Provider and the explanation of benefits to the Member that reimbursement is subject to the Contract Provider's agreement with First Health and the balance owed by the Member. The Claims Administrator will provide First Health with model samples of the proposed explanations of payment and benefits for approval prior to use.

3.2.6 The Mail Handlers Union agrees that all descriptive information including, but not limited to, communication materials for distribution to Members and the information contained in the Plan, regarding First Health or the services provided by First Health may not be disseminated by the Mail Handlers Union, the Claims Administrator or other related parties without the express written approval of First Health.

3.3 Contract Provider Payments. The Claims Administrator will submit all Members' medical services claims which it may receive to First Health in a timely manner. The Claims Administrator will pay all repriced claims within 30 days, and the Mail Handlers Union acknowledges that under the respective agreements between First Health and the Contract Providers, a Contract Provider may refuse to accept payment at the Contract Rates if the Contract Provider is not paid within 30 days of the Claims Administrator's receipt of accurate and complete bills.

3.4 Non-Network Negotiation Services Requirements. The Mail Handlers Union agrees that as part of First Health's non-network negotiation services as described in Section 2.2: (a) the Claims Administrator is permitted to pay claims within 10 working days from the date of the negotiated agreement. The Mail Handlers Union acknowledges that no discount will be available on claims paid after the negotiated payment date; (b) the explanation of payment will clearly state that payment is being made on the basis of the First Health negotiated discount; and (c) First Health may waive retrospective bill audit review of non-network negotiated claims, except in cases of fraud or illegal activity.

3.5 Contract Provider Information Requirements. The Mail Handlers Union acknowledges that all Contract Provider information is provided for the sole purpose of assisting the Mail Handlers Union in identifying Contract Providers to Members, and the Mail Handlers Union agrees not to modify or

commingle this information with any other information.

#### ARTICLE 4 PLAN REQUIREMENTS

4.1 Vendor for Health Benefits Services. The Mail Handlers Union represents and warrants that the Plan includes a provision which allows an outside entity, such as First Health, to provide health benefits services as set forth under this Agreement.

4.2 Financial Incentives. The Plan currently includes financial incentives to encourage Members to access the Network for Covered Services, and the parties intend to maintain appropriate financial incentives during each Term.

#### ARTICLE 5 EXCLUSIVITY AND NON-COMPETITION

5.1 Exclusivity. The Mail Handlers Union agrees that it will use First Health exclusively to provide all of the Members with all cost containment services specified in this Agreement. First Health intends to contract with other service providers, such as non-directed PPOs, to provide additional services to the Mail Handlers Union. If necessary, this Agreement will be amended to incorporate such additional services. In addition, the Mail Handlers Union will consider using new or additional cost containment services that may be made available by First Health on or after January 1, 2003.

5.2 Non-Competition. The Mail Handlers Union agrees that it will not directly enter into any contract with any Contract Provider for the delivery of PPO services to its Members for at least twelve months after the termination of this Agreement. This provision shall not apply to any contracts in existence between the Mail Handlers Union and Contract Providers as of the date on which this Agreement was entered, nor shall it prohibit the Mail Handlers Union from directly contracting with any other entity that provides a PPO after termination of this Agreement.

#### ARTICLE 6 DATA AND INFORMATION REQUIREMENTS

6.1 Reliance on Data. The Mail Handlers Union acknowledges that performance of the services provided under this Agreement is dependent upon the submission of timely, accurate and complete information as required by First Health, and the Mail Handlers Union or its designee agrees to furnish such information. The Mail Handlers Union understands that failure to submit such information accurately and completely to First Health within any requested time frames may delay or prevent access to the services provided under this Agreement. The Mail Handlers Union agrees that First Health may rely on such information in performing its services under this Agreement. Further, services will be performed using the then-current data as provided by the Mail Handlers Union or its designee. First Health is not responsible for, nor does First Health have any liability under this Agreement or any applicable law for, any errors or performance failures which result from the Mail Handlers Union's or its designee's failure to provide the information, its provision of erroneous information, or use of the then-current data during the standard time period required to update information received from the Mail Handlers Union or its designee. First Health may use data provided by the Mail Handlers Union or its designee for statistical, reporting or other related commercial purposes in a manner that will not disclose any Confidential Medical Information as defined in Section 10.2.1.

6.2 Reports. First Health will provide the Mail Handlers Union or its designee with its standard periodic reports of the on-going results of the services provided under this Agreement. For matters of special interest to the Mail Handlers Union, First Health may provide special reports which are requested in writing by the Mail Handlers Union. If First Health agrees to prepare a special report, and an additional expense will be incurred by First Health in preparing such report, First Health will promptly provide a written cost estimate and production schedule and obtain the Mail Handlers Union's approval of such costs prior to preparing the report. Notwithstanding the foregoing, First Health will not charge the Mail Handlers Union for any special report or data requests that are reasonable as to scope and cost. Further, First Health will also cooperate with the Mail Handlers Union in regard to any OPM requests for data collection and reporting requirements.

#### ARTICLE 7 FEES

7.1 Payment of Fees.

7.1.1 The Mail Handlers Union will require the Underwriter to pay First Health for all services provided pursuant to this Agreement as set forth in Exhibit I, the Schedule of Fees.

7.1.2 Payment must be made by the Underwriter within 30 days after receipt by it of monthly billing statements from First Health.

7.1.3 First Health's fees do not include taxes or governmental

charges. The Underwriter will pay, or reimburse First Health for, any applicable sales, use, value added or other tax or government or regulatory agency charge imposed based on transactions hereunder, exclusive of First Health's net income or corporate franchise taxes.

7.1.4 Effective on each anniversary date of this Agreement, First Health will annually adjust all fees that are charged on an hourly, per capita, per case, per bill, per claim or per unit basis, by giving 60 days notice to the Mail Handlers Union prior to the anniversary date of each year of this Agreement. Such fees for the next year of the Agreement will be increased by an amount equal to the percentage difference between the annual average of the CPI available for the most recently published year, and the annual average of the CPI available for the year prior to the most recently published year. For purposes of this Agreement, the term "CPI" means the Consumer Price Index - All Urban Consumers, Medical Care Services, Base Period: 1982-1984=100, Not Seasonally Adjusted. If the methodology for calculating the CPI is substantially revised, First Health will make an adjustment to such fees to produce results equivalent, as nearly as reasonably possible, to those which would have been obtained if the methodology for calculating CPI had not been so revised. First Health acknowledges that Section 7.1.4 does not apply to any percentage of Savings fees charged hereunder.

#### ARTICLE 8 TERM AND TERMINATION

8.1 Term. The term of this Agreement is five years beginning January 1, 2003 and ending December 31, 2007, and will automatically renew for consecutive four-year terms (each, a "Term") thereafter, unless terminated as hereinafter set forth in Sections 8.2, 8.3 or 14.12.

8.2 Termination By The Mail Handlers Union. This Agreement may be terminated by written notice thereof given by the Mail Handlers Union to First Health if any one of the following occurs:

8.2.1 Failure of First Health to meet any material covenant, agreement, or obligation provided for in this Agreement if it has not commenced to cure any such default within 20 days and has not cured such default within 90 days after written notice thereof to First Health by the Mail Handlers Union.

8.2.2 First Health becomes insolvent or is adjudicated as a bankrupt entity, or its business comes into possession or control of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors. If any of these events occurs: (a) no interest in this Agreement may be deemed an asset of creditors; (b) no interest in this Agreement may be deemed an asset or liability of First Health; and (c) no interest in this Agreement may pass by the operation of law without the consent of the Mail Handlers Union.

8.2.3 The Mail Handlers Union gives not less than forty days written notice before the first submission of benefits or rates is due to OPM for the Plan year following the last Plan year of the then-current Term. Such termination will be effective at the expiration of the then-current Term.

8.2.4 The Prime Subcontract is terminated or expires. Such termination will be effective at the end of the then-current Agreement Year.

8.3 Termination By First Health. This Agreement may be terminated by written notice thereof given by First Health to the Mail Handlers Union if any one of the following occurs:

8.3.1 Failure of the Mail Handlers Union to meet any material covenant, agreement, or obligation provided for in this Agreement if it has not commenced to cure any such default within 20 days and has not cured such default within 90 days after written notice thereof to the Mail Handlers Union by First Health.

8.3.2 Failure of the Underwriter to make payment under this Agreement when due, and if payment is not made within 20 days following written notice of non-payment sent by First Health to the Mail Handlers Union, provided that such failure was not due to any action or inaction of First Health or its affiliates.

8.3.3 The Mail Handlers Union becomes insolvent, or is adjudicated as a bankrupt entity, or its business comes into possession or control, even temporarily, of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors. If any of these events occurs: (a) no interest in this Agreement may be deemed an asset of creditors; (b) no interest in this Agreement may be deemed an asset or liability of the Mail Handlers Union; and (c) no interest in this Agreement may pass by operation of law without the consent of First Health.

8.3.4 First Health gives not less than forty days written notice

before the first submission of benefits or rates is due to OPM for the Plan year following the last Plan year of the then-current Term. Such termination will be effective at the expiration of the then-current Term.

8.3.5 The Prime Subcontract is terminated or expires. Such termination will be effective at the end of the then-current Agreement Year.

8.4 Obligations Upon Termination. Upon the effective date of the termination of this Agreement, in whole or in part, as applicable:

8.4.1 The Underwriter or First Health will promptly pay to the other party all moneys due hereunder.

8.4.2 Each party will immediately cease to use the other party's documents, systems, logos, service marks, trademarks, trade names, methods and techniques in any form.

8.4.3 The Underwriter will immediately cease reimbursing Contract Providers at the Contract Rates except for those Members admitted to or receiving services from a Contract Provider prior to the effective date of termination. For such Members, the Underwriter may reimburse Contract Providers at the Contract Rates for the duration of the inpatient stay or for a period of 60 days after the effective date of termination for outpatient care services.

#### ARTICLE 9 LIMITED ROLE OF FIRST HEALTH

9.1 First Health's Role in Relation to Medical Services. The parties acknowledge and agree that: (a) First Health does not provide, direct or control the provision of medical services to Members; (b) the provision of Contract Provider information in any medium by First Health is not the provision of medical diagnostic or treatment services, medical advice or health advice; (c) all decisions regarding medical services are made solely by the Member and the attending practitioner and the rendering of medical services to a Member and the results thereof are solely within the control of the provider of medical services providing the services, and the Members; and (d) execution of this Agreement and the performance of its obligations does not constitute an undertaking by the parties to render any medical services, or to assume or guarantee the results thereof to Members, or to guarantee that medical services will be rendered in accordance with generally accepted standards or procedures.

9.2 Cooperation. The parties will cooperate as necessary in order to comply with the requirements imposed by OPM related to the services provided hereunder.

#### ARTICLE 10 CONFIDENTIALITY OF INFORMATION

10.1 Confidential Proprietary Information.

10.1.1 "Confidential Proprietary Information" means any non-public proprietary information, including, but not limited to, the terms of this Agreement, information about fees, computer software, business procedures and manuals, data review criteria, Contract Provider databases and directories and Contract Rates. For purposes of this Agreement, Confidential Proprietary Information does not include: (a) information publicly available by means other than wrongful disclosure or lawfully obtained from third parties without any confidentiality obligations; (b) information which is required by law or by a government agency to be disclosed by a party, provided that such party immediately notifies the other party of the requirements for such disclosure and reasonably cooperates in obtaining any protective order desired by the other party with regard to such information; (c) information independently developed by the other party; or (d) information provided to the other party with the intention that it be published, disseminated, released or distributed by such other party to Members, Contract Providers, or to the general public.

10.1.2 The parties agree that all Confidential Proprietary Information of either party may not be disclosed, except as provided below, without the express written approval of the other party. Further, Confidential Proprietary Information may be disclosed only to those persons who need to know, and only to the extent necessary, in order to carry out the terms of this Agreement. The Mail Handlers Union will require any of its health benefits vendors with access to any Confidential Proprietary Information of First Health to keep such Confidential Proprietary Information confidential. Confidential Proprietary Information may not be used in any way not specifically allowed under this Agreement, including in each party's own business, whether or not competitive with the other party. Each party will notify the other party of any loss or accidental or unauthorized disclosure of Confidential Proprietary Information.

10.1.3 The parties recognize that no remedy of law may be adequate to compensate either party for a breach of the provisions of this Article;

therefore, both parties agree that either party may seek temporary and permanent injunctive relief against the breaching party, in addition to all other remedies which either is otherwise entitled, and this Section in no way limits such other remedies of the parties. Such temporary or permanent injunctive relief may be granted without bond which each party does hereby waive.

#### 10.2 Confidential Medical Information.

10.2.1 The parties agree that legal and professional considerations require that all Confidential Medical Information be kept confidential, and each party agrees to comply with all applicable laws governing the confidentiality of Confidential Medical Information. "Confidential Medical Information" means Members' non-public medical or personal information containing information which allows the identification of the Members, the Mail Handlers Union or the Plan. In connection with the disclosure or other transfer of Confidential Medical Information among Members' medical services providers, the Mail Handlers Union and/or Authorized Designees as necessary in the performance of duties under this Agreement or upon the Mail Handlers Union's request (each, a "Confidential Medical Information Transfer"), the Mail Handlers Union will obtain from the appropriate Member(s) a valid authorization form permitting the Confidential Medical Information Transfer ("Release Authorization"). If the Mail Handlers Union requests First Health to perform a Confidential Medical Information Transfer, under the provisions of this Agreement or by other means, such request constitutes the Mail Handlers Union's representation and warranty that the requested Confidential Medical Information Transfer is to an authorized representative of the Plan for a lawful purpose and the Mail Handlers Union has obtained the appropriate Release Authorization(s). Notwithstanding the above, the Mail Handlers Union may be required to provide a copy of the applicable Release Authorization(s) prior to a Confidential Medical Information Transfer.

10.2.2 The Mail Handlers Union agrees that First Health may release Confidential Medical Information: (a) to the Member to whom such information pertains, or his/her legal guardian or other representative, upon receipt of written authorization from such Member; and (b) as required by order of a court or administrative agency with jurisdiction in the matter.

#### ARTICLE 11 AUDIT

Subject to Article 10, the Mail Handlers Union agrees that at its office, during normal business hours, and upon not less than 30 days advance notice, First Health will have the right to examine records which the Mail Handlers Union has kept which relate directly to services received pursuant to this Agreement. Subject to Article 10, First Health agrees that at its office, during normal business hours, and subject to First Health's standard audit procedures, the Mail Handlers Union will have the right to examine records which First Health has kept which relate directly to services provided pursuant to this Agreement. The auditing party will provide a summary of the final results of such audit or examination to the other party. Such right of examination will continue for a period of not less than five years after the date of discharge, end of the treatment, or the end of First Health's services in relation to the specific episode of care. The auditing party agrees to pay the other party for its costs incurred in supporting such audits at the audited party's then-current audit fees. Each party may require the other party's representatives to execute a confidentiality agreement prior to commencing any such audit.

#### ARTICLE 12 ADDITIONAL OPM REQUIREMENTS

12.1 All provisions or clauses of the Prime Contract, including without limitation, the provisions listed below, that are required to be incorporated herein are so incorporated by reference thereto. For purposes of this Agreement, all applicable references in the following provisions of the Prime Contract to the "Contractor" or "Carrier" shall be treated as references to First Health, and all references to the "Contract" or "Prime Contract" therein shall be treated as references to this Agreement. The following provisions of the Prime Contract are specifically incorporated herein by reference and shall be binding on First Health:

- Section 1.6 Confidentiality of Records
- Section 3.8 Contractor Records Retention
- Section 5.19 Equal Opportunity
- Section 5.22 Affirmative Action for Disabled Veterans and Veterans of the Vietnam Era
- Section 5.23 Affirmative Action for Workers with Disabilities
- Section 5.60 Subcontracts for Commercial Items and Commercial Components

## ARTICLE 13 INDEMNIFICATION

Should the Mail Handlers Union incur any costs, expenses, judgments, damages, liabilities, legal fees, or other reasonable costs of litigation or defense of any claim, including reasonable attorneys' fees and costs (collectively, "Costs or Liabilities"), whether in settlement of any cause of action or threatened cause of action, which settlement First Health approves, or as a result of an order or judgment of a court of competent jurisdiction, which Costs or Liabilities result or arise from any third-party claims related to the performance of services hereunder by First Health, First Health agrees to indemnify, hold harmless and reimburse the Mail Handlers Union to the extent of any such Costs or Liabilities.

## ARTICLE 14 GENERAL PROVISIONS

14.1 Independent Contractors. The relationship between the parties is that of independent contractors. Nothing herein is intended or will be construed to establish any agency, employment, partnership, or joint venture relationship between the parties. Each party is solely responsible for the direction, control, and management of its subcontractors, agents and employees.

14.2 Non-Exclusivity. The Mail Handlers Union acknowledges that First Health offers its services on a national basis, including to businesses or organizations which may be competitive with the Mail Handlers Union. The Mail Handlers Union agrees that nothing, whether contained in this Agreement or otherwise, limits, restricts or prevents First Health from providing its services to any other entity.

14.3 No Third-Party Beneficiaries. This Agreement is entered into by and between the parties hereto solely for their benefit. The parties have not created or established any third-party beneficiary status or rights in any person or entity not a party hereto including, but not limited to, any Member, provider, subcontractor, or other third-party, and no such third-party will have any right to enforce any right or enjoy any benefit created or established under this Agreement.

14.4 Insurance. Each party will, so long as such coverage is available in the market and at a reasonable cost within each party's judgment, at all times for the Term maintain in effect insurance that is commonly maintained by similar entities in the same types of organization or industry.

14.5 Compliance. Each party will comply with all applicable licensing and regulatory requirements for each Geographic Area in which First Health provides services to the Mail Handlers Union under this Agreement. Upon request by the other party, each party will promptly provide to the requesting party such information and documentation as the requesting party deems necessary for its compliance with applicable licensing and regulatory requirements.

14.6 Force Majeure. The obligations of a party under this Agreement will be suspended for the duration of any force majeure applicable to that party. The term "force majeure" means any cause not reasonably within the control of the party claiming suspension, including, without limitation, an act of God, industrial disturbance, war, riot, weather-related disaster, earthquake and governmental action. The party claiming suspension under this Section will take reasonable steps to resume performance as soon as possible without incurring unreasonably excessive costs.

14.7 Entire Agreement; Amendments; Facsimile. This Agreement including any riders, attachments or amendments hereto, constitutes the entire agreement between the parties. This Agreement supersedes any prior agreement or understandings pertaining to the services provided hereunder, whether oral or written, and may be amended only by a writing executed by authorized representatives of First Health and the Mail Handlers Union. A facsimile or other reproductive type copy of this Agreement, so long as signed by both parties, will be considered an original and will be fully enforceable against both parties.

14.8 Choice of Law. All terms of this Agreement are intended by the parties to be subject to interpretation in accordance with the laws of the United States. However, to the extent that federal law is deemed not to govern this Agreement and the interpretation thereof, the laws of the State of Illinois will so govern without regard to principles of conflict or choice of law.

14.9 Assignment and Delegation. Neither party may assign its rights or duties under this Agreement without the prior written consent of the other, except that First Health may assign this Agreement or its rights and duties under this Agreement to a different subsidiary or affiliate of First Health (with the prior approval of OPM), provided that such assignment will not relieve First Health of its liabilities under this Agreement. The Mail Handlers Union acknowledges that certain services may be performed by affiliates of First Health, and First Health expressly delegates its obligations herein to perform such services to certain designated affiliates, provided that such delegation will not relieve First Health of any liability under this Agreement. This Agreement is binding upon and will

inure to the benefit of the respective parties hereto and their successors and permitted assigns.

14.10 Headings. All headings are for convenience only and may not be deemed to limit, define or restrict the meaning or contents of the Articles and Sections.

14.11 Use of Marks. Neither party may in any way infringe upon or harm the rights of the other party in its service marks, trademarks, copyrights, and other proprietary marks. Neither party may, without the prior written approval of the other party, use any mark or name of the other party. Notwithstanding the foregoing, this provision does not prohibit the Mail Handlers Union from identifying First Health as its vendor of health benefits services nor does it prohibit First Health from identifying the Mail Handlers Union as a party to whom First Health is providing such services.

14.12 Unenforceable Provisions. If any provision of this Agreement conflicts with the Prime Contract or is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of this Agreement to the greatest extent legally permissible. Notwithstanding the foregoing, if any such modification causes a material change in the obligations or rights of either party, upon written notice from one party to the other of the adverse effect thereof upon such notifying party, and then if the parties are not able to mutually agree as to an amendment hereto, the notifying party may terminate this Agreement upon 30 days written notice to the other party.

14.13 Notices. Any notice required pursuant to this Agreement must be in writing and sent by registered or certified mail, return receipt requested, by fax with proof of delivery, or by a nationally recognized private overnight carrier with proof of delivery, to the addresses of the parties set forth below in this Agreement. The date of notice will be the date on which the recipient receives notice or refuses delivery. All notices must be addressed as follows or to such other address as a party may identify in a notice to the other party:

For First Health: First Health Group Corp.  
3200 Highland Avenue  
Downers Grove, Illinois 60515  
Attn: Mr. Edward L. Wristen, CEO  
Fax Number: (630) 737-7878

CC: General Counsel  
Fax Number: (630) 737-7518

For the Mail Handlers Union:

Mr. William H. Quinn, National President  
Mr. Mark A. Gardner, National Secretary-Treasurer  
National Postal Mail Handlers Union  
1101 Connecticut Ave, N.W., Suite 500  
Washington, D.C. 20036  
Fax Number: (202) 833-0008

14.14 Waiver. A waiver of a breach or default under this Agreement is not a waiver of any other or subsequent breach or default. A failure or delay in enforcing compliance with any term or condition of this Agreement does not constitute a waiver of such term or condition unless it is expressly waived in writing.

14.15 Negotiated Agreement. Each party acknowledges that this Agreement resulted from negotiations by and between the parties, and therefore any rule of construction requiring ambiguities to be construed against the drafter of an agreement will not apply to any provision of this Agreement.

14.16 OPM Approval. The parties recognize that this Agreement is subject to approval by OPM, and that amendments hereto when so required by law are also subject to OPM approval.

14.17 Survivability. The provisions of Sections 5.2, 7.1 and 8.4 and Articles 9, 10, 11, 12, 13 and 14 will survive the termination of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement the day and date first above written by their duly authorized officers for and on behalf of said entity.

NATIONAL POSTAL MAIL HANDLERS UNION, A DIVISION OF THE LABORERS  
INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO d/b/a MAIL HANDLERS BENEFIT  
PLAN

By: \_\_\_\_\_

Title:

Date: -----  
-----

FIRST HEALTH GROUP CORP.

By: -----  
Edward L. Wristen

Title: CEO President & Chief Operating Officer  
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Date: -----  
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First Health[R] is a registered service mark of First Health Group Corp.

GEOGRAPHIC AREAS AND EFFECTIVE DATES

Geographic Area	The First Health[R] Network	Geographic Area	The First Health[R] Network
AL	1/1/2003	MT	1/1/2003
AK*	1/1/2003	NE	1/1/2003
AZ	1/1/2003	NV	1/1/2003
AR	1/1/2003	NH	1/1/2003
CA	1/1/2003	NJ	1/1/2003
CO	1/1/2003	NM	1/1/2003
CT	1/1/2003	NY*	1/1/2003
DE	1/1/2003	NC	1/1/2003
DC	1/1/2003	ND	1/1/2003
FL	1/1/2003	OH	1/1/2003
GA	1/1/2003	OK	1/1/2003
HI	1/1/2003	OR	1/1/2003
ID	1/1/2003	PA	1/1/2003
IL	1/1/2003	PR*	1/1/2003
IN	1/1/2003	RI	1/1/2003
IA	1/1/2003	SC	1/1/2003
KS	1/1/2003	SD	1/1/2003
KY	1/1/2003	TN	1/1/2003
LA	1/1/2003	TX	1/1/2003
ME*	1/1/2003	UT	1/1/2003
MD	1/1/2003	VT	1/1/2003
MA	1/1/2003	VA	1/1/2003
MI	1/1/2003	WA	1/1/2003
MN	1/1/2003	WV	1/1/2003
MS	1/1/2003	WI	1/1/2003
MO	1/1/2003	WY*	1/1/2003

\* The Mail Handlers Union acknowledges that The First Health[R] Network is not fully developed.

## AGREEMENT

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(Prime Subcontract No. L-35489 to OPM Contract No. CS 1146)

THIS AGREEMENT is made and entered into by and among the NATIONAL POSTAL MAIL HANDLERS UNION, A DIVISION OF THE LABORERS INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO, an unincorporated association having its principal place of business in Washington, D.C. (herein called "Mail Handlers Union"), FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY ("First Health Life"), a Texas corporation having its principal place of business in Downers Grove, IL, CAMBRIDGE LIFE INSURANCE COMPANY ("Cambridge Life"), a Missouri corporation having its principal place of business in Downers Grove, IL, and FEDERAL EMPLOYEE PLANS, INC. ("FEPI"), a Delaware corporation having its principal place of business in Downers Grove, IL (FEPI, First Health Life and Cambridge Life are sometimes collectively called "Company").

In consideration of the mutual agreements between the Mail Handlers Union and the Company, and in consideration of the payment of the subscription charges specified in paragraph six (6) hereof, it is agreed as follows:

1. This Agreement is entered into pursuant to the Act and Regulations (as both terms are defined in Section 1.1 of the Prime Contract) and is incorporated in its entirety into, and made a part of, Contract for Federal Employees Health Benefits No. CS 1146, as amended (herein called "Prime Contract"), between the Mail Handlers Union, as carrier of the Mail Handlers Benefit Plan (herein called "Plan"), and the United States Office of Personnel Management (herein called "OPM") pursuant to Section 1.19 thereof. In the event of an inconsistency between the terms of the Prime Contract and the terms of this Agreement, the terms of the Prime Contract will prevail. The Mail Handlers Union and the Company recognize that they have formed a contractor team arrangement as described in Subpart 9.6 of the Federal Acquisition Regulation ("FAR").

2. The Company shall provide the services and benefits of the Plan described in this Agreement on behalf of all Members (as defined in Section 1.1 of the Prime Contract) who enroll for coverage in and, subject to the provisions of the Act and Regulations, are eligible for coverage under the Plan. Amounts to be paid by the Company hereunder on behalf of the Plan to, or on behalf of, Members as a result of entitlement to benefits provided under the Plan shall be determined in the manner, and to the extent, set forth in the Prime Contract and the brochure authorized for distribution by OPM entitled "Mail Handlers Benefit Plan, RI 71-07," as revised for each contract term (herein sometimes called "Plan year"), a certified copy of which brochure is incorporated by reference in the Prime Contract as Appendix A thereto (herein called "Plan brochure"). The Union delegates to the Company its Carrier rights and responsibilities stated in Part II of the Prime Contract. Claims for benefits shall be submitted in the manner and within the time limits established by OPM. The rules for review of denied claims, duplicate coverage, subrogation, and coordination of benefits shall be as established by OPM (and supplemented as necessary and appropriate by Company administrative practices). The Company is vested with full discretion to compromise or waive the Plan's subrogation and overpayment recovery rights as established in the Prime Contract.

3. The Company shall provide OPM on behalf of the Mail Handlers Union with such reports and information as may be necessary for the Mail Handlers Union as carrier of the Plan under the Act and Regulations to comply with Sections 1.7, 1.9, 3.2 and 3.3 of the Prime Contract. In order to maintain the Plan's competitive position, the Mail Handlers Union and the Company agree not to release any such reports and information to any party or entity other than OPM prior to written notification to, and discussion with, the other party.

4. This Agreement shall take effect as of January 1, 2003, 12:01 a.m., Standard Time, Washington, D.C., and will continue in force until December 31, 2007, 11:59 p.m. The Agreement will automatically renew at the end of the initial term for additional four year terms thereafter, subject to initial OPM approval of this Agreement, and subsequent annual OPM approvals of proposed Plan benefit and/or rate changes, unless the Mail Handlers Union or the Company gives timely notice to the other, with a copy to OPM, of its intent not to renew this Agreement as of the end of the then-current term. In addition, if for a reason not within the control of the Company, the cost containment programs related only to utilization of hospital and physician preferred provider organizations are no longer provided by the Company's affiliates, then the Company may give timely notice of its intent to terminate this Agreement effective at the end of the current Plan year. The Mail Handlers Union's notice shall be timely if it is given at least forty (40) days before the date on which, pursuant to a call letter issued by OPM, the initial submission is due to OPM regarding either benefits or rates, whichever is issued first, for the Plan year following the last Plan year of the then-current term. The Company's notice shall be timely if it is given at least forty (40) days before such date, subject to the condition that within three (3) business days of receiving OPM's call letter for that Plan year's benefits and/or rates, the Company

must have given the Mail Handlers Union notice that it may exercise such nonrenewal option. In the event that the Company gives notice of its intent not to renew this Agreement, it will assist the Mail Handlers Union in locating a successor underwriter. In the event that either party gives notice of its intent not to renew this Agreement, the confidentiality obligation that paragraph 3 above imposes on the parties shall terminate.

5. The effective dates of eligibility for coverage by the Plan and the rights of Members enrolled in the Plan to its benefits shall be as provided in the Act and Regulations. Members may be added to the Plan at such times and under such conditions as may be specified by the Act and Regulations. Termination of eligibility for benefits shall be in accordance with the Act and Regulations. Members may obtain temporary continuation coverage and/or convert to the OPM-approved conversion policy offered by the Plan and underwritten by First Health Life or Cambridge Life in accordance with the Act and Regulations.

6. The biweekly subscription charges during the period this Agreement is in effect shall be as provided for in the applicable Prime Contract for the respective Plan year and are listed in Attachment A hereto for 2003.

The Company, subject to adjustment for error or fraud, will accept from OPM, in full payment the total subscription charges under this Agreement received by the Employees Health Benefits Fund (herein called "the Fund") plus any payments made by OPM from the Contingency Reserve, less the amounts necessary to fund the Mail Handlers Union administrative expenses and less the amounts set aside by OPM for the Contingency Reserve and for the administrative reserves held by OPM.

In the event the Prime Contract is terminated as of a date other than the end of a Member's then current pay period, the effective date of termination as to the Member shall be deferred to the end of such pay period or as otherwise provided for in OPM Regulations. The Company is entitled to receive all subscription charges due for the period of time such coverage is provided.

7. The Mail Handlers Union shall designate to OPM, on behalf of First Health Life, a financial institution at which First Health Life shall establish an account to receive subscription charges drawn from the Plan's Letter of Credit (LOC) account to pay health benefit charges incurred and administrative expenses chargeable under the contract pursuant to the FAR. Any notice received by the Mail Handlers Union of funds deposited into the Plan's LOC account shall be transmitted promptly to First Health Life. All requests for withdrawals or drawdowns of funds from the Plan's LOC account for allowable administrative expenses for the Mail Handlers Union shall be made to, and through, First Health Life. First Health Life shall be entitled as necessary to apply to the Plan's LOC account for a withdrawal or drawdown of funds deposited therein for the payment of claims filed under the Plan and/or its allowable administrative expenses and Service Charge (as such term is defined in Attachment B). Drawdowns from the Plan's LOC account must be made on a "checks presented basis" which means that the drawdowns must not occur until a demand for payment is made upon the financial institution designated by First Health Life. Concurrently with the withdrawal of any Service Charge, First Health Life will remit the Mail Handler Union's portion of the Service Charge (if any) as calculated in accordance with Attachment B. First Health Life shall be under no obligation to reimburse the Plan's LOC account for unrecouped benefit overpayments made erroneously but in good faith provided that it administers an overpayment recovery program that complies with Section 2.3(g) of the Prime Contract as implemented by FEPI's overpayment recovery procedures.

If upon liquidation of all claims incurred, or three years from the date of discontinuance of this Agreement, whichever is earlier, there remains a balance in First Health Life's account attributable to the discontinued Agreement, such balance, including any interest earned thereon, shall be paid to the Mail Handlers Union for deposit to the Plan's reserves.

8. As of any date on which this Agreement is in effect, the cumulative gain on operations under the Plan as represented by the current balance in the Plan's LOC account, adjusted by necessary accruals, shall constitute carrier held reserves within the meaning of the Act and Regulations.

9. During the term of this Agreement, the Mail Handlers Union shall request from OPM, if requested by First Health Life, a special transfer from the Contingency Reserve, pursuant to the requirements of the Act and Regulations. In all such instances in which the Mail Handlers requests a special transfer from the Contingency Reserve, First Health Life, through the Mail Handlers Union, shall provide to OPM Cash Flow Statements, current Balance Sheet information and the pertinent claims data in support of such a Special Contingency Reserve transfer.

10. Should this Agreement be discontinued for any reason, First Health Life shall be entitled to receive from the Plan's LOC account an amount equal to the carrier held reserves on the date of discontinuance (including any subscription income subsequently deposited in such account that is attributable to the Plan's operation while First Health Life served as the Plan's underwriter under this Agreement, including its predecessors) to the extent such funds are necessary (1) to discharge First Health Life's or

Cambridge Life's liability for the incurred but unpaid claims at the date of discontinuance and (2) to pay the Company's allowable administrative expenses incurred in the payment of such claims and for other contract costs pursuant to the FAR.. Such administrative expenses shall be subject to an amount separately negotiated with OPM from the limitation set forth in Attachment B to this Agreement or Appendix B to the Prime Contract. The Company also shall be entitled, if such is necessary to discharge its liability for (1) and (2) above, to the balance held in the Contingency Reserve as of the effective date of discontinuance of this Agreement.

11. The Company shall supply enrollees of the Plan with identification cards and forms, as provided in the Plan brochure, for the filing of claims for benefits under the Plan. Claims, with supporting proof, shall be submitted as provided in the Plan brochure and other applicable provisions of the Prime Contract. Payment of claims will be made as provided in the Plan brochure and other applicable provisions of the Prime Contract.

12. The Company shall void all checks issued in payment of benefits which have been outstanding for two (2) years on a quarterly basis. The amounts represented by such voided checks then shall be credited to the Plan's LOC account. For this purpose, the term "check" shall include any written instrument to pay or reimburse the payment of benefits under the Plan, including by way of illustration but not limitation, drafts, money orders, and checks.

13(a) FEPI hereby agrees to perform for the Mail Handlers Union all administrative services necessary to the operation of the Plan, including, but not limited to,

- (i) the maintenance of files to determine, and the determination of, enrollment and eligibility for payment of benefits under the Plan;
- (ii) the prompt investigation, adjudication and payment of claims for benefits under the Plan, including (A) the performance of reconsideration of denied claims as required by the Act and Regulations, (B) the provision of a defense to any litigation arising from claims under the Plan, which obligation shall include retaining or causing to be retained local counsel, paying or causing to be paid the legal fees of local counsel in connection therewith and paying or causing to be paid any settlements or judgments arising therefrom, and (C) the undertaking of reasonably diligent efforts to recoup benefit overpayments and (through its designee) to enforce the Plan's subrogation rights; and
- (iii) the preparation and maintenance of financial and statistical data and/or reports reflecting the operation of the Plan as required by law, and the establishment and maintenance of a quality assurance program in accordance with Section 1.9 of the Prime Contract.

One or more of the Company's affiliates will directly contract with the Mail Handlers Union for cost containment programs such as utilization of hospital and physician preferred provider organizations.

(b) The Company agrees that any advertising material, including promotional and marketing material and supplemental literature that it prepares or causes to be prepared for the Plan, shall be truthful, not misleading, and consistent with the guidelines set forth in the Prime Contract and the Regulations.

14. The Company's expense charges and Service Charge for the performance of the underwriting and the administrative functions (including administrative functions delegated to FEPI) set forth in Section 13(a) of this Agreement shall be as provided for in the applicable Prime Contract for the respective Plan year and are listed in Attachment B hereto for 2003.

15(a) First Health Life, on its behalf and on the behalf of Cambridge Life and FEPI, shall, if requested, submit, actually or by specific identification in writing if actual submission of the data is impracticable, to the Mail Handlers Union cost or pricing data prior to the Mail Handlers Union's execution of this Agreement, which shall be accomplished during the benefit and rate negotiations with OPM, and prior to the pricing of any modification to this Agreement which involves aggregate increases or decreases in costs, plus applicable profits, expected to exceed \$550,000.00, except where the price or price modification is for the acquisition of commercial items or is based on adequate price competition or prices set by law or regulation.

(b) First Health Life, on its behalf and on the behalf of Cambridge Life and FEPI, shall certify in writing to the Mail Handlers Union that to the best of its knowledge and belief the cost or pricing data submitted under subparagraph (a) above is accurate, complete and current as of the date of agreement on the negotiated price of this Agreement or modification thereto. First Health Life shall make this certification by using the following form:

Certificate of Current Cost or Pricing Data

This is to certify that, to the best of my knowledge and belief, cost or pricing data, submitted in writing, or specifically identified in writing if actual submission of the data is impracticable, to the Mail Handlers Union in support of the [insert description] are accurate, complete and current as of [insert date].

First Health Life and Health  
Insurance Company

By \_\_\_\_\_  
Its \_\_\_\_\_

\_\_\_\_\_  
Date of Execution

(c) First Health Life shall insert the substance of subparagraph (b), including this subparagraph (c), in each subcontract hereunder which exceeds \$550,000.00 when entered into except where the subcontract price thereof is for the acquisition of commercial items, or based on adequate price competition or prices set by law or regulation.

16(a) The Company undertakes to indemnify the Mail Handlers Union from any and all liability, loss, costs, and expenses, including attorneys' fees (hereafter "indemnifiable losses"), which the Mail Handlers Union may incur or sustain as a result of the occurrence of any one of the following acts:

- (i) First Health Life, pursuant to paragraph 15 of this Agreement, furnished the Mail Handlers Union with cost or pricing data which was not accurate, complete and current as certified in First Health Life's Certificate of Current Cost or Pricing Data; or
- (ii) First Health Life furnished the Mail Handlers Union with cost or pricing data which was required to be accurate, complete and current and to be submitted to support a subcontract cost estimate furnished by the Mail Handlers Union but which was not accurate, complete and current as of the date certified in the Mail Handlers Union's Certificate of Current Cost or Pricing Data; or
- (iii) First Health Life furnished the Mail Handlers Union with any data, not within (i) or (ii) above, which was not accurate as submitted; or
- (iv) Any act or omission of an employee or agent of First Health Life or one of its subcontractors at any tier which results in a cost or expense charged against the Prime Contract, that is deemed by OPM or other responsible Government authority to have been unallowable or improper pursuant to applicable law; or
- (v) Any intentionally wrongful or negligent act or omission of an employee or agent of the Company or one of its subcontractors at any tier related to the performance of any function for which the Company is responsible under this Agreement provided that the indemnifiable loss resulting therefrom is not an allowable charge against the Prime Contract.

(b) On such indemnification amounts, if any, the Company, if required by the Act or Regulations, agrees to pay the Mail Handlers Union interest at the rate at which the Company is required by the Act and Regulations to credit interest on investment income to the FEHBP, unless another rate is prescribed by federal law.

(c) As a condition to indemnification hereunder, the Mail Handlers Union promptly shall notify the Company in writing of the commencement of any judicial or administrative action that may give rise to an indemnifiable loss, must give the Company an opportunity to arrange and direct the defense of the matter, and shall provide the Company with all information and assistance necessary for such defense.

(d) These provisions (16(a)-(d)) shall survive the expiration of this Agreement.

17. All provisions or clauses of the Prime Contract, including without limitation, the provisions listed below, that are required to be incorporated herein are so incorporated by reference thereto. The following provisions of the Prime Contract, effective January 1, 2003, specifically are incorporated herein by reference and shall be binding on the Company:

- Section 1.6 Confidentiality of Records
- Section 1.9 FEHB Quality Assurance

Section 1.10	Notice of Significant Events
Section 1.11	FEHB Inspection
Section 1.12	Correction of Deficiencies
Section 1.13	Information and Marketing Materials
Section 1.14	Misleading, Deceptive, or Unfair Advertising
Section 1.16	Subcontracts
Section 1.21	Patients' Bill of Rights
Section 1.22	Administrative Simplification - HIPAA
Section 1.23	HIPAA Compliance
Section 1.24	Notice to Enrollees on Termination of FEHBP or Provider Contract
Section 1.25	Transitional Care
Section 2.9	Claims Processing
Section 2.10	Calculation of Cost Sharing Provisions
Section 2.12	Continuing Requirements after Termination of the Carrier
Section 3.4	Investment Income
Section 3.5	Non-Commingling of Funds
Section 3.8	Contractor Records Retention
Section 3.10	Audit, Financial and Other Information
Section 3.13	Taxpayer Identification Number
Section 4.1(c)	Participation in the DoD/FEHBP Demonstration Project
Section 5.5	Anti-Kickback Procedures
Section 5.7	Audit and Records - Negotiation
Section 5.14	Utilization of Small Business Concerns
Section 5.18	Contract Work Hours and Safety Standards Act-Overtime Compensation - General
Section 5.19	Equal Opportunity
Section 5.22	Affirmative Action for Disabled Veterans and Veterans of the Vietnam Era
Section 5.23	Affirmative Action for Workers with Disabilities
Section 5.41	Limitation of Liability-Services
Section 5.45	Limitation on Payments to Influence Certain Federal Transactions
Section 5.51	Pension Adjustments and Asset Reversions
Section 5.52	Reversion of Adjustment of Plans for Post Retirement Benefits Other Than Pensions (PRB)
Section 5.55	Employment Reports on Disabled Veterans and Veterans of the Vietnam Era
Section 5.56	Authorization and Consent
Section 5.57	Notice and Assistance Regarding Patent and Copyright Infringement
Section 5.59	Prohibition of Segregated Facilities
Section 5.60	Subcontracts for Commercial Items and Commercial Components

For purposes of this Agreement, all references in the foregoing provisions of the Prime Contract to the "contractor" or "carrier" shall be treated as references to the Company, and all references to the "contract" or "prime contract" therein shall be treated as references to this Agreement.

18. The Company, in its sole discretion, shall have the right of indirect appeal to the Armed Services Board of Contract Appeals or any

applicable court with respect to any final decision rendered by an OPM Contracting Officer pursuant to the Disputes clause of the Prime Contract (Section 5.36, FAR S 52.233-1). Indirect appeal means assertion and prosecution by the Company of the Mail Handlers Union's right to such appeal. In the event that the Company exercises such right of indirect appeal, any unallowable expenses of such appeal shall be borne by the Company.

During the term of this Agreement, the Company shall be entitled to assert, on behalf of the Mail Handlers Union, the right to an equitable adjustment under Section 5.38 of the Prime Contract, captioned "Changes - Negotiated Benefits Contracts," as the Company deems necessary and appropriate. In all such instances in which the Company requests an equitable adjustment, the Company shall provide the Mail Handlers Union with copies of any and all correspondence and information submitted to OPM in support of such an equitable adjustment request.

19. Upon thirty days advance written notice, the Mail Handlers Union may conduct an audit, during normal business hours, of the Company's records relating to its obligations under this Agreement. The Company will have the right to request a copy of audit results and will pay the reasonable copy costs associated with such a request.

20. This Agreement and any rights or obligation arising out of any act to be performed hereunder shall be governed exclusively by the laws of the United States.

21. This Agreement may be amended by the parties in writing at any time with the approval of OPM if so required.

22. Any notice provided for in this Agreement must be in writing, and either must be delivered by facsimile with proof of delivery, personally delivered or mailed by first class mail (registered or certified, return receipt requested) to the following addressees:

For the Mail Handlers Union:  
Mr. William H. Quinn, National President  
Mr. Mark A. Gardner, National Secretary-Treasurer  
National Postal Mail Handlers Union  
1101 Connecticut Ave, N.W., Suite 500  
Washington, D.C. 20036  
Facsimile No.: (202) 833-0008

For the Company:

President, First Health Life and Health Insurance Company  
President, Cambridge Life Insurance Company  
President, Federal Employee Plans, Inc.  
3200 Highland Avenue  
Downers Grove, IL 60515  
Facsimile No.: (630) 737-7878  
cc: Susan T. Smith  
Vice President, General Counsel  
Facsimile No.: (630) 737-7518

Except as otherwise provided in this Agreement, any notice shall be deemed to have been given at the time of delivery.

23. This Agreement may be executed in several counterparts, each of which shall be deemed an original but all of which shall constitute one and the same Agreement. A facsimile or other reproductive type copy of this Agreement, so long as signed by all parties, will be considered an original and will be fully enforceable against all parties.

24. Each signatory hereto warrants that he has been duly authorized to execute this Agreement on behalf of the party for whom he acts and that this Agreement is a binding and valid obligation of such party.

IN WITNESS WHEREOF, this Agreement has been executed in quadruplicate on this 15th day of April, 2002.

NATIONAL POSTAL MAIL HANDLERS UNION, A DIVISION OF THE LABORERS  
INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO d/b/a MAIL HANDLERS  
BENEFIT PLAN

By: \_\_\_\_\_  
Mr. William H. Quinn  
National President  
Mail Handlers Benefit Plan

FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY

By: \_\_\_\_\_  
Mr. Edward L. Wristen  
President

CAMBRIDGE LIFE INSURANCE COMPANY

By: \_\_\_\_\_  
Mr. Edward L. Wristen  
Vice President and Secretary

FEDERAL EMPLOYEE PLANS, INC.

By: \_\_\_\_\_  
Mr. Edward L. Wristen  
Acting President

Attachment A to Prime Subcontract No. L-35489

Effective January 1, 2003

- (a) Biweekly net-to-carrier rates, with appropriate adjustments for enrollees paid on other than a biweekly basis, are as follows(1):

	FEHB PROGRAM		DOD PROJECT	
	High Option	Standard Option	High Option	Standard
Option	-----	-----	-----	-----
Self Only	-----	-----	-----	-----
Self and Family	-----	-----	-----	-----

(1) In the third quarter of 2002, the biweekly net-to-carrier rates for 2003 will be finalized by the Mail Handlers Union, the Company and OPM. Attachment A will be amended with such finalized rates by written notice sent to all parties.

First Health Group Corp.  
 Computation of Diluted Earnings Per Common Share  
 (In 000's except per share amounts)

	Year Ended December 31,		
	2000	2001	2002
	-----	-----	-----
Net Income	\$ 82,619	\$102,920	\$132,938
	=====	=====	=====
Weighted average number of common shares outstanding:			
Shares outstanding from beginning of period	95,312	96,408	100,023
Purchase of treasury stock	(1,038)	--	(1,043)
Other issuances of common stock	1,424	1,925	1,717
Common share equivalents:			
Assumed exercise of common stock options	4,042	4,722	3,561
	-----	-----	-----
Weighted average common and common share equivalents	99,740	103,055	104,258
	=====	=====	=====
Net income per share	\$ .83	\$ 1.00	\$ 1.28
	=====	=====	=====

First Health Group Corp.  
 Computation of Basic Earnings Per Common Share  
 (In 000's except per share amounts)

	Year Ended December 31,		
	2000	2001	2002
Net Income	\$ 82,619	\$102,920	\$132,938
Weighted average number of common shares outstanding:			
Shares outstanding from beginning of period	95,312	96,408	100,023
Purchase of treasury stock	(1,038)	--	(1,043)
Other issuances of common stock	1,424	1,925	1,717
Weighted average common and common share equivalents	95,698	98,333	100,697
Net income per share	\$ .86	\$ 1.05	\$ 1.32

## Selected Financial Data

(in thousands except per share data)	Years Ended December 31,				
	1998	1999	2000	2001	2002
Statement of operations data:					
Revenues	\$ 503,077	\$ 458,493	\$ 506,741	\$ 593,108	\$ 759,966
Operating expenses:					
Cost of services	228,108	215,480	225,783	261,985	336,094
Selling and marketing	49,574	45,588	48,377	58,416	77,878
General and administrative	42,724	36,549	34,201	39,598	55,057
Health care benefits	18,542	6,192	13,044	13,293	15,455
Depreciation and amortization	25,235	29,445	38,389	46,527	56,077
Interest income	(20,470)	(6,293)	(6,639)	(6,844)	(6,698)
Interest expense	12,642	15,017	14,731	7,152	5,454
Total operating expenses	356,355	341,978	367,886	420,127	539,317
Income before income taxes	146,722	116,515	138,855	172,981	220,649
Income taxes	(58,719)	(47,218)	(56,236)	(70,061)	(87,711)
Net income	\$ 88,003	\$ 69,297	\$ 82,619	\$ 102,920	\$ 132,938
Weighted average shares					
outstanding-basic(1)	123,340	100,540	95,698	98,333	100,697
Net income per common share-basic(1)	\$ .71	\$ .69	\$ .86	\$ 1.05	\$ 1.32
Weighted average shares					
outstanding-diluted(1)	125,316	102,006	99,740	103,055	104,258
Net income per common share-diluted(1)	\$ .70	\$ .68	\$ .83	\$ 1.00	\$ 1.28
Balance sheet data:					
Cash and investments	\$ 199,776	\$ 128,596	\$ 127,582	\$ 137,353	\$ 152,712
Working capital	15,409	31,425	40,270	(159,130)	1,199
Total assets	557,879	488,734	491,596	780,734	843,361
Total liabilities (excluding debt)	194,752	162,002	182,683	243,935	309,215
Debt outstanding	225,000	240,000	127,500	197,500	120,000
Stockholders' equity	\$ 138,127	\$ 86,732	\$ 181,413	\$ 339,299	\$ 414,146

(1) All historical common share data have been adjusted for a 2-for-1 stock split in the form of a 100% stock distribution paid on June 23, 1998 to stockholders of record on June 2, 1998.

All historical common share data have been adjusted for a 2-for-1 stock split in the form of a 100% stock distribution paid on June 25, 2001 to stockholders of record on June 4, 2001.

Management's Discussion and Analysis  
-----  
of Financial Condition and Results of Operations  
-----

This Management's Discussion and Analysis of Financial Condition and Results of Operations may include certain forward-looking statements, within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended, including (without limitation) statements with respect to anticipated future operating and financial performance, growth and acquisition opportunities and other similar forecasts and statements of expectation. Words such as "expects," "anticipates," "intends," "plans," "believes," "seeks," "estimates," "could" and "should" and variations of these words and similar expressions, are intended to identify these forward-looking statements. Forward-looking statements made by the Company and its management are based on estimates, projections, beliefs and assumptions of management at the time of such statements and are not guarantees of future performance. The Company disclaims any obligation to update or revise any forward-looking statement based on the occurrence of future events, the receipt of new information or otherwise.

Actual future performance, outcomes and results may differ materially from those expressed in forward-looking statements made by the Company and its management as a result of a number of risks, uncertainties and assumptions. Representative examples of these factors include (without limitation) general industry and economic conditions; interest rate trends; cost of capital and capital requirements; competition from other managed care companies; customer contract cancellations; the ability to expand certain areas of the Company's business; shifts in customer demands; changes in operating expenses including employee wages, benefits and medical inflation; governmental and public policy changes and the continued availability of financing in the amounts and on the terms necessary to support the Company's future business. In addition, if the Company does not continue to successfully implement new contracts, programs and control healthcare benefit expenses; or if the Company does not successfully integrate the recently acquired Mail Handlers Benefit Plan administrative assets (discussed below); then the Company may not achieve its anticipated 2003 financial results.

Significant Developments.

Overview. The following information concerning significant business developments during 2002 is important to understanding the Company's 2002 financial results.

Mail Handlers Benefit Plan On April 16, 2002, the Company increased its business relationship with the National Postal Mail Handlers Union (the "Union"), the sponsors of the Mail Handlers Benefit Plan (the "Plan"). As a result of the Company's acquisition of Claims Administration Corporation ("CAC"), the prior underwriter and claims administrator of the Plan, the Company was able to assume underwriting and claims administration services to the Union and Plan in mid-2002. The new arrangements were built on an existing contract through which the Company provides The First Health[R] Network to the Plan's members. Through two important new contracts effective January 1, 2003, the Company and its wholly-owned subsidiary insurance companies, First Health Life and Health Insurance Company and Cambridge Life Insurance Company, will continue to be the underwriter and the claims administration provider to the Plan and, in addition, provide health benefit services to the Plan. Health benefit services include PPO and clinical management services. In addition, the Union has notified us that we have been awarded a third contract for Pharmacy Benefit Administration services, effective January 1, 2003, and that contract is being negotiated with the Union. The Plan has nearly 400,000 federal employees and annuitants representing approximately one million members nationwide, and is one of the nation's largest health plans. The Plan is the Company's largest customer with revenues earned of approximately \$160 million or 21% of total Company revenue in 2002. The Company expects the Plan to constitute approximately 25% of the 2003 revenue (discussed later in the MD&A section of this report).

On July 1, 2002, the Company acquired the stock of CAC, a subsidiary of Continental Casualty Company, which was the provider of many of the services required by the Plan (see Note 2 to the Consolidated Financial Statements), for a purchase price of \$18 million. In connection with this acquisition, the Company assumed the responsibility for supporting the Plan effective July 1, 2002. The acquisition includes the transfer of approximately 1,000 CAC employees and related assets which support the Plan in various offices throughout the United States. These employees have assumed the same function for First Health, providing the Company with an experienced team of personnel already accustomed to administering the one-million-member Plan. The Company believes this acquisition significantly reduced the need for typical implementation efforts related to these new contracts. The acquisition was financed from borrowings under the Company's line of credit.

CCN Acquisition On August 16, 2001, the Company completed the acquisition of all of the outstanding shares of capital stock of CCN Managed

Care, Inc. ("CCN") and Preferred Works, Inc. ("PW" and together with CCN, the "CCN Companies") from HCA-The Healthcare Company and VH Holdings, Inc. (collectively, the "Sellers") for a purchase price of \$195 million in cash, plus a working capital adjustment which increased the purchase price to \$198 million. The acquisition was closed pursuant to the terms of a Stock Purchase Agreement, dated as of May 18, 2001 (as amended as of August 16, 2001), among the Company and the Sellers. The acquisition was financed from borrowings under the Company's line of credit. At the date of acquisition, the Company reviewed the various businesses comprising the CCN Companies and determined to hold PW and the Resource Opportunity, Inc. ("ROI") business of CCN for sale. The Company completed the sale of ROI on December 28, 2001 for a gross sales price of \$9 million. The sale of PW was completed on June 28, 2002 for a gross sales price of \$4.1 million. The Company realized approximately \$10 million from these sales after selling expenses and liabilities assumed. The Company increased the goodwill on the CCN acquisition by \$6 million as a result of the completion of these sales.

In conjunction with the acquisition, the Company recorded as part of the purchase price a \$41.1 million reserve for restructuring and integration costs as part of an overall plan to reduce operating expenses and integrate the business of the acquired companies. During the third quarter of 2002, the Company reduced the reserve by \$14.4 million. This reserve reduction is due primarily to revisions in the cost of facilities integration and a reduction in losses on assumed contracts as discussed below. The specific actions included in the restructuring plan were substantially completed by December 31, 2002. The actions taken to implement the restructuring plan generated in excess of \$30 million in annualized savings for the Company primarily from lower salaries and benefits costs and, to a lesser extent, lower overall operating expenses during 2002. Components of the purchase reserve are as follows:

(in thousands)	Total	Accrual		Amount		Balance
-----	Charges	12/31/01	Adjustment	Paid	Reclass	12/31/02
-----	-----	-----	-----	-----	-----	-----
Severance and related	\$13,712	\$ 6,031	\$ --	\$(4,495)	\$ --	\$ 1,536
Facilities integration	10,370	9,528	(4,685)	(3,726)	--	1,117
Contract losses	10,000	9,750	(9,257)	(197)	--	296
Other reserves	7,031	7,028	(481)	(279)	(5,237)	1,031
Total	\$41,113	\$ 32,337	\$(14,423)	\$(8,697)	\$(5,237)	\$ 3,980
	=====	=====	=====	=====	=====	=====

The restructuring plan included the reduction of employees from various offices within the United States. The Company has reduced the number of CCN employees from approximately 1,300 at the time of the acquisition of CCN to approximately 580 at December 31, 2002. Approximately \$12.2 million has been paid for severance and related employee benefits as of December 31, 2002. The severance and related benefits accrued at December 31, 2002 represent costs for payments over the next twelve months for headcount reductions already incurred.

Facilities integration costs represent the costs to integrate CCN's facilities into the Company's existing operations. The majority of the facilities integration costs have been incurred to consolidate CCN's former corporate headquarters and various sales offices throughout the United States. During the quarter ended September 30, 2002, the Company reduced the reserve for facilities integration by \$4.7 million as the Company has capitalized a substantial amount of integration work as internally developed software that has future use in accordance with SOP 98-1, "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use." These costs were originally included in the purchase accounting reserve. Approximately \$4.6 million of costs for facilities integration have been charged to the purchase accounting reserve as of December 31, 2002. The majority of the remaining facilities integration costs are expected to be incurred during 2003.

Contract losses relate to the anticipated net loss to be incurred on an assumed contract to provide certain screening services to individuals who have agreed to be bound by a proposed settlement in a legal matter. CCN signed a contract in March 2000 to provide these services for four years and the Company has agreed to have its network providers provide these services after the acquisition of CCN. The Company currently estimates that as many as 325,000 covered persons may seek such screening services. During the quarter ended September 30, 2002, the Company reduced the reserve for contract losses by \$9.3 million. This reduction was due primarily to operational efficiencies the Company has achieved in the completion of these screening services. Approximately \$0.4 million of costs of this contract have been charged to the purchase reserve as of December 31, 2002.

Other reserves represent various operational liabilities the Company has incurred to fully integrate the Company's operations. During the quarter ended September 30, 2002, the Company reduced other reserves by \$0.5 million as the Company has revised several operational liability assumptions associated with the acquisition. During the quarter ended December 31, 2002, the Company reclassified \$5.2 million of reserves for pre-acquisition tax contingencies to the deferred tax liabilities amount in the Consolidated

Balance Sheet. Approximately \$0.3 has been charged to the reserve as of December 31, 2002. The majority of the remaining other reserves are expected to be utilized in 2003.

**HCVM Acquisition** On May 1, 2002, the Company completed the acquisition of HealthCare Value Management ("HCVM") for an initial purchase price of \$24 million plus additional amounts to be paid upon the completion of certain financial performance measures. The Company will pay \$3.1 million in March 2003 and anticipates paying an additional \$3.3 million in 2003 for contractual obligations based on financial performance measures that HCVM has met. HCVM is a New England based PPO company, headquartered in suburban Boston. The acquisition was financed from borrowings under the Company's line of credit. The integration of the HCVM operations was substantially completed by December 31, 2002.

**Stock Split** On May 22, 2001, the Company's Board of Directors authorized a 2-for-1 common stock split in the form of a 100% stock distribution. The split was payable on June 25, 2001 to stockholders of record on June 4, 2001. Treasury shares were not split. However, an adjustment was made to the stockholders' equity section of the Consolidated Balance Sheet to split the cost of treasury stock (in effect, a cancellation of treasury shares by reducing paid-in-capital and retained earnings). All historical common share amounts, per share amounts and stock option data for all periods presented have been restated to give effect to this 100% stock distribution.

**Results of Operations.** The following table presents the Company's sources of revenues and percentages of those revenues represented by certain statement of operations items.

Sources of revenue: (\$ in thousands):	Years Ended December 31,					
	2000	%	2001	%	2002	%
PPO services	\$ 272,196	54	\$ 346,944	59	\$ 437,822	58
Claims administration	153,807	30	167,905	28	237,473	31
Fee schedule services	36,848	7	35,262	6	40,476	5
Clinical management services	31,715	6	28,325	5	28,654	4
Premiums, net	12,175	3	14,672	2	15,541	2
<b>Total</b>	<b>\$ 506,741</b>	<b>100</b>	<b>\$ 593,108</b>	<b>100</b>	<b>\$ 759,966</b>	<b>100</b>

Percent of revenue:	Years Ended December 31,		
	2000	2001	2002
<b>Expenses:</b>			
Cost of services	45%	44%	44%
Selling and marketing	10	10	10
General and administrative	7	7	7
Health care benefits	2	2	2
Depreciation and amortization	7	8	8
Interest income	(1)	(1)	(1)
Interest expense	3	1	1
<b>Subtotal</b>	<b>73</b>	<b>71</b>	<b>71</b>
<b>Income before income taxes</b>	<b>27</b>	<b>29</b>	<b>29</b>
<b>Net income</b>	<b>16%</b>	<b>17%</b>	<b>17%</b>

**Revenues.** The Company's revenues consist primarily of fees for cost management services provided under contracts on a percentage of savings basis (PPO services) or on a predetermined contractual basis (claims administration, fee schedule, clinical management services and, to a lesser extent, PPO services). Revenues also include a small amount of premium revenue. Total revenues increased \$166,858,000 (28%) from 2001 to 2002 and increased \$86,367,000 (17%) from 2000 to 2001. The increase in revenues from 2001 to 2002 is due primarily to growth in PPO revenue and to revenue from the administration of the Plan associated with the acquisition of CAC. The increase in revenue from 2000 to 2001 was also due primarily to growth in PPO revenue as well as the CCN acquisition.

Revenue from PPO services increased from 2000 to 2002 as a result of numerous new clients such as Mail Handlers Benefit Plan, existing clients utilizing more PPO services, the addition of new medical providers to the PPO network and to the addition of CCN and HCVM revenue. Claims administration primarily represents revenue earned from processing claims in client-sponsored health care plans. The increase from 2001 to 2002 reflects the CAC business discussed above. The increase from 2000 to 2001 reflects the addition of new business particularly in the commercial sector. Fee schedule services revenue increased from 2001 to 2002 due primarily to the inclusion of CCN business. Fee schedule services revenue decreased from 2000 to 2001 due to the loss of General Motors and some smaller workers' compensation carriers who have exited the business. This loss of business was partially offset by approximately \$6 million in CCN revenue. Revenue

from clinical management services increased from 2001 to 2002 due primarily to new business. Revenue from clinical management services decreased from 2000 to 2001 due to the loss of business from focusing on multi-sited, national employers as well as the termination of various healthcare management contracts with various state Medicaid programs. Premium revenue increased from 2000 to 2002 as a result of new and existing clients that were sold stop-loss insurance contracts.

Change in Revenue Reporting. Effective for the quarter ending March 31, 2003, the Company will report its revenue as follows:

Group Health Revenue  
Workers' Compensation Revenue  
Public Sector Revenue

Additionally, its group health and workers' compensation revenue will be further broken down between PPO Services and PPO plus Administrative Services. The Company believes this revenue presentation represents how the Company currently sells its services. The Company is selling a predominance of its group health PPO services coupled with administrative services (especially claims administration) and, to a lesser extent, its workers' compensation PPO services are often coupled with fee schedule services. If the Company had used this presentation methodology for the years 2000 through 2002, its revenues would have been presented as follows:

(in thousands)	Years ended December 31,		
	2000	2001	2002
-----	-----	-----	-----
Group Health			
PPO	\$152,496	\$200,497	\$210,846
PPO plus Admin Services	140,576	145,877	255,341
-----	-----	-----	-----
Total Group Health	293,072	346,374	466,187
Workers' Compensation			
PPO	29,707	40,429	54,961
PPO plus Admin Services	77,106	90,297	106,363
-----	-----	-----	-----
Total Workers' Compensation	106,813	130,726	161,324
Public Sector	106,856	116,008	132,455
-----	-----	-----	-----
Total Revenue	\$506,741	\$593,108	\$759,966
=====	=====	=====	=====

Cost of Services. Cost of services increased \$74,109,000 (28%) from 2001 to 2002 due primarily to the inclusion of CCN costs, HCVM costs and the costs associated with the administration of the Plan. Cost of services increased \$36,202,000 (16%) from 2000 to 2001 due primarily to the inclusion of CCN costs for the last four months of 2001. Cost of services consists primarily of salaries and related costs for personnel involved in claims administration, PPO administration, development and expansion, clinical management programs, fee schedule, information technology and other cost management and administrative services offered by the Company. To a lesser extent, it includes telephone expenses, facility expenses and information processing costs. Cost of services as a percent of revenue decreased from 45% in 2000 to 44% in 2001 and 2002. The Company has achieved significant operating efficiencies as CCN has been substantially integrated into the Company's business. The Company has made significant technology infrastructure investments between 2000 and 2002 which are intended to further improve the efficiency of its operations. Historically, the Company has invested approximately 10% of revenue in its infrastructure and currently expects to continue this level of investment.

Selling and Marketing. Selling and marketing expenses increased \$19,462,000 (33%) from 2001 to 2002 due primarily to increased expenditures for the Company's national marketing campaign and to the addition of CCN costs. The Company began a national consumer advertising campaign in the third quarter of 2002 designed to increase name recognition. The campaign includes television commercials, print ads and billboard ads in a number of markets. To a lesser extent, the increase in selling and marketing costs is due to costs associated with the administration of the Plan. Selling and marketing expenses increased \$10,039,000 (21%) from 2000 to 2001 due primarily to increased expenditures for the Company's national marketing campaign and to the addition of CCN sales personnel. As a percentage of revenues, selling and marketing expenses have remained approximately 10% from 2000 to 2002.

General and Administrative. General and administrative expenses increased \$15,459,000 (39%) from 2001 to 2002 due primarily to the inclusion of CCN costs and costs associated with the administration of the Plan. General and administrative expenses increased \$5,397,000 (16%) from 2000 to 2001 due primarily to the inclusion of CCN costs.

Health Care Benefits. Healthcare benefit expenses increased \$2,162,000 (16%) from 2001 to 2002 and \$249,000 (2%) from 2000 to 2001. These expenses represent medical losses incurred by insureds of the Company's insurance entities. The medical loss ratio (healthcare benefits as a percent of premiums) was 107% for 2000, 91% for 2001 and 99% for 2002. The Company's insurance business is small and volatile, so the loss ratio is somewhat

unpredictable. Management continues to review the book of business in detail to minimize the loss ratio. Stop-loss insurance is related to the PPO and claims administration businesses and is used as a way to attract additional PPO business which is the Company's most profitable product.

Depreciation and Amortization. Depreciation and amortization expenses increased \$9,550,000 (21%) from 2001 to 2002 and \$8,138,000 (21%) from 2000 to 2001. These expenses increased from 2000 to 2002 principally as a result of the significant infrastructure investments made over the past several years and, to a lesser extent, amortization of intangible assets related to the various acquisitions the Company has made. As a percentage of revenues, these costs increased from 7% in 2000 to 8% in 2001 and 8% in 2002. Depreciation expense will continue to grow primarily as a result of continuing investments the Company is making in its infrastructure. The increase was partially offset by the reduction in goodwill amortization of \$4,986,000 in 2002 due to the adoption of Statement of Financial Accounting Standards No. 142 ("SFAS 142"), "Goodwill and other Intangible Assets" (see Note 1 to the Consolidated Financial Statements).

Interest Income. Interest income decreased \$146,000 (2%) from 2001 to 2002 and increased \$205,000 (3%) from 2000 to 2001. Interest income represented 1% of revenues in 2000, 2001 and 2002. Interest income has remained fairly constant as the Company has used much of its available cash to repay debt and repurchase its common stock.

Interest Expense. Interest expense decreased \$1,698,000 (24%) from 2001 to 2002 and \$7,579,000 (51%) from 2000 to 2001 due primarily to the debt repayment the Company has made with its available cash. Interest expense represents interest incurred on the Company's revolving credit agreement. The floating interest rate incurred was between 3% and 7% from 2000 to 2002.

Income Taxes. Income taxes were provided at an effective rate of approximately 40% from 2000 to 2002. The higher than statutory rate for the three years includes provisions for state income taxes and expenses that are not deductible for income tax purposes.

Seasonality. The Company has historically experienced increases in salaries and related costs during its first and fourth calendar quarters in anticipation of an increase in the number of new participants in client-sponsored health care plans. Since group health care plans typically offer an open enrollment period for new participants during January of each year, the Company anticipates that its future first and fourth quarters will continue to reflect similar cost increases. The Company's future earnings could be adversely affected if the Company were to incur costs in excess of those necessary to service the actual number of new participants resulting from the open enrollment.

Inflation. Although inflation has not had a significant effect on the Company's operations to date, management believes that the rate at which health care costs have increased has contributed to the demand for PPO, clinical cost management and other cost management services, including the services provided by the Company.

Other Information. There continues to be discussion of health care reform. Although specific features of any legislation that ultimately may be enacted into law cannot be predicted at this time, based on the Company's review of legislation previously considered by Congress and various state legislatures, management believes that the Company's existing programs and those under development provide a foundation that will help prevent any material adverse affect on the operations of the Company.

Liquidity and Capital Resources. The Company had positive working capital of \$1,199,000 at December 31, 2002 compared to negative working capital of \$159,130,000 at December 31, 2001 and positive working capital of \$40,270,000 at December 31, 2000. All of the Company's outstanding debt at December 31, 2001 was classified as a current liability as the Company's credit facility was due to expire on June 30, 2002. On April 23, 2002, the Company obtained a new credit facility which matures in 2007; consequently, the outstanding debt is now classified as long-term. Total cash and investments of the Company amounted to \$152,712,000 at December 31, 2002, \$137,353,000 at December 31, 2001 and \$127,582,000 at December 31, 2000.

For the three year period ended December 31, 2002, the Company generated \$600,092,000 of cash from operating activities. During 2002, investment activities used \$117,965,000 in cash representing capital expenditures of \$71,583,000, acquisitions of \$42,959,000 and net purchases of investments of \$4,346,000 partially offset by \$923,000 in changes in assets held for sale (relating to the sales of ROI and PW). Investment activities used \$267,547,000 in cash during 2001 representing \$189,645,000 used to acquire the CCN Companies (net of \$9,000,000 received for the sale of ROI), net purchases of investments of \$14,248,000 and capital expenditures of \$63,654,000. Investment activities used \$67,270,000 in cash during 2000 representing net purchases of investments of \$4,828,000 and capital expenditures of \$62,442,000. Financing activities used \$152,715,000 in cash during 2002 representing \$77,500,000 in repayment of long-term debt (net of \$240,000,000 in debt issuance) and \$109,322,000 in purchases of Company common stock (representing 4,515,000 shares) partially offset by \$32,243,000 in proceeds from issuance of common stock (representing 3,163,000 shares), \$1,489,000 in stock option loan repayments (net of \$2,272,000 in stock

option loans granted) and \$375,000 in proceeds from the sale of put options. Financing activities provided \$106,662,000 in cash during 2001 representing \$70,000,000 in net proceeds from issuance of long-term debt (net of \$145,000,000 in repayment of debt) and \$36,807,000 in proceeds from issuance of common stock (representing 3,616,000 shares) partially offset by \$145,000 in stock option loans to employees (net of \$1,594,000 in loan repayments). Financing activities used \$116,044,000 in cash during 2000 representing \$112,500,000 in net reductions of long-term debt and \$46,059,000 in purchases of treasury stock (representing 1,705,000 shares) partially offset by \$40,907,000 in proceeds from the issuance of common stock (representing 1,693,000 shares), \$1,228,000 in stock option loan repayments (net of \$3,637,000 in stock option loans granted) and \$380,000 in sales of put options.

The Company had a revolving line of credit in the amount of \$350 million which was due to expire on June 30, 2002. On April 23, 2002, the Company obtained a new \$400 million revolving line of credit that replaced the previous credit facility. The new facility has a five-year term and provides for interest at a Euro dollar rate (which approximates LIBOR) plus a variable margin and a facility fee that fluctuate based on the Company's debt rating. As of December 31, 2002, \$120 million was outstanding under the new facility.

The following table summarizes the contractual obligations the Company has outstanding as of December 31, 2002:

(in thousands) Years Ending December 31, -----	Leases -----	Revolving Line of Credit -----	Total -----
2003	\$12,922	\$ --	\$ 12,922
2004	10,344	--	10,344
2005	8,242	--	8,242
2006	4,957	--	4,957
2007	3,848	120,000	123,848
Thereafter	7,282	--	7,282
	-----	-----	-----
Total	\$47,595	\$120,000	\$167,595
	=====	=====	=====

The Company believes that its working capital, long-term investments, credit facility and cash generated from future operations will be sufficient to fund the Company's operations and anticipated expansion plans.

Company Stock Options. The Company maintains employee and director stock option plans that provide for the granting of options to employees, directors and consultants of the Company and its subsidiaries to purchase common stock at the fair market value at date of grant. The Company has granted stock options to all employees meeting certain defined performance requirements annually since 1988. Management believes this plan has been invaluable in finding, attracting, retaining and providing incentive to employees by offering them an ownership interest in the Company.

The Company elected the disclosure-only provisions of SFAS No. 123, as amended by SFAS No. 148. The Company continues to account for its employee and director stock compensation under the intrinsic value method in accordance with APB No. 25.

Market Risk. Market risk is the risk that the Company will incur losses due to adverse changes in interest rates and prices. The Company's market risk exposure is limited to the \$69,184,000 and \$68,147,000 of marketable securities owned by the Company at December 31, 2002 and 2001, respectively, and the \$120,000,000 and \$197,500,000 of variable rate debt owed by the Company at December 31, 2002 and 2001, respectively. The Company does not hold any market risk sensitive instruments for trading purposes. The Company has established policies and procedures to manage sensitivity to interest rate and market risk. These procedures include the monitoring of the Company's level of exposure to each market risk and the use of derivative financial instruments to reduce risk.

The Company's marketable equity and debt securities are classified as available for sale and are recorded in the consolidated balance sheets at fair value with unrealized gains or losses reported as a separate component of other comprehensive income (loss) in stockholders' equity, net of applicable deferred taxes. As of December 31, 2002, the fair value of the Company's marketable securities was \$69,184,000, consisting of \$64,904,000 invested in debt securities and \$4,280,000 invested in equity securities. As of December 31, 2001, the fair value of the Company's marketable securities was \$68,147,000, consisting of \$61,113,000 invested in debt securities and \$7,034,000 invested in equity securities. The Company measures its interest rate risk by estimating the net amount by which potential future net earnings would be impacted by hypothetical changes in market interest rates related to all interest rate sensitive assets and liabilities, including derivative financial instruments. Assuming a hypothetical 20% increase in interest rates as of December 31, 2002, the estimated reduction in future earnings, net of tax, would be less than \$1.0 million. Assuming the same 20% increase in interest rates as of December 31, 2001, the estimated reduction in future earnings, net of tax, would also have been less than \$1.0 million. Equity price risk arises when the Company could incur economic losses due to adverse changes in a particular stock index or price. The Company's

investments in equity securities are exposed to equity price risk and the fair value of the portfolio is correlated to the S&P 500. At December 31, 2002, management estimates that an immediate 10% decrease in the S&P 500 would result in a decrease in the fair value of its equity securities of less than \$1.0 million. Management estimated that a 10% decrease in the S&P 500 at December 31, 2001 would have affected the fair value of its equity securities by less than \$1.0 million.

**Critical Accounting Policies.** The consolidated financial statements are prepared with accounting principles generally accepted in the United States of America and include amounts based on management's prudent judgments and estimates. Management believes that any reasonable deviation from those judgments and estimates would not have a material impact on the Company's financial position or results of operations. However, to the extent that the estimates used differ from actual results, adjustments to the statement of operations and the balance sheet would be necessary. Some of the more significant estimates include the recognition of revenue, allowance for doubtful accounts and insurance claim reserves. The Company uses the following techniques to determine estimates:

**Revenue recognition** - The Company receives revenues for PPO services, claims administration services, fee schedule services, clinical cost management and other services on a predetermined contractual basis (such as a percentage of the derived savings). Revenues on a percentage of savings basis for PPO services are recognized based upon client claims processed. Additionally, the Company records revenues based upon a fixed fee per covered participant, and the fee varies depending upon the programs selected or on a per-transaction basis. Within the Company's fiscal agent business, the Company has certain contracts to develop software for Medicaid claims adjudication. The Company's policy is to recognize revenue for services under these contracts as milestones are met and customer acknowledgment of such achievement of milestones is received.

**PPO revenue** and, to a lesser extent, claims administration revenue are recognized net of estimated fees associated with claims that a client is not responsible for reimbursing (such as claims from ineligible members, non-insured services and other insurance being the primary payor). In a limited number of cases, client contracts include performance guarantees. Adjustments to revenue related to guarantee amounts are recognized as known and/or earned. In other cases, estimates are made of the annual savings rates and revenues are recognized in accordance with these estimates. Periodically, specific client-related accounts receivable issues may impact revenue recognition including issues where a client disputes specific items from the current year's monthly billings.

**Allowance for doubtful accounts** - The allowance for doubtful accounts is maintained at an amount management considers appropriate in relation to the outstanding receivable balance based on factors such as portfolio credit risk quality, historical loss experience and current economic circumstances. These factors require management judgment; different assumptions or changes in economic circumstances could result in changes to the allowance for doubtful accounts.

**Insurance claim reserves** - Claims reserves are developed based on medical claims payment history adjusted for specific benefit plan elements (such as deductibles) and expected savings generated by utilization of The First Health [R] Network. Based upon this process, management believes that the insurance claims reserves are appropriate; however, actual claims incurred and actual settlement values of claims may differ from the original estimates requiring adjustments to the reserves.

**Derivative Financial Instruments.** As discussed in Note 13 to the consolidated financial statements, the Company may use derivative financial instruments to reduce interest rate risk and potentially increase the return on invested funds and to manage the cost of its common stock repurchase programs. In addition, collateralized mortgage securities have been purchased that have relatively stable cash flow patterns in relation to interest rate changes. Investments in derivative financial instruments are approved by the Board of Directors of the Company. The Company has no derivatives outstanding at December 31, 2002.

**HIPAA Administrative Simplification.** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") directed the Department of Health and Human Services ("HHS") to issue regulations setting standards for the electronic exchange of health care claims information among health care providers, payors, and plans ("EDI"), as well as security for the exchange of information via the internet ("E-Commerce"). This directive is commonly referred to as "HIPAA Administrative Simplification". HHS has issued several rules with various implementation dates in 2002 and 2003. The Company has met and management anticipates the Company will meet all the current and future implementation dates and continues to monitor HHS activity for future decisions which may affect the Company's business operations.

The Company has instituted a corporate HIPAA Administrative Simplification Committee and Workgroup to identify processes, systems or policies that will require modification and to implement appropriate remediation and contingency plans to avoid any adverse impact on its ability to perform services in accordance with the applicable standards. The Company is also communicating with significant third-party business partners to assess their

readiness and the extent to which the Company will need to modify its relationship with these third parties when conducting EDI (Electronic Data Interchange) or E-commerce.

The cost for this compliance effort is expected to be approximately \$5 million and is already included in the Company's current EDI and E-Commerce initiatives. However, there can be no guarantee that the costs will not materially differ from those anticipated or that the Company will not be materially impacted. Additionally, the Company expects to receive reimbursement directly from a number of its clients due to the nature of the contractual arrangement with these entities.

#### New Accounting Pronouncements.

In July 2001, the Financial Accounting Standards Board ("FASB") issued SFAS No. 141 ("SFAS 141"), "Business Combinations." SFAS 141 requires the purchase method of accounting for business combinations initiated after June 30, 2001 and eliminates the pooling-of-interests method. In July 2001, the FASB also issued SFAS 142, "Goodwill and Other Intangible Assets", which the Company adopted effective January 1, 2002. SFAS 142 specifies that goodwill and certain intangible assets will not be amortized, but rather be subject to periodic impairment testing.

In accordance with these pronouncements, the Company accounted for the acquisitions of the CCN companies, HCVM and CAC as purchases and allocated the purchase price to all identifiable tangible and intangible assets and liabilities. The goodwill resulting from these acquisitions of approximately \$195 million has not been amortized. Goodwill of approximately \$102 million acquired in business combinations completed before July 1, 2001 was amortized through December 31, 2001. In accordance with SFAS 142, none of the Company's \$279.4 million in goodwill was amortized in 2002. The Company recorded goodwill amortization expense of \$3.6 million and \$5.0 million in 2000 and 2001, respectively.

In accordance with the provisions of SFAS 142, the Company completed a transitional goodwill impairment test within six months of the date of adoption. The Company used standard valuation techniques including an analysis of expected business performance and analysis of recent acquisitions within the healthcare industry. There was no impairment in goodwill amounts as a result of this transitional impairment test. The Company will perform an annual impairment test during the third quarter of each year or at such earlier time that circumstances warrant an interim valuation. There was no impairment in goodwill amounts as a result of the annual impairment test performed during the third quarter of 2002.

Effective January 1, 2002, the Company adopted SFAS No. 144 ("SFAS 144"), "Accounting for the Impairment or Disposal of Long-Lived Assets." SFAS 144 addresses accounting and reporting for the impairment or disposal of long-lived assets, including discontinued operations, and establishes a single accounting model for long-lived assets to be disposed of by sale. The adoption of this pronouncement did not have a material impact on the financial position and results of operations of the Company.

In June 2002, the FASB issued SFAS No. 146, ("SFAS 146") "Accounting for Costs Associated with Exit or Disposal Activities", which requires companies to recognize costs associated with exit or disposal activities when the liabilities are incurred rather than at the date of a commitment to an exit or disposal plan. Examples of costs covered by the standard include lease termination costs and certain employee severance costs that are associated with a restructuring, discontinued operation, or other exit or disposal activity. SFAS 146 is to be applied prospectively to exit or disposal activities initiated after December 31, 2002. The Company does not expect that the adoption of SFAS 146 will have a material impact on the Company's financial position, results of operations or cash flows.

In November 2002, the FASB issued Interpretation No. 45, (FIN 45) "Guarantees, Including Indirect Guarantees of Indebtedness to Others", which expands previously issued accounting guidance and disclosure requirements for certain guarantees. FIN 45 requires the Company to recognize an initial liability for fair value of an obligation assumed by issuing a guarantee. The provision for initial recognition and measurement of the liability will be applied on a prospective basis to guarantees issued or modified after December 31, 2002. The disclosure requirements are effective immediately and have been considered for purposes of the Company's footnote disclosures. The adoption of FIN 45 is not expected to have a material impact on the Company's financial position, results of operations or cash flows.

In December 2002, the FASB issued SFAS No. 148 ("SFAS 148"), "Accounting for Stock-Based Compensation - Transition and Disclosure - an amendment of SFAS No. 123." This Statement amends SFAS No. 123 to provide alternative methods of transition for a voluntary change to the fair value based method of accounting for stock-based employee compensation and amends the disclosure requirements to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. The transition guidance and disclosure provisions of SFAS 148 are effective as of the December 31, 2002 financial statements (see Note 10 to the consolidated financial statements).

Commitments and Contingencies. The Company and its subsidiaries are subject to various claims arising in the ordinary course of business and are parties to various legal proceedings which constitute litigation incidental to the business of the Company and its subsidiaries. The Company's wholly owned subsidiary, First Health Services Corporation ("Services") continues to be subject to an investigation by the District of Columbia Office of Inspector General ("OIG"). In July 2000, the OIG issued a report evaluating the District of Columbia's Medicaid program and suggesting ways to improve the program. Services, a subsidiary of the Company that was acquired in July 1997, had acted as the program's fiscal agent intermediary for more than 20 years. The OIG report included allegations that from 1993 to 1996, Services, in its role as fiscal agent intermediary, made erroneous Medicaid payments to providers on behalf of patients no longer eligible to receive Medicaid benefits. The Company does not believe that the outcome of the claim or the investigation will have a material adverse affect on the Company's business or financial position.

The Company's largest client (Mail Handlers Benefit Plan) generated revenue of approximately \$160 million in 2002 or 21% of total revenues. This amount is net of a reserve established by the Company for various issues associated with the potential disallowance of certain expenses charged to the Plan. In addition, the provisions of the contract with the Plan's sponsor, the National Postal Mail Handlers Union, require that the Company fund any deficits in the Plan after the Plan's reserves have been fully utilized. As of December 31, 2002, the Plan has approximately \$313 million in reserves to cover Plan expenses which may exceed the premiums charged and collected from the Plan participants by the Plan sponsor. Management believes that these reserves are adequate to cover any Plan deficits as of December 31, 2002. There are no known Plan deficits as of December 31, 2002.

FIN 45 requires the Company to disclose certain guarantees, including contractual indemnifications, it has assumed. The Company generally declines to provide indemnification to its customers. In limited circumstances, to secure long-term customer contracts at favorable rates, the Company may negotiate risk allocation through mutual indemnification provisions that, in the Company's judgment, appropriately allocate risk relative to the value of the customer. Management believes that any liability under these indemnification provisions would not be material.

Independent Auditors' Report  
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Board of Directors and Stockholders,  
First Health Group Corp.  
Downers Grove, Illinois

We have audited the consolidated balance sheets of First Health Group Corp. and Subsidiaries as of December 31, 2002 and 2001, and the related consolidated statements of operations, of comprehensive income, of cash flows and of stockholders' equity for each of the three years in the period ended December 31, 2002. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of First Health Group Corp. and Subsidiaries as of December 31, 2002 and 2001, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2002 in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the consolidated financial statements, effective January 1, 2002, the Company changed its method of accounting for goodwill and intangible assets to conform to Statement of Financial Accounting Standards (SFAS) No. 142, "Goodwill and Other Intangible Assets,".

Deloitte & Touche LLP  
Chicago, Illinois  
February 14, 2003

Report by Management  
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Management is responsible for the preparation and integrity of the consolidated financial statements and financial comments appearing in this annual report. The financial statements were prepared in accordance with accounting principles generally accepted in the United States of America and include certain amounts based on management's best estimates and judgments. Other financial information presented in the annual report is consistent with the financial statements.

The Company maintains a system of internal accounting controls designed to provide reasonable assurance that assets are safeguarded, and that transactions are executed as authorized and are recorded and reported properly. This system of controls is based upon written policies and procedures, appropriate divisions of responsibility and authority, and careful selection and training of personnel. Policies and procedures prescribe that the Company and all employees are to maintain the highest ethical standards and that business practices are to be conducted in a manner which is above reproach.

Deloitte & Touche LLP, independent auditors, has audited the Company's consolidated financial statements and its report is presented herein. Management has made available to Deloitte & Touche LLP all the Company's financial records and related data, as well as the minutes of the Board of Directors' meetings. Management believes that all representations made to Deloitte & Touche LLP during its audit were valid and appropriate.

The Board of Directors has an Audit Committee composed solely of outside Directors. The independent auditors have direct access to the Audit Committee and periodically meet with the Audit Committee to discuss accounting, auditing and financial reporting matters.

First Health Group Corp.  
Downers Grove, Illinois  
February 14, 2003

Consolidated Balance Sheets

(in thousands, except share amounts)

Assets	December 31,	
	2001	2002
Current assets:		
Cash and cash equivalents	\$ 14,001	\$ 20,852
Short-term investments	2,381	1,304
Accounts receivable, less allowances for doubtful accounts of \$14,327 and \$14,782, respectively	78,793	69,981
Deferred taxes	27,429	35,255
Other current assets	20,757	16,183
Assets held for sale	6,958	-
<b>Total current assets</b>	<b>150,319</b>	<b>143,575</b>
Long-term investments:		
Marketable securities	65,766	67,880
Other	55,205	62,676
<b>Total long-term investments</b>	<b>120,971</b>	<b>130,556</b>
Property and equipment:		
Land, building and improvements	87,468	97,826
Computer equipment and software	180,152	222,796
Office furniture and equipment	20,282	34,518
	287,902	355,140
Less accumulated depreciation and amortization	(105,393)	(149,637)
<b>Total property and equipment, net</b>	<b>182,509</b>	<b>205,503</b>
Goodwill	255,855	279,447
Intangible assets, less accumulated amortization \$955 and \$4,541, respectively	42,859	54,086
Reinsurance recoverable	26,140	26,185
Other assets	2,081	4,009
	\$ 780,734	\$ 843,361

Liabilities and Stockholders' Equity	December 31,	
	2001	2002
Current liabilities:		
Accounts payable	\$ 33,257	\$ 50,841
Accrued expenses	66,384	53,535
Claims reserves	12,308	14,235
Income taxes payable	-	23,765
Current maturities of long-term debt	197,500	-
<b>Total current liabilities</b>	<b>309,449</b>	<b>142,376</b>
Long-term debt	-	120,000
Claims reserves	26,140	26,185
Deferred taxes	84,828	114,692
Other non-current liabilities	21,018	25,962
<b>Total liabilities</b>	<b>441,435</b>	<b>429,215</b>
Commitments and contingencies	-	-
Stockholders' equity:		
Preferred stock, par value \$1.00; authorized 1,000,000 shares; none issued	-	-
Common stock, par value \$.01; authorized 155,000,000 shares; issued 131,320,000 and 134,491,000 shares, respectively	1,313	1,344
Additional paid-in capital	255,489	304,663
Retained earnings	384,533	518,960
Accumulated other comprehensive income	161	764
Treasury stock, at cost; 31,298,000 and 35,815,000 shares, respectively	(302,197)	(411,585)
<b>Total stockholders' equity</b>	<b>339,299</b>	<b>414,146</b>
	\$ 780,734	\$ 843,361

See Notes to Consolidated Financial Statements.

Consolidated Statements of Operations

(in thousands, except share amounts)

	Years Ended December 31,		
	2000	2001	2002
Revenues	\$ 506,741	\$ 593,108	\$ 759,966
Operating expenses:			
Cost of services	225,783	261,985	336,094
Selling and marketing	48,377	58,416	77,878
General and administrative	34,201	39,598	55,057
Health care benefits	13,044	13,293	15,455
Depreciation and amortization	38,389	46,527	56,077
Interest income	(6,639)	(6,844)	(6,698)
Interest expense	14,731	7,152	5,454
	367,886	420,127	539,317
Income before income taxes	138,855	172,981	220,649
Income taxes	(56,236)	(70,061)	(87,711)
Net income	\$ 82,619	\$ 102,920	\$ 132,938
Weighted average shares outstanding-basic	95,698	98,333	100,697
Net income per common share-basic	\$ .86	\$ 1.05	\$ 1.32
Weighted average shares outstanding-diluted	99,740	103,055	104,258
Net income per common share-diluted	\$ .83	\$ 1.00	\$ 1.28

See Notes to Consolidated Financial Statements.

Consolidated Statements of Comprehensive Income

(in thousands)

	Years Ended December 31,		
	2000	2001	2002
Net income	\$ 82,619	\$ 102,920	\$ 132,938
Other comprehensive income, before tax:			
Unrealized gains on securities:			
Unrealized holding gains arising during period	5,119	3,125	989
Less: reclassification adjustment for losses included in net income	(313)	(479)	(35)
Other comprehensive income, before tax	4,806	2,646	954
Income tax expense related to items of other comprehensive income	(1,914)	(976)	(351)
Other comprehensive income	2,892	1,670	603
Comprehensive income	\$ 85,511	\$ 104,590	\$ 133,541

See Notes to Consolidated Financial Statements.

Consolidated Statements of Cash Flows  
(in thousands)

	Years Ended December 31,		
	2000	2001	2002
Cash flows from operating activities:			
Net income	\$ 82,619	\$ 102,920	\$ 132,938
Adjustments to reconcile net income to net cash provided by operating activities:			
Change in provision for uncollectible accounts receivable	(33)	(487)	3,455
Depreciation and amortization	38,389	46,527	56,077
Provision for deferred income taxes	34,846	26,858	10,448
Tax benefits from stock options exercised	12,714	16,634	16,521
Other, net	(1,450)	(1,589)	(2,797)
Changes in assets and liabilities (net of effects of acquired businesses):			
Accounts receivable	2,378	(10,764)	13,495
Other current assets	(3,834)	(10,401)	4,920
Reinsurance recoverable	22,595	2,075	(45)
Accounts payable and accrued expenses	4,342	(16,337)	13,833
Claims reserves	(20,210)	(2,780)	1,972
Income taxes payable	(1,493)	-	23,698
Non-current assets and liabilities	350	(1,308)	3,016
Net cash provided by operating activities	171,213	151,348	277,531
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	-	(198,645)	(42,959)
Purchases of investments	(25,242)	(50,233)	(80,269)
Sales or maturities of investments	20,414	35,985	75,923
Assets held for sale	-	9,000	923
Purchases of property and equipment	(62,442)	(63,654)	(71,583)
Net cash used in investing activities	(67,270)	(267,547)	(117,965)
Cash flows from financing activities:			
Proceeds from issuance of long-term debt	25,000	215,000	240,000
Principal payments of long-term debt	(137,500)	(145,000)	(317,500)
Purchase of treasury stock	(46,059)	-	(109,322)
Stock option loans to employees	(3,637)	(1,739)	(2,272)
Stock option loan repayments	4,865	1,594	3,761
Proceeds from issuance of common stock	40,907	36,807	32,243
Proceeds from sales of put options on common stock	380	-	375
Net cash provided by (used in) financing activities	(116,044)	106,662	(152,715)
Net increase (decrease) in cash and cash equivalents	(12,101)	(9,537)	6,851
Cash and cash equivalents, beginning of period	35,639	23,538	14,001
Cash and cash equivalents, end of period	\$ 23,538	\$ 14,001	\$ 20,852

See Notes to Consolidated Financial Statements.

	Years Ended December 31,		
	2000	2001	2002
-----			
Supplemental cash flow data:			
Acquisition of businesses:			
Fair value of assets acquired,			
net of cash acquired	\$ -	\$ 41,893	\$ 10,686
Goodwill	-	166,865	28,042
Intangible assets	-	43,814	14,813
Fair value of liabilities assumed	-	(53,927)	(7,513)
Future payments on acquisition	-	-	(3,069)
Net cash paid	\$ -	\$ 198,645	\$ 42,959
Stock options exercised in			
exchange for common stock	\$ 8,733	\$ -	\$ 66
Health care benefits paid	(8,486)	(15,369)	(14,748)
Interest paid	(14,506)	(7,713)	(5,087)
Interest income received	5,357	4,571	3,587
Income taxes paid, net	(11,527)	(38,493)	(29,461)

See Notes to Consolidated Financial Statements.

Consolidated Statements Of Stockholders' Equity  
(in thousands)

	Common Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (loss)	Treasury Stock	
	Shares	Amount				Shares	Amount
Balance, January 1, 2000	76,976	\$ 770	\$ 189,383	\$ 450,581	\$ (4,401)	29,320	\$ (549,601)
Issuance of common stock through stock option and purchase plans	2,525	25	49,615	-	-	-	-
Purchase of treasury stock	-	-	-	-	-	1,978	(54,792)
Tax benefit related to stock options exercised	-	-	12,714	-	-	-	-
Change in unrealized holding loss on marketable securities, net of tax	-	-	-	-	2,892	-	-
Sale of put options on common stock	-	-	380	-	-	-	-
Loans granted to employees to exercise stock options	-	-	-	(3,637)	-	-	-
Repayment of employee stock option loans	-	-	-	4,865	-	-	-
Net income	-	-	-	82,619	-	-	-
Balance, December 31, 2000	79,501	\$ 795	\$ 252,092	\$ 534,428	\$ (1,509)	31,298	\$ (604,393)
2-for-1 stock split Effective June 25, 2001	48,203	482	(50,008)	(252,670)	-	-	302,196
Issuance of common stock through stock option and purchase plans	3,616	36	36,771	-	-	-	-
Tax benefit related to stock options exercised	-	-	16,634	-	-	-	-
Change in unrealized holding gain on marketable securities, net of tax	-	-	-	-	1,670	-	-
Loans granted to employees to exercise stock options	-	-	-	(1,739)	-	-	-
Repayment of employee stock option loans	-	-	-	1,594	-	-	-
Net income	-	-	-	102,920	-	-	-
Balance, December 31, 2001	131,320	\$1,313	\$ 255,489	\$ 384,533	\$ 161	31,298	\$ (302,197)
Issuance of common stock through stock option and purchase plans	3,171	31	32,278	-	-	-	-
Purchase of treasury stock	-	-	-	-	-	4,517	(109,388)
Tax benefit related to stock options exercised	-	-	16,521	-	-	-	-
Change in unrealized holding gain on marketable securities, net of tax	-	-	-	-	603	-	-
Sale of put options on common stock	-	-	375	-	-	-	-
Loans granted to employees to exercise stock options	-	-	-	(2,272)	-	-	-
Repayment of employee stock option loans	-	-	-	3,761	-	-	-
Net income	-	-	-	132,938	-	-	-
Balance, December 31, 2002	134,491	\$1,344	\$ 304,663	\$ 518,960	\$ 764	35,815	\$ (411,585)

See Notes to Consolidated Financial Statements.

1. Summary of Significant Accounting Policies:

The Company: First Health Group Corp. (the "Company") is a full-service integrated national health benefits company. The Company specializes in serving large, national payors with a single source for their group health programs - providing integrated comprehensive, cost-effective and innovative solutions for all the health benefits needs of their membership nationwide. Through its workers' compensation service line, the Company provides a full range of services for insurance carriers, state insurance funds, third party administrators, auto insurers and large, self-insured national employers. Through its First Health Services service line, the Company provides services to various state Medicaid and entitlement programs for claims administration, pharmacy benefit management programs and medical management and quality review services. Through its insurance subsidiaries, the Company provides insurance products, primarily stop-loss insurance.

Principles of consolidation: The financial statements include the accounts of the Company and its wholly-owned subsidiaries. Material inter-company balances and transactions have been eliminated.

Use of estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and cash equivalents and investments: Cash and cash equivalents are defined as all highly liquid investments with original maturities of three months or less at date of purchase.

Investments with maturities between three months and twelve months and other investments needed for current cash requirements are classified as short-term investments. All remaining investments are classified as long-term. Investments, which are classified as available-for-sale securities, are reported at fair value. The fair value of marketable securities is estimated based on quoted market prices, when available. If a quoted price is not available, fair value is estimated using quoted market prices for similar financial instruments. The difference between amortized cost and fair value is recorded as an adjustment to accumulated other comprehensive income, net of applicable deferred taxes. Realized gains and losses from sales of investments are based upon the specific identification method.

Property and equipment: Property and equipment are stated at cost. Expenditures for the maintenance and repair of property and equipment are charged to expense as incurred. Expenditures for major replacement or betterment are capitalized.

In accordance with Statement of Position 98-1, ("SOP 98-1"), "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use", certain internal payroll and payroll related costs are capitalized during the application development stage of a project and depreciated over the computer software's useful life. The Company capitalized approximately \$8.1 million of such internal costs during 2002, \$5.3 million of such costs during 2001 and \$4.9 million of such costs during 2000 that would have otherwise been expensed. In accordance with SOP 98-1, the Company also capitalizes external consulting costs related to software development. The total of the internal and external costs are considered work-in-progress until the software is put into use. Computer equipment and software includes approximately \$16.6 million of work-in-progress as of December 31, 2002 related to internally developed software programs. There were approximately \$19.7 million of such work-in-progress amounts as of December 31, 2001.

Depreciation is provided over the estimated useful lives of the related assets using the straight-line method. These lives range from 5 years to 31.5 years for buildings and improvements, 1.5 years to 5 years for computer equipment and software and 3 years to 5 years for office furniture and equipment. Leasehold improvements are amortized over the shorter of the estimated useful life of the asset or the term of the lease.

Long-lived assets: The carrying amount of all long-lived assets is evaluated periodically to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets and the projected, undiscounted cash flows of the operations in which the long-lived assets are deployed.

Fair value of financial instruments: The carrying amounts for cash and cash equivalents, accounts receivable and accounts payable are reasonable estimates of their fair value. The fair value of marketable securities and investments is discussed in Note 4 to the consolidated financial statements. The carrying value of long-term debt is a reasonable estimate of its fair value as amounts are borrowed at current market rates.

Revenue recognition:

PPO services - The Company's proprietary, national PPO network The First Health [R] Network includes hospitals, physicians and other healthcare providers that offer services at pre-negotiated rates to healthcare payors. PPO revenues are earned based on either a percentage of savings in medical costs achieved by our clients when their covered participants utilize our national network of healthcare providers or on a per-employee, per-month basis (capitated basis). PPO services are provided at varying fee structures to our clients based on specific contractual arrangements. In a limited number of cases, contracts include performance guarantees. The performance guarantees are based on an annual period coinciding with the calendar year. Revenues are recognized on a monthly basis either as members utilize a contracted provider and savings are generated or on a fixed monthly basis. Adjustments to revenue related to guarantee amounts are recognized as known and/or earned. In other cases, estimates are made of the annual savings rates and revenues are recognized in accordance with these estimates. Client specific revenue reserves are established based on historical experience and are adjusted monthly based upon updated information. These reserves are for such items as non-covered services, ineligible members, other insurance, etc. Periodically, specific client-related accounts receivable issues may impact revenue recognition including issues where a client disputes specific items from the current year's billing. Accounts receivable reserves for client specific items were \$41.2 million, \$18.2 million and \$23.4 million as of December 31, 2002, 2001 and 2000, respectively, and are netted against the gross accounts receivable balance in the Consolidated Balance Sheets. Since premiums for medical benefits are not collected by the Company and benefit expenses are not the obligation of the Company, premium revenues and benefit expenses are not included in the Company's consolidated financial statements.

Claims administration services - Claims administration revenues are earned based on contracted services performed. Payors retain full risk of financing the benefits with the exception of the National Postal Mail Handlers Union contract with the Company's wholly-owned insurance companies. The Company has access to funds to pay benefit expenses and its earned administrative fee. Since benefit expenses are not the obligation of the Company, premium revenue and benefit expenses for these contracts are not included in the Company's consolidated financial statements. Within the Company's fiscal agent business, the Company has certain contracts to develop software for Medicaid claims adjudication. The Company's policy is to recognize revenue for services under these contracts as milestones are met and customer acknowledgment of such achievement of milestones is received.

Fee schedule services - Revenues for fee schedule services are based primarily on a fixed fee generated on a per-transaction basis.

Clinical management services - Revenues for clinical management services are generated either on a capitated basis or a time and materials basis.

Insurance premiums -Health premiums, primarily stop-loss insurance, are earned ratably over the terms of the related insurance and reinsurance contracts or policies. The contracts obligate the Company to financial risk based upon its ability to manage healthcare costs below contractual fixed amounts.

Change in Revenue Reporting. Effective for the quarter ending March 31, 2003, the Company will report its revenue as follows:

Group Health Revenue  
Workers' Compensation Revenue  
Public Sector Revenue

Additionally, its group health and workers' compensation revenue will be further broken down between PPO Services and PPO plus Administrative Services. The Company believes this revenue presentation represents how the Company currently sells its services. The Company is selling a predominance of its group health PPO services coupled with administrative services (especially claims administration) and, to a lesser extent, its workers' compensation PPO services are often coupled with fee schedule services. If the Company had used this presentation methodology for the years 2000 through 2002, its revenues would have been presented as follows:

(in thousands)	Years ended December 31,		
	2000	2001	2002
-----	-----	-----	-----
Group Health			
PPO	\$152,496	\$200,497	\$210,846
PPO plus Admin Services	140,576	145,877	255,341
-----	-----	-----	-----
Total Group Health	293,072	346,374	466,187
Workers' Compensation			
PPO	29,707	40,429	54,961
PPO plus Admin Services	77,106	90,297	106,363
-----	-----	-----	-----
Total Workers' Compensation	106,813	130,726	161,324
Public Sector	106,856	116,008	132,455

Total Revenue	----- \$506,741 =====	----- \$593,108 =====	----- \$759,966 =====
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Insurance operations:

Claims Reserves - Claims reserves include traditional life insurance, such as whole life insurance, term life insurance, stop loss insurance and accident and health insurance, as well as universal life insurance policies and annuity contracts which do not have significant mortality or morbidity risk. The vast portion of life insurance reserves represent business ceded to National Farmers Union Life Insurance Company ("National Farmers"). Stop loss reserves and accident and health reserves are established based on medical claims payment history adjusted for specific benefit plan elements (such as deductibles) and expected savings generated by utilization of The First Health [R] Network.

Reinsurance Recoverable - Reinsurance recoverable represents the amount due from other insurance companies as a result of the cession of a portion of the Company's insurance risk to such companies. All of this balance is due from National Farmers.

Reinsurance recoverable and the related claim reserves are reported separately in the consolidated balance sheets.

Net income per common share: Net income per common share-basic is based on the weighted average number of common shares outstanding during the period. Net income per common share-diluted is based on the weighted average number of common shares and common share equivalents outstanding during the period. In calculating earnings per share, earnings are the same for the basic and diluted calculations. Weighted average shares outstanding increased for diluted earnings per share by 4,042,000, 4,722,000 and 3,561,000 for 2000, 2001 and 2002, respectively, due to the effect of stock options. Diluted net income per share was lower than basic by \$0.03 for 2000, by \$0.05 for 2001 and by \$0.04 for 2002 as a result of the increased weighted average shares outstanding due to the effect of stock options.

All historical common share data have been adjusted for a 2-for-1 stock split in the form of a 100% stock distribution paid on June 25, 2001 to stockholders of record on June 4, 2001. Treasury shares were not split. However, an adjustment was made to the stockholders' equity section of the Consolidated Balance Sheet to split the cost of treasury stock (in effect, a cancellation of treasury shares by reducing paid-in-capital and retained earnings).

Segment information: The Company has determined it currently operates in one reportable segment. Each of the Company's products and services have similar long-term financial performance and have similar economic characteristics. All of the Company's products and services relate to programs that provide the Company's customers with a single source for all of their medical programs, providing comprehensive, cost-effective and innovative solutions for all the health benefits needs of their employees.

New Accounting Pronouncements:

In July 2001, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 141 ("SFAS 141"), "Business Combinations." SFAS 141 requires the purchase method of accounting for business combinations initiated after June 30, 2001 and eliminates the pooling-of-interests method. In July 2001, the FASB also issued SFAS No. 142 ("SFAS 142"), "Goodwill and Other Intangible Assets", which the Company adopted effective January 1, 2002. SFAS 142 specifies that goodwill and certain intangible assets will not be amortized, but rather be subject to periodic impairment testing.

In accordance with these pronouncements, the Company accounted for the acquisitions of the CCN Companies (defined in footnote 2), Healthcare Value Management ("HCV") and the stock of Claims Administration Corporation ("CAC"), a subsidiary of Continental Casualty Company (see Note 2 to the consolidated financial statements) as purchases and allocated the purchase price to all identifiable tangible and intangible assets and liabilities. The goodwill resulting from these acquisitions of approximately \$195 million has not been amortized. Goodwill of approximately \$102 million acquired in business combinations completed before July 1, 2001 was amortized through December 31, 2001. In accordance with SFAS 142, none of the Company's \$279.4 million in net goodwill will be amortized beginning January 1, 2002.

The following table reflects the effect of SFAS 142 on net income and earnings per share as if SFAS 142 had been in effect for all periods presented:

(in thousands, except per share amounts)	Years ended December 31,		
	2000	2001	2002
Net income	\$ 82,619	\$102,920	\$132,938
Add back goodwill amortization	3,654	4,986	-

Adjusted net income	\$ 86,273	\$107,906	\$132,938
	=====	=====	=====
Basic net income per share:			
Reported net income per share	\$ .86	\$ 1.05	\$ 1.32
Goodwill amortization	.04	.05	--
	-----	-----	-----
Adjusted net income per share	\$ .90	\$ 1.10	\$ 1.32
	=====	=====	=====
Diluted net income per share:			
Reported net income per share	\$ .83	\$ 1.00	\$ 1.28
Goodwill amortization	.03	.05	--
	-----	-----	-----
Adjusted net income per share	\$ .86	\$ 1.05	\$ 1.28
	=====	=====	=====

Effective January 1, 2002, the Company adopted SFAS No. 144 ("SFAS 144"), "Accounting for the Impairment or Disposal of Long-Lived Assets." SFAS 144 addresses accounting and reporting for the impairment or disposal of long-lived assets, including discontinued operations, and establishes a single accounting model for long-lived assets to be disposed of by sale. The adoption of this pronouncement did not have a material impact on the financial position and results of operations of the Company.

In June 2002, the FASB issued SFAS No. 146, ("SFAS 146") "Accounting for Costs Associated with Exit or Disposal Activities", which requires companies to recognize costs associated with exit or disposal activities when they are incurred rather than at the date of a commitment to an exit or disposal plan. Examples of costs covered by the standard include lease termination costs and certain employee severance costs that are associated with a restructuring, discontinued operation, or other exit or disposal activity. SFAS 146 is to be applied prospectively to exit or disposal activities initiated after December 31, 2002. The Company does not expect that the adoption of SFAS 146 will have a material impact on the Company's financial position, results of operations or cash flows.

In November 2002, the FASB issued Interpretation No. 45, ("FIN 45") "Guarantees, Including Indirect Guarantees of Indebtedness to Others", which expands previously issued accounting guidance and disclosure requirements for certain guarantees. FIN 45 requires the Company to recognize an initial liability for fair value of an obligation assumed by issuing a guarantee. The provision for initial recognition and measurement of the liability will be applied on a prospective basis to guarantees issued or modified after December 31, 2002. The disclosure requirements are effective immediately and have been considered for purposes of the Company's footnote disclosures. The adoption of FIN 45 is not expected to have a material impact on the Company's financial position, results of operations or cash flows.

In December 2002, the FASB issued SFAS No. 148 ("SFAS 148"), "Accounting for Stock-Based Compensation - Transition and Disclosure - an amendment of SFAS No. 123." This Statement amends SFAS No. 123 to provide alternative methods of transition for a voluntary change to the fair value based method of accounting for stock-based employee compensation and amends the disclosure requirements to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. The transition guidance and disclosure provisions of SFAS 148 are effective as of the December 31, 2002 financial statements (see Note 10 to the consolidated financial statements).

## 2. Acquisition:

On August 16, 2001, the Company completed the acquisition of all of the outstanding shares of capital stock of CCN Managed Care, Inc. ("CCN") and Preferred Works, Inc. ("PW" and together with CCN, the "CCN Companies") from HCA-The Healthcare Company and VH Holdings, Inc. (collectively, the "Sellers") for a purchase price of \$195 million in cash, plus a working capital adjustment which increased the purchase price to approximately \$198 million. The acquisition was accounted for by the purchase method of accounting in accordance with SFAS 141. The allocation of the purchase price to the fair value of assets acquired and liabilities assumed was as follows:

(Dollars in thousands)

Purchase price	\$195,000
Working capital adjustment	3,514
Transaction costs	2,000
	-----
Total purchase price	\$200,514
	-----

Purchase price has been allocated as follows:

Fair value of tangible assets acquired	\$ 33,797
Assets held for sale	9,965
Goodwill	166,865
Intangible assets	43,814

Liabilities assumed	(27,237)
Liability for restructuring and integration costs	(26,690)
	-----
	\$200,514
	-----

In conjunction with the acquisition, the Company recorded as part of the allocation of the purchase price a \$41.1 million reserve for restructuring and integration costs as part of an overall plan to reduce operating expenses and integrate the business of the acquired companies. During the third quarter of 2002, the Company reduced the reserve by \$14.4 million. This reserve reduction is due primarily to revisions in the cost of facilities integration and a reduction in the expected cost of contract losses as discussed below. The specific actions included in the restructuring plan were substantially completed by December 31, 2002. Components of the purchase accounting reserve are as follows:

(in thousands)	Total Charges	Accrual Balance 12/31/01	Adjustment	Amount Paid	Reclass	Balance 12/31/02
Severance and related Facilities	\$13,712	\$ 6,031	\$ --	\$ (4,495)	\$ --	\$ 1,536
integration	10,370	9,528	(4,685)	(3,726)	--	1,117
Contract losses	10,000	9,750	(9,257)	(197)	--	296
Other reserves	7,031	7,028	(481)	(279)	(5,237)	1,031
	-----	-----	-----	-----	-----	-----
Total	\$41,113	\$32,337	\$ (14,423)	\$ (8,697)	\$ (5,237)	\$ 3,980
	=====	=====	=====	=====	=====	=====

The restructuring plan included the reduction of employees from various offices within the United States. The Company has reduced the number of CCN employees from approximately 1,300 at the time of the acquisition of CCN to approximately 580 at December 31, 2002. Approximately \$12.2 million has been paid for severance and related employee benefits as of December 31, 2002. The severance and related benefits accrued at December 31, 2002 represent costs for payments over the next twelve months for headcount reductions already incurred.

Facilities integration costs represent the costs to integrate CCN's facilities into the Company's existing operations. The majority of the facilities integration costs have been incurred to consolidate CCN's former corporate headquarters and various sales offices throughout the United States. During the quarter ended September 30, 2002, the Company reduced the reserve for facilities integration by \$4.7 million as the Company has capitalized a substantial amount of integration work as internally developed software that has future use in accordance with SOP 98-1, "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use." These costs were originally included in the purchase accounting reserve. Approximately \$4.6 million of costs for facilities integration have been charged to the purchase accounting reserve as of December 31, 2002. The majority of the remaining facilities integration costs are expected to be incurred during 2003.

Contract losses relate to the anticipated net loss to be incurred on an assumed contract to provide certain screening services to individuals who have agreed to be bound by a proposed settlement in a legal matter. CCN signed a contract in March 2000 to provide these services for four years and the Company has agreed to have its network providers provide these services after the acquisition of CCN. The Company currently estimates that as many as 325,000 covered persons may seek such screening services. During the quarter ended September 30, 2002, the Company reduced the reserve for contract losses by \$9.3 million. This reduction was due primarily to operational efficiencies the Company has achieved in the completion of these screening services. Approximately \$0.4 million of costs of this contract have been charged to the purchase reserve as of December 31, 2002.

Other reserves represent various operational liabilities the Company has incurred to fully integrate the Company's operations. During the quarter ended September 30, 2002, the Company reduced other reserves by \$0.5 million as the Company has revised several operational liability assumptions associated with the acquisition. During the quarter ended December 31, 2002, the Company reclassified \$5.2 million of reserves for pre-acquisition tax contingencies to the deferred tax liabilities amount in the Consolidated Balance Sheet. Approximately \$0.3 has been charged to the reserve as of December 31, 2002. The majority of the remaining other reserves are expected to be utilized during 2003.

The Company reviewed the various businesses comprising the CCN Companies and determined to hold PW and the Resource Opportunity, Inc. ("ROI") business of CCN for sale. The sale of ROI was completed on December 28, 2001 for a gross sales price of \$9 million. The sale of PW was completed on June 28, 2002 for a gross sales price of \$4.1 million. The Company realized approximately \$10 million from these sales after selling expenses and liabilities assumed.

The Company increased the goodwill on the CCN acquisition by \$6 million as a result of the completion of these sales.

The following unaudited pro forma information reflects the results of the Company's operations as if the acquisition had occurred at the beginning of 2001 adjusted for (i) the effect of recurring charges related to the acquisition, primarily the amortization of intangible assets over estimated useful lives of 15 or 20 years, as appropriate, and the recording of interest expense on borrowings to finance the acquisition; (ii) the reduction of depreciation expense due to the write-down to fair value of fixed assets, the elimination of amortization expense related to the CCN Companies' preexisting goodwill at the date of acquisition and the elimination of compensation and benefit expenses for certain executives of the CCN Companies who were terminated at or immediately subsequent to the acquisition and were not replaced, and (iii) the removal of revenues and related cost of services and expenses for acquired businesses that were held for sale.

	Year Ended December 31,	
	-----	
	(In thousands except per share data)	
	2000	2001
Pro forma:	-----	-----
Revenue	\$604,394	\$655,455
Net income	79,018	103,564
Net income per common share - basic	.83	1.05
Net income per common share - diluted	\$ .79	\$ 1.00

These pro forma results have been prepared for comparative purposes only and do not purport to be indicative of what operating results would have been had the acquisition actually taken place at the beginning of 2001, nor do they purport to represent results of future operations of the merged companies.

On May 1, 2002, the Company completed the acquisition of HCVM for an initial purchase price of \$24 million plus additional amounts to be paid upon the completion of certain financial performance measures. The Company will pay \$3.1 million in March 2003 and anticipates paying an additional \$3.3 million in 2003 for contractual obligations based on financial performance measures that HCVM has met. HCVM is a New England based PPO company, headquartered in suburban Boston. The acquisition was accounted for by the purchase method of accounting in accordance with SFAS 141. The acquisition was financed from borrowings under the Company's existing line of credit. The integration of the HCVM operations was substantially completed by December 31, 2002. The results of operations and assets acquired are immaterial to the consolidated financial statements of the Company. Consequently, no pro forma financial results are included herein.

Purchase price has been allocated as follows:

Fair value of tangible assets acquired	\$ 654
Goodwill	21,284
Intangible assets	5,658
Liabilities assumed	(239)
Liability for restructuring and integration costs	(250)
Future payments on acquisition	(3,069)
	-----
	\$ 24,038
	-----

On July 1, 2002, the Company acquired the stock of CAC for a purchase price of \$18 million. Included in this transaction is the transfer of approximately 1,000 CAC employees and related assets which support the Mail Handlers Benefit Plan (the "Plan"). The acquisition relates to long-term contracts that the Company was awarded in April 2002 to provide its comprehensive health plan services to the Plan. The acquisition was accounted for by the purchase method of accounting in accordance with SFAS 141 and was financed with borrowings under the Company's existing line of credit. The results of operations and assets acquired are immaterial to the consolidated financial statements of the Company. Consequently, no pro forma financial results are included herein.

Purchase price has been allocated as follows:

Fair value of tangible assets acquired	\$ 9,111
Goodwill	6,758
Intangible assets	9,155
Liabilities assumed	(5,024)
Liability for restructuring and integration costs	(2,000)
	-----
	\$ 18,000
	-----

### 3. Acquired Intangible Assets

As of December 31, 2002

(in thousands)	Gross Carrying Amount	Accumulated Amortization
-----	-----	-----
Amortized intangible assets		
Customer contracts and relationships	\$48,700	\$4,140
Provider contracts	9,927	401
	-----	-----
Total	\$58,627	\$4,541
	=====	=====

Customer contracts and relationships represent value added to the Company's business for existing long-term contracts and long-term business relationships. Provider contracts represent additions to The First Health[R] Network that the Company has acquired. The aggregate amortization expense recorded in 2002 was \$3,586,000. The estimated amortization expense for each of the years ending December 31, 2003 through 2007 is \$7,056,000.

The changes in the carrying amount of goodwill for the year ended December 31, 2002 are as follows:

(in thousands)	Amount
-----	-----
Balance, January 1, 2002	\$255,855
Goodwill acquired during year	28,042
Other changes	(4,450)
	-----
Balance, December 31, 2002	\$279,447
	=====

The goodwill acquired during 2002 represents \$21.3 million acquired in the HCVM acquisition and \$6.7 million acquired in the CAC acquisition. The other goodwill adjustments primarily represent the \$14.4 million reduction in the CCN purchase reserve partially offset by a \$6 million addition for the completion of the ROI and PW sales and adjustments to the related deferred tax items. In accordance with the provisions of SFAS 142, the Company completed a transitional goodwill impairment test within six months of the date of adoption. The Company used standard valuation techniques including an analysis of expected business performance and analysis of recent acquisitions within the healthcare industry. There was no impairment in goodwill amounts as a result of the transitional impairment test. The Company will perform an annual impairment test during the third quarter of each year or at such earlier time that circumstances warrant an interim valuation. There was no impairment in goodwill amounts as a result of the annual impairment test performed in 2002.

#### 4. Marketable Securities and Investments:

Information related to the Company's marketable securities and investments at December 31 is as follows:

(in thousands)	Amortized Cost	2001 Fair Value	Amortized Cost	2002 Fair Value
-----	-----	-----	-----	-----
United States Government securities	\$19,600	\$20,130	\$20,875	\$21,725
State and municipal securities	6,379	6,437	6,616	6,858
Foreign government securities	479	438	625	531
Corporate securities	29,137	30,134	29,120	30,589
Mortgage and asset-backed securities	3,955	3,974	5,146	5,201
	-----	-----	-----	-----
Total debt securities	59,550	61,113	62,382	64,904
Equity securities	7,522	7,034	4,769	4,280
	-----	-----	-----	-----
Total	\$67,072	\$68,147	\$67,151	\$69,184
Less-classified as current		2,381		1,304
	-----	-----	-----	-----
Classified as long-term		\$65,766		\$67,880
	-----	-----	-----	-----

Gross unrealized gains and (losses) were \$2,178,000 and \$(1,105,000), respectively, at December 31, 2001 and \$2,863,000 and \$(830,000), respectively, at December 31, 2002.

Contractual maturities of marketable debt securities at December 31 are as follows:

(in thousands)	Amortized Cost	2001 Fair Value	Amortized Cost	2002 Fair Value
-----	-----	-----	-----	-----
Due in one year or less	\$ 2,362	\$ 2,381	\$ 1,310	\$ 1,304
Due after one year through five years	35,990	37,319	33,385	34,689
Due after five years through ten years	8,015	8,116	7,689	8,150
Due after ten years	13,183	13,297	19,998	20,761

Total debt securities	\$59,550	\$61,113	\$62,382	\$ 64,904
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Gross realized gains and (losses) on sales or maturities of marketable securities were \$1,795,000 and \$(2,124,000), respectively, for the year ended December 31, 2000; \$672,000 and \$(1,071,000) respectively, for the year ended December 31, 2001 and \$1,045,000 and \$(643,000) respectively, for the year ended December 31, 2002.

Included in other long-term investments at December 31, 2000, 2001 and 2002 is an investment in a limited liability company ("LLC") which invests in equipment which is leased to third parties. The investment is accounted for on the equity method. The total investment in this LLC was \$47,054,000 at December 31, 2001 and \$54,037,000 at December 31, 2002 including \$5,000,000 invested during 2002. The Company's proportionate share of the partnership's income was \$2,300,000 in 2000, \$2,851,000 in 2001 and \$3,096,000 in 2002, and is included in interest income. A member of the Company's Board of Directors is associated with a group that owns approximately 90% of this partnership. The Company has between a 20% and 25% interest in each individual tranche of the partnership.

#### 5. Reinsurance:

On October 1, 1996, in anticipation of being acquired by the Company, First Health Life and Health Insurance Company, formerly known as Loyalty Life Insurance Company ("Loyalty"), entered into a reinsurance agreement whereby it ceded 100 percent of its life insurance and annuity contracts in force ("pre-acquisition business") to a former affiliate, National Farmers. Under the terms of the reinsurance agreement, all premiums and deposits received by Loyalty which relate to pre-acquisition business are transferred to National Farmers. Additionally, the cash and investments transferred by Loyalty to National Farmers which support ceded insurance liabilities are held in escrow for the benefit of Loyalty's policy holders. Premiums and policy benefits, which are not material in amount, are ceded to National Farmers and shown net of such cessions in the consolidated statements of operations. Loyalty has received approvals from the insurance regulators to transfer the pre-acquisition business. As the policy holders of each state agree to the legal replacement of Loyalty by National Farmers, Loyalty will be released from future liability for its pre-acquisition business and result in the removal of such policy liabilities from the Company's consolidated balance sheets. These liabilities are included in long-term claims reserves on the Company's consolidated balance sheets.

The Company also assumes and cedes reinsurance with other insurance companies in the normal course of business. Reinsurance is ceded primarily to limit losses from large exposures and to permit recovery of a portion of direct losses. The Company continues to have primary liability as the direct insurer for all ceded risks. Reinsurance is assumed to increase the Company's revenues and to provide additional diversification of its insured risks. The effects of reinsurance on premiums and contract charges earned are as follows:

(in thousands)	Years Ended December 31,		
	2000	2001	2002
Life and health premiums and contract charges:			
Direct	\$17,678	\$18,620	\$20,799
Assumed	1,256	944	589
Ceded	(6,759)	(4,892)	(5,847)
Net	\$12,175	\$14,672	\$15,541

The recoverable amounts at December 31, 2002 include \$26,185,000 estimated by the Company with respect to ceded unpaid losses (including claims incurred but not reported) which are not billable until the losses are paid. Estimating amounts of reinsurance recoverable is impacted by the uncertainties involved in the establishment of loss reserves. Management believes the recoverables are appropriately established; however, the amount ultimately recoverable may vary from amounts currently recorded.

#### 6. Accrued Expenses:

Accrued expenses at December 31, 2001 include approximately \$36,475,000 for merger-related restructuring expenses; \$17,564,000 for accrued salaries, wages and benefits; and \$4,586,000 for insurance accruals. Accrued expenses at December 31, 2002 include approximately \$11,393,000 for merger-related restructuring expenses; \$22,552,000 for accrued salaries, wages and benefits; and \$6,026,000 for insurance accruals.

#### 7. Long-Term Obligations:

On April 23, 2002, the Company obtained a \$400 million revolving credit facility to replace its previous \$350 million credit facility that was due to expire on June 30, 2002. As of December 31, 2002, \$120 million was outstanding under the new facility. The new credit facility has a five-year term and provides for interest at a Euro dollar rate (which approximates

LIBOR) plus a variable margin which fluctuates based on the Company's debt rating. The facility also has a corresponding fee calculated at a variable rate of the available facility balance depending on the debt rating of the Company. The Company capitalized \$2.9 million in legal and advisory costs associated with this new debt agreement. As of December 31, 2002, the effective interest rate was approximately 3.5% per annum. No principal payments are due on this facility until its maturity.

The Agreement contains provisions which require the Company to maintain a specified level of net worth and comply with various financial ratios and includes, among other provisions, restrictions on investments, dividend payments, acquisitions and incurrence of additional indebtedness. At December 31, 2002, \$433 million was available for dividend distributions under these provisions. The Company was in compliance with all provisions as of December 31, 2002.

#### 8. Income Taxes:

Components of the provision for income taxes are as follows:

(in thousands)	Years Ended December 31,		
	2000	2001	2002
Current provision:			
Federal	\$ 17,556	\$ 33,216	\$ 62,497
State	3,834	9,987	14,766
	21,390	43,203	77,263
Deferred provision:			
Federal	28,771	24,974	10,569
State	6,075	1,884	(121)
	34,846	26,858	10,448
Provision for income taxes	\$ 56,236	\$ 70,061	\$ 87,711

Deferred tax assets and (liabilities) comprise the following, as of December 31:

(in thousands)	2001	2002
Current assets:		
Purchase accounting reserves	\$ 7,259	\$ 4,743
Revenue adjustments	6,275	16,214
Allowance for doubtful accounts	5,664	5,807
Vacation accrual	4,248	5,006
Other, net	3,983	3,485
Total current assets	27,429	35,255
Non-current assets (liabilities):		
Tax benefit of limited partnership investment	(55,245)	(67,580)
Internally developed software	(23,561)	(25,001)
Intangible assets	(16,480)	(17,816)
Revenue adjustments	--	2,360
Purchase accounting reserves	5,087	(4,707)
Depreciation	4,656	(1,746)
Market value adjustment	(352)	(703)
Other, net	1,067	501
Total non-current liabilities	(84,828)	(114,692)
Net deferred tax liabilities	\$ (57,399)	\$ (79,437)

Income tax benefits associated with the exercise of stock options were \$12,714,000 in 2000, \$16,634,000 in 2001 and \$16,521,000 in 2002. Such amounts are credited to additional paid-in-capital.

(in thousands)	Years Ended December 31,		
	2000	2001	2002
Provision for income taxes at federal statutory rate	\$48,599	\$60,545	\$77,227
State taxes, net of federal benefit	6,506	7,548	10,267
Expenses not deductible for income tax purposes	1,339	2,127	311
Non-taxable interest income and dividends	(208)	(159)	(94)
Provision for income taxes	\$56,236	\$70,061	\$87,711

#### 9. Employment Agreements:

The Company has employment agreements which expire between 2003 and 2007 with certain officers and key employees. The agreements provide for, among other things, annual base salaries aggregating \$4,326,000 plus additional incentive compensation. The Company recorded incentive compensation to certain key officers and employees in the aggregate amount of \$2,487,000, \$3,150,000 and \$4,100,000 in 2000, 2001 and 2002, respectively.

10. Stockholders' Equity:

Employee Stock Purchase Plan: The Company maintains an Employee Stock Purchase Plan which allows employees of the Company and its subsidiaries to purchase shares of common stock on the last day of two six-month purchase periods (i.e., February 28 or 29 and August 31 of each year) at a purchase price which is 85% of the closing sale price of the shares as quoted on the Nasdaq national market on the first or last day of such purchase period, whichever is lower. A maximum of 4,000,000 shares has been authorized for issuance under the plan. As of December 31, 2002, 3,354,000 shares had been issued pursuant to the plan.

Stock options: The Company maintains an Employee Stock Option Plan which provides for the granting of options to employees and consultants of the Company and its subsidiaries to purchase common stock at a price not less than 100% of fair market value at date of grant. These grants have contractual lives that range from 5 to 10 years.

The Company also maintains a Stock Option Plan which provides for the granting of options to purchase common stock at fair market value at date of grant to non-employee members of its Board of Directors. These grants have a 10-year contractual life. The Company has also granted options to certain of its employees and members of its Board of Directors under individual option agreements, which expire between 2003 and 2008.

The Company has extended loans to various members of management to enable them to exercise options to purchase shares of Company common stock. Each loan is secured by the common stock purchased and the Company has full recourse in the event of default. There were \$1.8 million and \$0.3 million of such loans outstanding at December 31, 2001 and 2002, respectively. Such loans are classified as an offset to stockholders' equity. As of December 31, 2002, there were no loans outstanding to executive officers of the Company. The Company no longer grants these loans to executive officers.

The following table summarizes changes in common stock under option plans.

	Years Ended December 31,					
	2000		2001		2002	
	# of Shares	Wtd. Avg. Exercise Price	# of Shares	Wtd. Avg. Exercise Price	# of Shares	Wtd. Avg. Exercise Price
Number of Shares (in thousands):						
Outstanding at beginning of the year	17,060	\$ 9.64	13,294	\$10.34	13,378	\$14.83
Granted	1,554	16.66	3,705	26.40	1,243	26.64
Exercised	(4,858)	9.82	(3,457)	9.97	(3,008)	9.66
Canceled/expired	(462)	11.10	(164)	14.13	(184)	20.34
Outstanding at end of the year	13,294	10.34	13,378	14.83	11,429	17.38
Exercisable at December 31	5,816	\$10.73	5,331	\$12.40	6,655	\$14.73
Available for grant	1,676		4,429		3,369	

The following table summarizes information about stock options outstanding and exercisable at December 31, 2002:

(shares in thousands)		Options Outstanding		Options Exercisable	
Range of Exercise Price	# of Shares	Wtd. Avg. Contractual Life In Years	Wtd. Avg. Exercise Price	# of Shares	Wtd. Avg. Exercise Price
\$ 1.00 to \$10.00	2,714	3.18	\$ 7.78	1,470	\$ 7.72
\$10.01 to \$20.00	3,784	4.20	12.53	3,557	12.30
\$20.01 to \$30.00	4,931	6.09	\$26.39	1,628	\$26.35

The Company accounts for its stock-based employee compensation plans under the recognition and measurement principles of APB Opinion No. 25, "Accounting for Stock Issued to Employees." No stock-based employee compensation cost is reflected in net income as all options granted under those plans had an exercise price equal to the market value of the stock at

date of grant. As permitted by SFAS 123, and amended by SFAS 148, the Company follows the disclosure requirements only of SFAS 123. The following table illustrates the effect on net income and earnings per share if the Company had applied the fair value recognition provisions of SFAS 123.

(in thousands except per share amounts)	Years ended December 31,		
	2000	2001	2002
Net Income:	\$82,619	\$102,920	\$132,938
Deduct: Stock-based employee Compensation cost, net of taxes	10,764	9,815	15,173
Proforma net income	\$71,855	\$ 93,105	\$117,765
Earnings per share-basic			
As reported	\$ .86	\$ 1.05	\$ 1.32
Proforma	\$ .75	\$ .95	\$ 1.17
Earnings per share-diluted			
As reported	\$ .83	\$ 1.00	\$ 1.28
Proforma	\$ .72	\$ .91	\$ 1.13

The weighted average fair values at date of grant for options granted during 2000, 2001 and 2002 were \$16.09, \$12.20 and \$11.69, respectively, and were estimated using the Black-Scholes option pricing model with the following assumptions:

	Years ended December 31,		
	2000	2001	2002
Risk-free interest rate	6.06%	4.16%	3.35%
Dividend yield	-	-	-
Expected volatility	49.03%	47.37%	45.62%
Expected life in years	1 to 7	1 to 7	1 to 7

Treasury Stock: The Company's Board of Directors approved the repurchase of up to 15 million shares of the Company's outstanding common stock under a prior authorization. In 2002, the Board approved a new authorization to repurchase up to an additional 10 million shares of common stock. Purchases may be made from time to time depending on market conditions and other relevant factors. The Company had approximately 10.7 million shares available for repurchase under these repurchase authorizations as of December 31, 2002.

During 2000, the Company repurchased 1,705,000 shares of its outstanding common stock in the open market for a total cost of \$46,059,000. The Company did not repurchase any common stock shares during 2001. During 2002, the Company repurchased 4,515,000 shares of its outstanding common stock in the open market for a total cost of \$109,322,000. The repurchased stock was recorded as treasury stock, at cost, and is available for general corporate purposes. In connection with the exercise of options to purchase 832,000 shares of common stock during 2000, certain employees paid the exercise price by delivering to the Company approximately 273,000 shares of previously acquired stock. In connection with the exercise of options to purchase 8,000 shares of common stock during 2002, a certain employee paid the exercise price by delivering to the Company approximately 2,000 shares of previously acquired stock.

Employee Benefit Plan: The Company maintains a Savings and Investment Plan which allows eligible employees to allocate up to 15% of their salary, through payroll deductions, among various mutual funds. The Company matches 75% of the employee's contribution, up to 6% of his or her salary. This contribution percentage rises to 85% in 2003. The cost of this plan (net of forfeitures) was \$3,442,000 in 2000, \$4,180,000 in 2001 and \$5,348,000 in 2002.

#### 11. Commitments and Contingencies:

The Company and its subsidiaries are subject to various claims arising in the ordinary course of business and are parties to various legal proceedings which constitute litigation incidental to the business of the Company and its subsidiaries. The Company's wholly owned subsidiary, First Health Services Corporation ("Services") continues to be subject to an investigation by the District of Columbia Office of Inspector General ("OIG"). In July 2000, the OIG issued a report evaluating the District of Columbia's Medicaid program and suggesting ways to improve the program. Services, a subsidiary of the Company that was acquired in July 1997, had acted as the program's fiscal agent intermediary for more than 20 years. The OIG report included allegations that from 1993 to 1996 Services, in its role as fiscal agent intermediary, made erroneous Medicaid payments to providers on behalf of patients no longer eligible to receive Medicaid benefits. The Company does not believe that the outcome of the claim or the investigation will have a material adverse affect on the Company's business or financial position.

The Company's largest client (Mail Handlers Benefit Plan) generated revenue of approximately \$160 million in 2002 or 21% of total revenues. This amount

is net of a reserve established by the Company for various issues associated with the potential disallowance of certain expenses charged to the Plan. In addition, the provisions of the contract with the Plan's sponsor, the National Postal Mail Handlers Union, require that the Company fund any deficits in the Plan after the Plan's reserves have been fully utilized. As of December 31, 2002, the Plan has approximately \$313 million in reserves to cover Plan expenses which may exceed the premiums charged and collected from the Plan participants by the Plan sponsor. Management believes that these reserves are adequate to cover any Plan deficits as of December 31, 2002. There are no known Plan deficits as of December 31, 2002.

FIN 45 requires the Company to disclose certain guarantees, including contractual indemnifications, it has assumed. The Company generally declines to provide indemnification to its customers. In limited circumstances, to secure long-term customer contracts at favorable rates, the Company may negotiate risk allocation through mutual indemnification provisions that, in the Company's judgment, appropriately allocate risk relative to the value of the customer. Management believes that any liability under these indemnification provisions would not be material.

Leases: The Company leases office facilities under leases through 2010. At December 31, 2002, future minimum annual rental commitments, gross of \$3.0 million in future income under noncancelable contractual sublease agreements, were as follows:

(in thousands)	
Years Ending December 31,	Amount
2003	\$12,922
2004	10,344
2005	8,242
2006	4,957
2007	3,848
Thereafter	7,282
<b>Total</b>	<b>\$47,595</b>

Total rent expense, recognized under the straight-line method, was \$7,849,000 in 2000, \$9,904,000 in 2001 and \$13,285,000 in 2002.

Agreement with EDS: The Company has an agreement (the "EDS Agreement") with Electronic Data Systems Corporation ("EDS"), primarily for the purpose of developing and jointly marketing medical and administrative cost management services to workers' compensation payors. The initial term of the EDS Agreement was to January 1, 2005, and has been extended to at least 2010. EDS provides data processing, electronic claims transmission and marketing support services to the Company. Fees paid by the Company to EDS for its medical cost management services is based upon the greater of a specified minimum annual payment (based on 1999 fees), or a per-bill charge plus percentage of savings method.

EDS processes all of the workers' compensation fee schedule claims for the Company. Although there are other data processing service organizations available, a loss of EDS's services would adversely affect the operating results of the Company's fee schedule service business.

#### 12. Major Customers:

During 2000, the Company had no customers which individually accounted for 10% or more of revenues. During 2001 and 2002, the Company had one customer (Mail Handlers Benefit Plan) which accounted for 13% and 21%, respectively, of revenues.

#### 13. Derivative Financial Instruments:

The use of derivatives by the Company has not been material although they have been used from time to time to reduce interest rate risks, potentially increase the return on invested funds and manage the cost of common stock repurchase programs. Investments in derivative financial instruments are approved by the Board of Directors of the Company. The Company had no derivatives outstanding as of December 31, 2002.

#### 14. Quarterly Financial Data (Unaudited):

The following is a summary of unaudited results of operations (\$ in thousands except per share data) for the years ended December 31, 2001 and 2002.

	Year Ended December 31, 2001			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue	\$136,984	\$138,949	\$152,207	\$164,968
Net income	\$ 24,400	\$ 25,329	\$ 26,364	\$ 26,827
Net income per common share - basic	\$ .25	\$ .26	\$ .27	\$ .27
Weighted average shares				

outstanding - basic	96,726	97,765	99,280	99,698
Net income per common share - diluted	\$ .24	\$ .25	\$ .25	\$ .26
Weighted average shares outstanding - diluted	101,698	102,396	103,946	104,343

	Year Ended December 31, 2002			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue	\$169,361	\$175,923	\$204,928	\$209,754
Net income	\$ 31,014	\$ 32,484	\$ 33,743	\$ 35,697
Net income per common share - basic	\$ .31	\$ .32	\$ .33	\$ .36
Weighted average shares outstanding - basic	100,257	101,217	101,526	100,204
Net income per common share - diluted	\$ .30	\$ .31	\$ .32	\$ .35
Weighted average shares outstanding - diluted	104,443	104,735	104,972	103,342

#### Corporate and Investor Information

Form 10-K. The Company has filed an Annual Report on Form 10-K for the year ended December 31, 2002 with the Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing: Joseph E. Whitters, Vice President, Finance and Chief Financial Officer, First Health Group Corp., 3200 Highland Avenue, Downers Grove, IL 60515. Additionally, it is available on the Internet by accessing the Company's website at [www.FirstHealth.com](http://www.FirstHealth.com)

Common Stock. First Health Group Corp. common stock is quoted on the Nasdaq National Market under the symbol FHCC. The following tables show the quarterly range of high and low sales prices of the common stock during the calendar periods indicated:

	High	Low
2001		
First Quarter	\$23.63	\$17.31
Second Quarter	28.80	21.38
Third Quarter	30.40	23.38
Fourth Quarter	29.33	21.35
2002		
First Quarter	\$26.25	\$22.00
Second Quarter	30.15	23.75
Third Quarter	28.35	23.49
Fourth Quarter	29.60	20.79
2003		
Through March 14	\$24.88	\$20.70

As of March 14, 2003, the Company had 814 stockholders of record.

Dividend Policy. The Company has not paid any dividends on its common stock and expects that its earnings will continue to be retained for use in the operation and expansion of its business.

Independent Auditors  
Deloitte & Touche LLP  
Chicago, Illinois

Corporate Counsel  
Latham & Watkins  
Chicago, Illinois

Transfer Agent & Registrar  
The LaSalle National Bank of Chicago  
Chicago, Illinois

## SUBSIDIARIES OF FIRST HEALTH GROUP CORP.

First Health Strategies, Inc. Incorporated in Delaware	First Health Insurance Services, Inc. Incorporated in Illinois
First Health Services Corporation Incorporated in Virginia	First Health Benefits Administrators Corp. Incorporated in Illinois
First Health Life & Health Insurance Company Incorporated in Texas	American Life and Health Insurance Company Incorporated in Missouri
First Health Realty, Inc. Incorporated in Utah	First Health Strategies of Ohio, Inc. Incorporated in Ohio
First Health Services of Arkansas, Inc. Incorporated in Arkansas	Cambridge Life Insurance Company Incorporated in Missouri
CCN Managed Care, Inc. Incorporated in Delaware	Preferred Works, Inc. Incorporated in Delaware
First Health Services of South Carolina, Inc. Incorporated in Delaware	First Health Strategies of Utah, Inc. Incorporated in Utah
First Health Strategies of Texas, Inc. Incorporated in Texas	First Health Insurance Agency, Inc. Incorporated in Massachusetts
First Health Strategies of New Mexico, Inc. Incorporated in New Mexico	First Health Services of Tennessee, Inc. Incorporated in Tennessee
First Health Strategies of Pennsylvania Inc. Incorporated in Pennsylvania	First Health Services of Florida, Inc. Incorporated in Delaware
Midwest Benefits Corporation Incorporated in Michigan	First Health Services of Montana, Inc. Incorporated in Delaware
First Peer Review of Tennessee, Inc. Incorporated in Delaware	First Peer Review of Oregon Incorporated in Delaware
First Health Services of North Carolina, Inc. Incorporated in Delaware	First Peer Review of Michigan, Inc. Incorporated in Delaware
First Health Services of New York, Inc. Incorporated in Delaware	First Peer Review of Ohio, Inc. Incorporated in Delaware
First Peer Review of Colorado Incorporated in Delaware	First Peer Review of Arizona, Inc. Incorporated in Delaware
PPO Alliance Incorporated in California	Claims Administration Corp. Incorporated in Maryland
HealthCare Value Management, Inc. Incorporated in Massachusetts	Federal Employee Plans, Inc. Incorporated in Delaware

INDEPENDENT AUDITORS' CONSENT

First Health Group Corp.:

We consent to the incorporation by reference in the previously filed Registration Statements of First Health Group Corp. on Form S-8 (file numbers 333-67570, 333-67568, 333-67566, 333-57228, 333-57226, 333-68941, 333-68943, 33-26640, and 33-62747) of our reports dated February 14, 2003 (which expressed an unqualified opinion and included an explanatory paragraph as to the Company's change in its accounting for goodwill and intangible assets in 2002), appearing in this Annual Report on Form 10-K of First Health Group Corp. for the year ended December 31, 2002.

Deloitte & Touche, LLP

Chicago, Illinois  
March 25, 2003

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of First Health Group Corp. (the "Company") on Form 10-K for the period ended December 31, 2002, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Edward L. Wristen, Chief Executive Officer of the Company, do hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Edward L. Wristen  
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Edward L. Wristen  
Chief Executive Officer  
March 26, 2003

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of First Health Group Corp. (the "Company") on Form 10-K for the period ended December 31, 2002, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joseph E. Whitters, Chief Financial Officer of the Company, do hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph E. Whitters  
-----  
Joseph E. Whitters  
Chief Financial Officer  
March 26, 2003

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