Item 1. Business

Overview

We are the nation's leading provider of diagnostic testing, information and services, providing insights that enable physicians and other healthcare professionals to make decisions to improve health. We offer patients and physicians the broadest access to diagnostic laboratory services through our nationwide network of laboratories and patient service centers. We provide interpretive consultation through the largest medical and scientific staff in the industry, with more than 500 M.D.'s and Ph.D.'s around the country. We are the leading provider of esoteric testing, including gene-based testing and the leading provider of testing for drugs of abuse. We are also a leading provider of anatomic pathology services, testing for clinical trials and risk assessment services for the life insurance industry. We empower healthcare organizations and clinicians with state-of-the-art information technology solutions that can improve patient care and medical practice.

During 2005, we generated net revenues of $5.5 billion and processed approximately 144 million requisitions for testing. Each requisition form accompanies a patient specimen, indicating the tests to be performed and the party to be billed for the tests. Our customers include patients, physicians, hospitals, employers, governmental institutions and other commercial clinical laboratories.

We operate a nationwide network of greater than 2,000 patient service centers, principal laboratories located in more than 35 major metropolitan areas throughout the United States, and approximately 150 smaller "rapid response" laboratories (including, in each case, facilities operated at our joint ventures). We provide full esoteric testing services, including gene-based testing, on both coasts through our Quest Diagnostics Nichols Institute laboratory facilities, located in San Juan Capistrano, California and Chantilly, Virginia. We also have laboratory facilities in Mexico City, Mexico, San Juan, Puerto Rico and Heston, England.

We are a Delaware corporation. We sometimes refer to our subsidiaries and ourselves as the "Company". We are the successor to MetPath Inc., a New York corporation that was organized in 1967. From 1982 to 1996, we were a subsidiary of Corning Incorporated, or Corning. On December 31, 1996, Corning distributed all of the outstanding shares of our common stock to the stockholders of Corning. In August 1999, we completed the acquisition of SmithKline Beecham Clinical Laboratories, Inc., or SBCL, which operated the clinical laboratory business of SmithKline Beecham plc, or SmithKline Beecham.

Our principal executive offices are located at 1290 Wall Street West, Lyndhurst, New Jersey 07071, telephone number: (201) 393-5000. Our filings with the Securities and Exchange Commission, or the SEC, including our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports, are available free of charge on our website as soon as reasonably practicable after they are filed with, or furnished to, the SEC. Our website is www.questdiagnostics.com.

The United States Clinical Laboratory Testing Market

Clinical laboratory testing is an essential element in the delivery of healthcare services. Physicians use laboratory tests to assist in the detection, diagnosis, evaluation, monitoring and treatment of diseases and other medical conditions. Clinical laboratory testing is generally categorized as clinical testing and anatomic pathology testing. Clinical testing is performed on body fluids, such as blood and urine. Anatomic pathology testing is performed on tissues, including biopsies, and other samples, such as human cells. Many clinical laboratory tests are considered routine and can be performed by most commercial clinical laboratories. Tests that are not routine and that require more sophisticated equipment and highly skilled personnel are considered esoteric tests. Esoteric tests, including gene-based tests, are generally referred to laboratories that specialize in performing those tests.

We believe that the United States clinical laboratory testing market exceeded $40 billion in annual revenues in 2005. Most laboratory tests are performed by one of three types of laboratories: commercial clinical laboratories; hospital-affiliated laboratories; and physician-office laboratories. In 2005, we believe that hospital-affiliated laboratories accounted for approximately 60% of the market, commercial clinical laboratories approximately one-third and physician-office laboratories the balance.

The underlying fundamentals of the diagnostic testing industry have improved since the early to mid-1990s. Since that time there has been significant industry consolidation, particularly among commercial laboratories, resulting in fewer but larger commercial laboratories with greater economies of scale, better equipped to service the members of large healthcare plans, and more disciplined in their approach to operating their business. Orders for laboratory testing are generated from physician offices, hospitals and employers. As such, factors including changes in the United States economy which can affect the number of unemployed and uninsured,

and design changes in healthcare plans which impact the number of physician office and hospital visits, can impact the utilization of laboratory testing.

While the diagnostic testing industry in the United States may be impacted by a number of factors, we believe it will continue to grow over the long term as a result of the following:

- the growing and aging population;
- continuing research and development in the area of genomics (the study of DNA, genes and chromosomes) and proteomics (the analysis of individual proteins and collections of proteins), which is expected to yield new, more sophisticated and specialized diagnostic tests;
- increasing recognition by consumers and payers of the value of laboratory testing as a means to improve health and reduce the overall cost of healthcare through early detection and prevention; and
- increasing affordability of, and access to, tests due to advances in technology and cost efficiencies.

Corporate Strategy and Growth Opportunities

Our mission is to be the undisputed world leader in diagnostic testing, information and services. We focus on Patients, Growth and People to help achieve our goals.

Patients are at the center of everything we do. Increasingly, patients and their doctors have a choice when it comes to selecting a healthcare provider, and we strive to give them new and compelling reasons to put their trust in us. We differentiate our Company to patients and doctors by:

- *Providing the Highest Quality Services:* We strive to provide the highest quality in all that we do including: phlebotomy and specimen transport services; analytical testing processes in our laboratories; providing accurate and timely lab reports; and billing information. We use Six Sigma processes to continuously reduce defects and enhance quality, and we are utilizing Lean Six Sigma principles to further increase the efficiency of our operations. Six Sigma is a management approach that utilizes a thorough understanding of customer needs and requirements, root cause analysis, process improvements and rigorous tracking and measuring to enhance quality. Lean Six Sigma streamlines processes and eliminates waste. We also use Six Sigma and Lean principles to help to standardize operations and processes across the Company and adopt identified Company best practices.
- *Offering Unparalleled Access and Distribution:* We offer the broadest test menu and national access to testing services, with facilities in substantially all of the major metropolitan areas in the United States. We operate a nationwide network of greater than 2,000 patient service centers, principal laboratories located in more than 35 major metropolitan areas throughout the United States and about 150 smaller "rapid response" laboratories that enable us to serve patients, physicians, hospitals, employers and other healthcare providers throughout the United States. We believe that customers will increasingly seek to utilize laboratory-testing providers that offer a comprehensive range of tests and services and the most convenient access to those services.

Growth is driven organically and through acquisition. We expect to grow organically at or above the industry growth rate by gaining more customers and selling more to existing customers. Historically, our industry has focused primarily on service levels and aggressive pricing to drive organic volume growth. We believe that the differentiation we are creating through our focus on Six Sigma quality, unparalleled access and distribution, the most comprehensive test menu and innovative test and information technology offerings will provide us with a competitive advantage and enable us to maintain pricing discipline as we drive profitable organic growth. Additionally, we are investing in sales and marketing, providing the sales force with better tools and training and adding innovative new products to sell. We are specifically focused on driving profitable organic growth in higher-growth areas by being a leading innovator. Our principal areas of focus include:

- *Physician Sub Specialties:* While we provide a strong value proposition in routine and esoteric clinical testing, we have not been the provider of choice for certain pathology testing needs. We are enhancing our test menu and service capabilities to more effectively compete in several physician sub specialties, including urology, gastroenterology, dermatology and oncology, where we have had a smaller market share.
- *Anatomic Pathology:* Of the total United States clinical laboratory testing market, which we believe exceeded $40 billion in annual revenues in 2005, we estimate that the current United States market for

anatomic pathology services is approximately $7 billion per year. We estimate that cytology represents approximately $1 billion per year of this market, and that tissue pathology represents approximately $6 billion per year of this market. With the aging of the population and the increased incidence of cancer, we believe that the tissue pathology business is growing more rapidly and is more profitable than the cytology business. We are one of the leading providers of anatomic pathology services in the United States. We have traditionally been strongest in cytology, specifically in the analysis of Pap tests to detect cervical cancer. We led the industry in converting Pap testing to the use of liquid-based technology, a more effective means of screening for cervical cancer. We are also leading the industry in educating physicians about human papilloma virus (HPV) molecular testing. The American College of Obstetricians and Gynecologists (ACOG) and the American Cancer Society recommend women over 30 are screened for HPV in addition to a Pap test. We intend to continue to expand our anatomic pathology business, particularly in tissue pathology. In conjunction with our physician sub-specialty focus, we have been enhancing our anatomic pathology capabilities and service offerings and are adding specially trained sales representatives. We generated approximately $550 million in net revenues from anatomic pathology services during 2005.

- *Innovation Leadership:* We intend to build upon our reputation as a leading innovator in the clinical laboratory industry by continuing to introduce new tests, technology and services. As the industry leader with the largest and broadest network and the leading provider of esoteric testing, we believe that we are the best partner for developers of new technologies and tests to introduce their products to the marketplace. Through our relationships with the academic community, pharmaceutical and biotechnology firms and emerging medical technology companies that develop and commercialize novel diagnostics, pharmaceutical and device technologies, we believe that we are one of the leaders in transferring technical innovation to the market. Our innovation activities are focused on:

  - *Gene-Based and Other Esoteric Testing Capabilities:* We intend to remain a leading innovator in the diagnostic testing industry by continuing to introduce new tests, technology and services. We believe that gene-based and other esoteric tests are the fastest growing area within the diagnostic testing industry. We believe that we have the largest gene-based testing business in the United States, with over $660 million in net revenues during 2005, and that this business is growing approximately 10% per year. We believe that the unveiling of the human genome, the discovery of new genes and the linkages of these genes and the proteins they produce with disease will result in more complex and thorough predictive and diagnostic testing. We believe that we are well positioned to benefit from this growth. We intend to focus on commercializing diagnostic applications of discoveries in the areas of functional genomics and proteomics.

  - *Information Technology:* We continue to invest in the development and improvement of information technology products for customers and healthcare providers. We develop differentiated products that provide more convenient ordering and reporting of laboratory tests and better access to patient-centric information. We believe that these products enhance the value we provide to our customers and result in increased customer loyalty. Our Care360™ products, including our Care360 Physician Portal, enable doctors to order diagnostic tests and review laboratory results from Quest Diagnostics online. In addition, the Care360 Physician Portal enables doctors to electronically prescribe medication, view clinical and administrative information from various sources, file certain documents into a patient-centric health record maintained in our repository and share confidential information with medical colleagues in a manner consistent with the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The Care360 Physician Portal and related Care360 products allow us to replace older technology products that we currently provide to many physicians and thereby streamline our support structure. Demand has been growing for our information technology solutions as physicians have expanded their usage of the Internet. By the end of 2005, approximately 45% of our orders were being transmitted via the Internet.

    The Care360 Physician Portal was developed by MedPlus Inc., or MedPlus, our wholly owned healthcare information technology subsidiary. MedPlus' ChartMaxx® patient record systems and Care360 connectivity system are designed to support the creation and management of electronic patient records, by bringing together, in one patient-centric view, information from various sources, including physician's records and laboratory and hospital data. We intend to expand the services offered through our portal over time through both internal development and the formation of strategic relationships.

We expect to continue pursuing growth through acquisitions. Historically, as the clinical laboratory industry consolidated, acquisitions contributed a significant portion of our growth. We believe that organic growth will become more significant, while acquisitions will continue to be an important contributor to growth.

The clinical laboratory industry remains highly fragmented. We expect to continue to selectively evaluate potential acquisitions of regional clinical laboratories that can be integrated into our existing laboratories, thereby increasing access for patients and enabling us to reduce costs and improve efficiencies. See "Recent Acquisition" for a discussion of our recent acquisitions. We will also selectively assess potential acquisition opportunities that will increase clinical capabilities, geographic presence, or move us into related adjacent spaces, both domestically and internationally. During 2005, through the acquisition of LabOne, we entered into a new testing-related field, providing laboratory testing and risk assessment services to the life insurance industry.

Rapid development of new tests and technologies continues. In addition, hospitals and physician office laboratories increasingly are internalizing testing, moving testing closer to the patient. As a result, we will consider acquiring or exclusively licensing selective products to complement the services we provide.

Technology is making possible the convergence of various healthcare disciplines. Information technology will eventually enable doctors to diagnose and treat disease by aggregating a patient's genetic predisposition, diagnostic test results and diagnostic images into a patient-centric electronic medical record available in a timely fashion at the point of care. Having such clinical data in one easily accessed place will enable better decision-making and drive improved outcomes for patients. Accordingly, potential acquisitions in adjacent industries such as healthcare information technology and diagnostic imaging may also be considered. Our acquisition of MedPlus in 2001 was our first acquisition of a healthcare information technology company.

People enable us to realize our mission. In this regard, an important challenge is to prepare our workforce for the future. Our people strategy is built on concepts of stringent employee selection, effective engagement and ongoing development resulting in a staff of highly qualified and motivated employees who are committed to our goals. In addition, we are committed to improving the health of our employees and reducing healthcare costs for them and our Company. Through our HealthyQuest initiative, we provide employees with the opportunity to lose weight, quit smoking and generally pursue healthier lifestyles. Quest Diagnostics is recognized as a "best place to work" in numerous locales as a consequence of our workplace initiatives that reflect our belief that people are our most important asset. We take diversity seriously, believing that our organization should reasonably reflect the communities that we serve. We strive to make all of our employees effective ambassadors of our Company.

Recent Acquisition

On November 1, 2005, we acquired Lab*One*, Inc., or LabOne, in a transaction valued at approximately $947 million, including approximately $138 million of assumed debt of LabOne. LabOne provides health screening and risk assessment services to life insurance companies, as well as clinical diagnostic testing services to healthcare providers and drugs-of-abuse testing to employers. LabOne operates major laboratories in Lenexa, Kansas, and Cincinnati, Ohio, as well as a state-of-the-art call center in Lee's Summit, Missouri, and provides paramedical examination services throughout the United States and Canada to serve the life insurance industry. The acquisition of LabOne supports our growth strategy in a number of ways, including: solidifying our leadership position in diagnostic testing by expanding access for physicians and patients and giving us added presence in several geographic areas; strengthening our drugs-of-abuse testing business and establishing us as the leader in a new testing net related business, providing health screening and risk assessment services to the life insurance industry.

Our Services

For 2005, our clinical laboratory testing business accounted for approximately 95% of our net revenues, with the balance derived from clinical trials testing, risk assessment services and other services and products. Laboratory testing includes routine testing and gene-based and esoteric testing, which generated approximately 78% and 17%, respectively, of our net revenues. Clinical trials testing generated less than 3% of our net revenues and risk assessment services generated less than 1% of our net revenues. We derive approximately 2% of our net revenues from foreign operations. We expect that the risk assessment business will represent approximately 4% of our net revenues in 2006, bringing the total net revenues attributable to our non-clinical testing businesses to approximately 8% of our consolidated net revenues.

Routine Testing

Routine tests measure various important bodily health parameters such as the functions of the kidney, heart, liver, thyroid and other organs. Commonly ordered tests include:

- blood cholesterol level;
- blood chemistries;
- complete blood cell counts;
- Pap tests;
- urinalyses;
- pregnancy and other prenatal tests; and
- alcohol and other substance-abuse tests.

We perform routine testing through our network of major laboratories, rapid response laboratories and patient service centers. We also perform routine testing at the hospital laboratories we manage. Major laboratories offer a full line of routine clinical tests. Rapid response laboratories are smaller facilities where we can quickly perform an abbreviated menu of routine tests for customers that require rapid turnaround times. Patient service centers are facilities where specimens are collected, and are typically located in or near a building used by medical professionals.

We operate 24 hours a day, 365 days a year. We perform and report most routine procedures within 24 hours. The majority of test results are delivered electronically.

Esoteric Testing

Esoteric tests are those tests that require more sophisticated technology, equipment or materials, professional "hands-on" attention from highly skilled and technical personnel, and that may be performed less frequently than routine tests. Because it is not cost-effective for most hospital and clinical laboratories to perform low-volume esoteric tests in-house, they generally refer many of these tests to an esoteric clinical testing laboratory that specializes in performing these more complex tests. Due to their complexity, esoteric tests are generally reimbursed at higher levels than routine tests.

Our two esoteric testing laboratories, which conduct business as Quest Diagnostics Nichols Institute, are among the leading esoteric clinical testing laboratories in the world. In 1998, our esoteric testing laboratory in San Juan Capistrano, California, was the first clinical laboratory in North America to achieve International Organization for Standardization, or ISO, 9001 certification. Our esoteric testing laboratory in Chantilly, Virginia enables us to provide full esoteric testing services on the east coast. Our two esoteric testing laboratories perform hundreds of esoteric tests that are not routinely performed by our regional laboratories. These esoteric tests are generally in the following fields:

- endocrinology and metabolism (the study of glands, their hormone secretions and their effects on body growth and metabolism);
- genetics (the study of chromosomes, genes and their protein products and effects);
- hematology (the study of blood and bone marrow cells) and coagulation (the process of blood clotting);
- HLA and immunogenetics (solid organ and bone marrow transplantation; eligibility for vaccines and immunotherapy);
- immunology (the study of the immune system including antibodies, immune system cells and their effects);
- microbiology and infectious diseases (the study of microscopic forms of life including bacteria, viruses, fungi and other infectious agents);
- oncology (the study of abnormal cell growth including benign tumors and cancer);
- serology (a science dealing with body fluids and their analysis, including antibodies, proteins and other characteristics); and
- toxicology (the study of chemicals and drugs and their effects on the body's metabolism).

New Test Introductions

We intend to build upon our reputation as a leading innovator in the clinical laboratory industry by continuing to introduce new diagnostic tests. As the industry leader with the largest and broadest laboratory network and the leading provider of esoteric testing, we believe that we are the best partner for developers of new technology and tests to introduce their products to the marketplace.

We continued to be a leading innovator in the industry in 2005, through tests that we developed at Quest Diagnostics Nichols Institute, the largest provider of molecular diagnostic testing in the United States, as well as through relationships with technology developers. We believe that we are one of the leaders in transferring technical innovations to the market, through our relationships with the academic community and pharmaceutical and biotechnology firms, as well as collaborations with emerging medical technology companies that develop and commercialize novel diagnostics, pharmaceutical and device technologies.

We primarily focus our resources on three disease states, cardiovascular disease, cancer and infectious disease, as well as on continued advancements in molecular diagnostics. During 2005, we introduced approximately 75 new and improved assays, including:

- The initial two tests in a family of new plasma-based tests for leukemia and lymphoma. We believe that these tests, which are based on technology licensed from M.D. Anderson Cancer Center, will reduce and, in the future, might replace the need for painful bone marrow biopsies.
- A gene-based assay to help physicians identify metastatic Cancers of Unknown Primary origin. Cancer of unknown primary origin refers to metastatic cancer in which cancer cells are found somewhere in the body, but the place of origin where they first started growing cannot be identified from physical examination, pathologic analysis or other forms of diagnostic testing. This test is intended to aid physicians in identifying the primary site of origin of cancer, establishing prognosis and determining appropriate therapy.
- We also added tests to support our leadership in infectious diseases and endocrinology, including testing using liquid chromatography-tandem mass spectrometry (LC-MS/MS), as well as tests in immunology, particularly autoimmune disorders and coagulation, an increasingly important factor in cancer treatment, cardiovascular health and pre-surgical preparation.

We proactively search for new opportunities in screening, diagnosis, prognosis, treatment choice and treatment monitoring. We believe that, with the unveiling of the human genome, and its extension into proteomics, new genes and combinations of proteins will continue to be discovered at an accelerating pace and will result in ever more complex and thorough predictive and diagnostic testing. We believe that we are well positioned to benefit from these advances.

As testing methods become more complex, we believe that it is also important to provide sound medical and scientific consultation to ensure the correct application and interpretation of the test results. Our medical and scientific directors are always available for consultation to our customers. In 2005, we further enhanced our consultation programs, supported with our enhanced reporting initiatives, particularly in the complex areas of hematopathology and coagulation. We believe consultation services will provide higher confidence in the adoption of the new tests we develop and lead to improved client satisfaction and improved patient outcomes.

Risk Assessment Services

We believe that we are the largest provider of risk assessment services to the life insurance industry in the United States. Our risk assessment services comprise underwriting support services to the life insurance industry including teleunderwriting, specimen collection and paramedical examinations, laboratory testing, medical record retrieval, motor vehicle reports, telephone inspections and credit checks. The laboratory tests performed and data gathered by us are specifically designed to assist an insurance company in objectively evaluating the mortality and morbidity risks posed by policy applicants. The majority of the testing is performed on specimens of individual life insurance policy applicants, but also includes specimens of individuals applying for individual and group medical and disability policies. We also provide risk assessment services in Canada.

Clinical Trials Testing

We believe that we are the world's second largest provider of clinical laboratory testing performed in connection with clinical research trials on new drugs. Clinical research trials are required by the Food and Drug

Administration, or FDA, and other international regulatory authorities to assess the safety and efficacy of new drugs. We have clinical trials testing centers in the United States and in the United Kingdom. We also provide clinical trials testing in Australia, Singapore and South Africa through arrangements with third parties. Clinical trials involving new drugs are increasingly being performed both inside and outside the United States. Approximately 50% of our net revenues from clinical trials testing in 2005 represented testing for GlaxoSmithKline plc, or GSK. We currently have a long-term contractual relationship with GSK, under which we are the primary provider of testing to support GSK's clinical trials testing requirements worldwide.

Other Services and Products

We manufacture and market diagnostic test kits and systems primarily for esoteric testing through our Nichols Institute Diagnostics subsidiary. These are sold principally to hospitals, clinical laboratories and dialysis centers, both domestically and internationally.

Our MedPlus subsidiary is a developer and integrator of clinical connectivity and data management solutions for healthcare organizations, physicians and clinicians primarily through its ChartMaxx® electronic medical record system for hospitals and our Care360 suite of products. The Care360 Physician Portal was developed by MedPlus and enables physicians to order diagnostic tests and review laboratory results from Quest Diagnostics online. In addition, the Care360 Physician Portal enables physicians to electronically prescribe medications, view clinical and administrative information from multiple sources, file certain documents into a patient-centric health record maintained in our repository and share confidential patient information with medical colleagues in a manner that is consistent with HIPAA privacy and security requirements.

Payers and Customers

We provide testing services to a broad range of healthcare providers. We consider a "payer" as the party that pays for the test and a "customer" as the party who refers the test to us. Depending on the billing arrangement and applicable law, the payer may be (1) the physician or other party (such as a hospital, another laboratory or an employer) who referred the testing to us, (2) the patient, or (3) a third party who pays the bill for the patient, such as an insurance company, Medicare or Medicaid. Some states, including New York, New Jersey and Rhode Island, prohibit us from billing physician clients. During 2005, only three customers accounted for 5% or more of our net revenues, and no single customer accounted for more than 8% of our net revenues. We believe that the loss of any one of our customers would not have a material adverse effect on our financial condition, results of operations or cash flows.

The following table shows current estimates of the breakdown of the percentage of our total volume of requisitions and net revenues associated with our clinical laboratory testing business during 2005 applicable to each payer group:

	Requisition Volume as % of Total Volume	Net Revenues as % of Total Clinical Laboratory Testing Net Revenues
Patient	2% – 5%	5% – 10%
Medicare and Medicaid	15% – 20%	15% – 20%
Physicians, Hospitals, Employers and Other Monthly-Billed Clients	30% – 35%	20% – 25%
Healthcare Insurers-Fee-for-Service	30% – 35%	40% – 45%
Healthcare Insurers-Capitated	15% – 20%	5% – 10%

Physicians

Physicians requiring testing for patients are the primary referral source of our clinical laboratory testing volume. Testing referred by physicians is typically billed to healthcare insurers, government programs such as Medicare and Medicaid, patients and physicians. Physicians are typically billed on a fee-for-service basis based on negotiated fee schedules. Fees billed to patients and healthcare insurers are based on the laboratory's patient fee schedule, subject to any limitations on fees negotiated with the healthcare insurers or with physicians on

behalf of their patients. Medicare and Medicaid reimbursements are based on fee schedules set by governmental authorities.

Healthcare Insurers

Healthcare insurers, including managed care organizations and other healthcare insurance providers, which typically negotiate directly or indirectly with a number of clinical laboratories on behalf of their members, represent approximately one-half of our total testing volumes and one-half of our net revenues. Larger healthcare insurers typically prefer to use large commercial clinical laboratories because they can provide services to their members on a national or regional basis. In addition, larger laboratories are better able to achieve the low-cost structures necessary to profitably service the members of large healthcare plans and can provide test utilization data across various products in a consistent format. Healthcare insurers frequently require test utilization data in order to meet the reporting requirements of the National Committee for Quality Assurance, or NCQA, to implement disease management programs and for other health plan operation purposes. In certain markets, such as California, healthcare insurers may delegate their covered members to independent physician associations, or IPAs, which in turn negotiate with laboratories for clinical laboratory services on behalf of their members.

In recent years, healthcare insurers have begun to offer more freedom of choice to their members, including greater freedom to determine which laboratory to use and which tests to order. Accordingly, most of our agreements with major healthcare insurers are non-exclusive arrangements. As a result, under these non-exclusive arrangements, physicians and patients have more freedom of choice in selecting laboratories, and laboratories are likely to compete more on the basis of service and quality than they may otherwise. Also, healthcare plans are increasingly offering programs such as preferred provider organizations, or PPOs, and consumer driven health plans that offer a greater choice of healthcare providers. Pricing for these programs is typically negotiated on a fee-for-service basis, which generally results in higher revenue per requisition than under capitation arrangements. If consumer driven plans and PPO plans increase in popularity, it will be increasingly important for healthcare providers to differentiate themselves based on quality, service and convenience to avoid competing on price alone. Despite these trends, healthcare insurers continue to aggressively seek cost reductions in order to keep premiums to their customers competitive. If the Company is unable to agree on terms with a healthcare insurer, we could become a "non-participating" provider which may require us to bill the patient, or in certain cases the physician, rather than the healthcare insurer. This "non-participating" status could lead to loss of business since typically in these instances patients have a higher co-insurance responsibility and physicians may therefore not refer testing to a non-participating provider.

The trend of consolidation among healthcare insurers has continued, resulting in fewer but larger insurers with significant bargaining power to negotiate fee arrangements with healthcare providers, including clinical laboratories. These healthcare insurers, as well as IPAs, demand that clinical laboratory service providers accept discounted fee structures or assume all or a portion of the financial risk associated with providing testing services to their members through capitated payment arrangements. Under these capitated payment arrangements, we and healthcare insurers agree to a predetermined monthly reimbursement rate for each member of the healthcare insurer's plan, regardless of the number or cost of services provided by us. Some services, such as various esoteric tests, new technologies and anatomic pathology services, may be carved out from a capitated rate and, if carved out, are charged on a fee-for-service basis. We work closely with healthcare insurers as they evaluate new tests; however, as innovation in the testing area increases, there is no guarantee that healthcare insurers will agree to offer the technology as a covered service, carve out these services or reimburse them at rates that reflect the true cost or value associated with such services.

Historically, most Medicare beneficiaries were covered under the traditional Medicare program, but the federal government has, over the last several years, effected various proposals in an effort to increase enrollment of Medicare beneficiaries in the private managed care system. With the enactment of The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, which renamed the private Medicare program "Medicare Advantage" and created an additional product that allows for regional Preferred Provider Organization, it is possible that the Company may begin to experience a shift of traditional Medicare beneficiaries to private Medicare Advantage programs.

A significant portion of the laboratory costs incurred by healthcare insurers is for payments made to non-contracted providers (primarily hospitals) at rates exceeding those of contracted providers. We offer QuestNet™, a service whereby we develop and administer customized networks of clinical laboratory providers for healthcare insurers. Through QuestNet™, physicians and members are provided multiple choices for clinical laboratory

testing while healthcare insurers realize cost reductions from reducing testing performed by non-contracted providers.

Hospitals

Hospitals generally maintain an on-site laboratory to perform testing on patients and refer less frequently needed and highly specialized procedures to outside laboratories, which typically charge the hospitals on a negotiated fee-for-service basis. Fee schedules for hospital reference testing are typically negotiated on behalf of the hospitals by group purchasing organizations. We believe that most hospital laboratories perform approximately 90% to 95% of their patients' clinical laboratory tests. We provide services to hospitals throughout the United States that vary from esoteric testing to helping manage their laboratories. We believe that we are the industry's market leader in servicing hospitals. Our hospital customers account for approximately 12% of our net revenues, the majority of which represents services billed to the hospitals for certain testing that the hospitals do not perform internally. Hospitals continue to look for ways to fully utilize their existing laboratory capacity through test internalization as well as competing with commercial laboratories for outreach (non-hospital patients) testing. Most physicians have admitting privileges or other relationships with hospitals as part of their medical practice. Many hospitals leverage their relationships with community physicians and encourage the physicians to send their outreach testing to the hospital's laboratory. In addition, hospitals that own physician practices generally require the physicians to refer tests to the hospital's affiliated laboratory.

We have dedicated sales and service teams focused on serving the unique needs of hospital customers. We believe that the combination of full-service, bi-coastal esoteric testing capabilities, medical and scientific professionals for consultation, innovative connectivity products, focus on Six Sigma quality and dedicated sales and service professionals has positioned us to be a partner of choice for hospital customers.

We have joint venture arrangements with leading integrated healthcare delivery networks in several metropolitan areas. These joint venture arrangements, which provide testing for affiliated hospitals as well as for unaffiliated physicians and other healthcare providers in their geographic areas, serve as our principal laboratory facilities in their service areas. Typically, we have either a majority ownership interest in, or day-to-day management responsibilities for, our hospital joint venture relationships. We also manage the laboratories at a number of other hospitals.

Employers, Governmental Institutions and Other Clinical Laboratories

We provide testing services to federal, state and local governmental agencies and to large employers. We believe that we are the leading provider of clinical laboratory testing to employers for drugs of abuse. We also provide wellness testing to employers to enable employees to take an active role in improving their health. Testing services for employers account for approximately 3% of our net revenues. The volume of testing services for employers, which generally have relatively low profit margins, has increased moderately in 2005, driven by an increase in hiring. We also perform esoteric testing services for other commercial clinical laboratories that do not have a full range of testing capabilities. All of these customers are charged on a fee-for-service basis.

Sales and Marketing

We market to and service our customers through our direct sales force, healthplan sales force, customer service representatives and couriers.

We focus our sales efforts on obtaining and retaining profitable accounts. We have an active customer management process to evaluate the growth potential and profitability of all accounts.

Our sales force is organized by customer type with the majority of representatives focused on marketing clinical laboratory testing and related services to physicians, including specialty physicians such as oncologists, urologists and gastroenterologists. Additionally, we have a healthplan sales organization that focuses on regional and national insurance and healthcare organizations. We also have a hospital sales organization that focuses on meeting the unique needs of hospitals and promotes the specialized capabilities of our Nichols Institute esoteric testing laboratories. Supporting our physician sales teams are genomics and esoteric testing specialists, who are specially trained and focused on educating our clients on new and more complex tests. A smaller portion of our sales force focuses on selling substance-of-abuse and wellness testing to employers. With the completion of the

LabOne acquisition, we now have a sales force that focuses on selling risk assessment testing services to life insurance companies.

Customer service representatives perform a number of services for patients and customers. They monitor services, answer questions and help resolve problems. Our couriers pick up specimens from most clients daily.

Our corporate marketing function is organized by customer type and is responsible for developing and executing marketing strategies, new product launches, and promotional and advertising support.

Information Systems

Information systems are used extensively in virtually all aspects of our business, including laboratory testing, billing, customer service, logistics and management of medical data. The successful delivery of our services depends, in part, on the continued and uninterrupted performance of our information technology, or IT, systems. IT systems are vulnerable to damage from a variety of root causes, including telecommunications or network failures, malicious human acts and natural disasters. Moreover, despite network security measures, some of our servers are potentially exposed to physical or electronic break-in attempts, computer viruses and similar disruptive problems. Despite the precautionary measures that we have taken to prevent unanticipated problems that could affect our IT systems, sustained or repeated system failures that would interrupt our ability to process test orders, deliver test results or perform tests in a timely manner could adversely affect our reputation and result in a loss of customers and net revenues.

Historically, acquired companies were often operated as local decentralized units, and we did not standardize their billing, laboratory or their other core information systems. This resulted in many different information systems for billing, test results reporting and other transactions.

During 2002, we began implementation of a standard laboratory information system and a standard billing system across all of our operations, including those from our most recent acquisitions. The deployment of standardized systems is continuing and we expect that it will take several years to complete. It will result in significantly more centralized systems than we have even today and better control over the operational environment. We expect the integration of these systems will improve operating efficiency and provide management with more timely and comprehensive information with which to make management decisions. However, failure or delays in properly implementing this standardization process could materially adversely affect our business. During system conversions of this magnitude, workflow is re-engineered to take advantage of best practices and enhanced system capabilities and may temporarily affect the delivery of our services. In addition, the implementation process, including the transfer of databases and master files to new data centers, presents significant conversion risks that need to be managed very carefully.

Billing

Billing for laboratory services is complicated. Depending on the billing arrangement and applicable law, we must bill various payers, such as patients, insurance companies, Medicare, Medicaid, physicians and employer groups, all of which have different billing requirements. Additionally, auditing for compliance with applicable laws and regulations as well as internal compliance policies and procedures adds further complexity to the billing process. Other factors that complicate billing include:

- differences between our fee schedules and the reimbursement rates of the payers;
- disparity in coverage and information requirements among various payers;
- missing, incomplete or inaccurate billing information provided by ordering physicians; and
- disputes with payers as to which party is responsible for payment.

We incur additional costs as a result of our participation in Medicare and Medicaid programs, as billing and reimbursement for clinical laboratory testing is subject to considerable and complex federal and state regulations. These additional costs include those related to: (1) complexity added to our billing processes; (2) training and education of our employees and customers; (3) compliance and legal costs; and (4) costs related to, among other factors, medical necessity denials and advance beneficiary notices. Compliance with applicable laws and regulations, as well as internal compliance policies and procedures, adds further complexity and costs to our operations. Changes in laws and regulations could negatively impact our ability to bill our

clients. The Centers for Medicare & Medicaid Services, or CMS, establishes procedures and continuously evaluates and implements changes to the reimbursement process.

We believe that most of our bad debt expense, which was 4.2% of our net revenues in 2005, is primarily the result of missing or incorrect billing information on requisitions received from healthcare providers and the failure of patients to pay the portion of the receivable that is their responsibility rather than credit related issues. In general, we perform the requested tests and report test results regardless of whether the billing information is incorrect or missing. We subsequently attempt to contact the healthcare provider or patient to obtain any missing information and rectify incorrect billing information. Missing or incorrect information on requisitions adds complexity to and slows the billing process, creates backlogs of unbilled requisitions, and generally increases the aging of accounts receivable and bad debt expense (see "Regulation of Reimbursement for Clinical Laboratory Services").

Competition

While there has been significant consolidation in the clinical laboratory testing industry in recent years, our industry remains fragmented and highly competitive. We primarily compete with three types of laboratory providers: hospital-affiliated laboratories, other commercial clinical laboratories and physician-office laboratories. We are the leading clinical laboratory testing provider in the United States, with net revenues of $5.5 billion during 2005, and facilities in substantially all of the country's major metropolitan areas. Our largest competitor is Laboratory Corporation of America Holdings, Inc. In addition, we compete with many smaller regional and local commercial clinical laboratories, specialized esoteric labs, as well as laboratories owned by physicians and hospitals (see "Payers and Customers").

We believe that healthcare providers consider a number of factors when selecting a laboratory, including:

- service capability and quality;
- accuracy, timeliness and consistency in reporting test results;
- number and type of tests performed by the laboratory;
- number, convenience and geographic coverage of patient service centers;
- reputation in the medical community; and
- pricing.

We believe that we compete favorably in each of these areas.

We believe that large commercial clinical laboratories may be able to increase their share of the overall clinical laboratory testing market due to their large service networks and lower cost structures. These advantages should enable larger clinical laboratories to more effectively serve large customers and members of large healthcare plans. In addition, we believe that consolidation in the clinical laboratory testing industry will continue. However, a majority of the clinical laboratory testing is likely to continue to be performed by hospitals, which generally have affiliations with community physicians that refer testing to us (see "Payers and Customers – Hospitals"). As a result of these affiliations, we compete against hospital-affiliated laboratories primarily on the basis of service capability and quality as well as other non-pricing factors. Our failure to provide service superior to hospital-affiliated laboratories and other laboratories could have a material adverse effect on our net revenues and profitability.

The diagnostic testing industry is faced with changing technology and new product introductions. Advances in technology may lead to the development of more cost-effective tests that can be performed outside of a commercial clinical laboratory such as (1) point-of-care tests that can be performed by physicians in their offices; (2) esoteric tests that can be performed by hospitals in their own laboratories; and (3) home testing that can be carried out without requiring the services of clinical laboratories. Development of such technology and its use by our customers and patients would reduce the demand for our laboratory testing services and negatively impact our net revenues (see "Regulation of Clinical Laboratory Operations").

Quality Assurance

Our goal is to continually improve the processes for collection, storage and transportation of patient specimens, as well as the precision and accuracy of analysis and result reporting. Our quality assurance efforts

focus on proficiency testing, process audits, statistical process control and personnel training for all of our laboratories and patient service centers. We continue to implement our Six Sigma and standardization initiatives to help achieve our goal of becoming recognized as the undisputed quality leader in the healthcare services industry. Our Nichols Institute facility in San Juan Capistrano was the first clinical laboratory in North America to achieve ISO certification. Two of our clinical trials laboratories, our diagnostic kits facility and two of our routine laboratories are also ISO certified. These certifications are international standards for quality management systems.

Internal Proficiency Testing, Quality Control and Audits. Quality control samples are processed in parallel with the analysis of patient specimens. The results of tests on quality control samples are monitored to identify trends, biases or imprecision in our analytical processes. We also perform internal process audits as part of our comprehensive Quality Assurance program.

External Proficiency Testing and Accreditation. All of our laboratories participate in various external quality surveillance programs. They include, but are not limited to, proficiency testing programs administered by the College of American Pathologists, or CAP, as well as some state agencies.

CAP is an independent, non-governmental organization of board certified pathologists. CAP is approved by CMS to inspect clinical laboratories to determine compliance with the standards required by the Clinical Laboratory Improvement Amendments of 1988, or CLIA. CAP offers an accreditation program to which laboratories may voluntarily subscribe. All of our major regional laboratories are accredited by CAP. Accreditation includes on-site inspections and participation in the CAP (or equivalent) proficiency testing program. "CAP whistle blower" hotline posters, which are used to escalate unresolved quality and laboratory safety concerns to CAP, are posted in all of our CAP accredited laboratories.

Regulation of Clinical Laboratory Operations

The clinical laboratory industry is subject to significant federal and state regulation, including inspections and audits by governmental agencies. Governmental authorities may impose fines or criminal penalties or take other actions to enforce laws and regulations, including revoking a clinical laboratory's federal certification, which is required to operate a clinical laboratory operation. Changes in regulations may (i) increase our operating costs including, but not limited to, those costs associated with performing clinical laboratory tests, and administrative requirements related to billing or (ii) decrease the amount of reimbursement related to testing services performed.

CLIA and State Regulation. All of our laboratories and (where applicable) patient service centers are licensed and accredited by the appropriate federal and state agencies. CLIA regulates virtually all clinical laboratories by requiring they be certified by the federal government and comply with various operational, personnel and quality requirements intended to ensure that their clinical laboratory testing services are accurate, reliable and timely. CLIA does not preempt state laws that are more stringent than federal law. For example, state laws may require additional personnel qualifications, quality control, record maintenance and/or proficiency testing. The cost of compliance with CLIA makes it cost prohibitive for many physicians to operate clinical laboratories in their offices. However, manufacturers of laboratory equipment and test kits could seek to increase their sales by marketing point-of-care laboratory equipment to physicians and by selling to both physicians and patients test kits approved by the FDA for home use. Diagnostic tests approved or cleared by the FDA for home use are automatically deemed to be "waived" tests under CLIA and may be performed in physician office laboratories with minimal regulatory oversight under CLIA as well as by patients in their homes.

Drug Testing. The Substance Abuse and Mental Health Services Administration, or SAMHSA, regulates drug testing for public sector employees and employees of certain federally regulated businesses. SAMHSA has established detailed performance and quality standards that laboratories must meet to perform drug testing on these employees. All laboratories that perform such testing must be certified as meeting SAMHSA standards. All of our laboratories that perform such testing are certified as meeting SAMHSA standards.

Controlled Substances. The federal Drug Enforcement Administration, or DEA, regulates access to controlled substances used to perform drugs of abuse testing. To obtain access to controlled substances, laboratories must be licensed by the DEA. All of our laboratories that use controlled substances are licensed by the DEA.

Medical Waste, Hazardous Waste and Radioactive Materials. Clinical laboratories are also subject to federal, state and local regulations relating to the handling and disposal of regulated medical waste, hazardous waste and radioactive materials. We generally use outside vendors to dispose of such waste.

FDA. The FDA has regulatory responsibility over instruments, test kits, reagents and other devices used to perform diagnostic testing by clinical laboratories. In the past, the FDA has claimed regulatory authority over laboratory-developed tests, but has exercised enforcement discretion in not regulating most laboratory-developed tests performed by high complexity CLIA-certified laboratories. In December 2000, the Department of Health and Human Services, or HHS, Secretary's Advisory Committee on Genetic Testing recommended that the FDA be the lead federal agency to regulate genetic testing. In late 2002, a new HHS Secretary's Advisory Committee on Genetics, Health and Society, or SACGHS, was appointed to replace the prior Advisory Committee. In June 2004, SACGHS announced that its priorities included Overview of the Oversight of Genetic Technologies. Ultimately, SACGHS decided that it would continue to monitor the progress of the federal agencies in the oversight of genetic technologies, but it did not believe that further action was warranted. In the meantime, the FDA is considering revising its regulations on analyte specific reagents, which are used in laboratory-developed tests, including laboratory-developed genetic testing. FDA interest in or actual regulation of laboratory-developed tests or increased regulation of the various medical devices used in laboratory-developed testing could lead to periodic inquiry letters from the FDA and increased costs and delays in introducing new tests, including genetic tests. Representatives of clinical laboratories (including Quest Diagnostics) and the American Clinical Laboratory Association (our industry trade association), or ACLA, have communicated industry concerns to representatives of the FDA regarding potential FDA regulation of genetic testing in general and issues with regard to the impact of potential increased oversight over analyte specific reagents. We expect those discussions to continue.

Occupational Safety. The federal Occupational Safety and Health Administration, or OSHA, has established extensive requirements relating specifically to workplace safety for healthcare employers. This includes requirements to develop and implement multi-faceted programs to protect workers from exposure to blood-borne pathogens, such as HIV and hepatitis B and C, including preventing or minimizing any exposure through sharps or needle stick injuries.

Specimen Transportation. Transportation of most clinical laboratory specimens and some laboratory supplies are considered hazardous materials subject to regulation by the Department of Transportation, the Public Health Service, the United States Postal Service and the International Air Transport Association.

Corporate Practice of Medicine. Many states, including some in which our principal laboratories are located, prohibit corporations from engaging in the practice of medicine. The corporate practice of medicine doctrine has been interpreted in certain states to prohibit corporations from employing licensed healthcare professionals to provide services on the corporation's behalf. The scope of the doctrine, and how it applies, varies from state to state. In certain states these restrictions affect our ability to directly provide anatomic pathology services and/or to provide clinical laboratory services directly to consumers.

Healthcare Information Technology

Clinical laboratories use information technology to obtain laboratory orders and to communicate results and provide other laboratory reporting. Innovations in healthcare information technology, or HCIT, have the potential to improve patient care, promote efficiency and reduce expense. Both at the federal and state levels, there are public and private efforts to bring together healthcare providers, information technology vendors, and other stakeholders to coordinate federal healthcare information standards and develop a national healthcare network, including adopting standard code sets and developing standards for electronic interoperability (standards for the exchange and use of electronic healthcare data).

We and MedPlus, our HCIT subsidiary, could be impacted by any national healthcare information network and the adoption of standards for HCIT interoperability, because of substantial existing investments in software and hardware and the potential for having to make substantial future investments to comply with new or different standards. On October 11, 2005, as required by the MMA, the Office of the Inspector General, or OIG, published a proposed safe harbor to the federal anti-kickback statute and CMS published proposed exceptions to the Stark self-referral prohibition law that would permit certain providers other than clinical laboratories to provide e-prescribing items and services to physicians for free. If these regulations are adopted as proposed, certain providers would be able to provide broader packages of HCIT items or services than clinical laboratories which could create incentives for some customers to choose such providers. We are commenting on the proposed rules through our industry trade association, ACLA, reflecting our position that if

any providers are permitted to be donors of e-prescribing or EHR items or services, then all providers should be entitled to the same protections afforded by the proposed safe harbor and self-referral prohibition exceptions.

We and ACLA, our trade association, are monitoring standards development, proposed legislation and rulemaking proceedings and we are providing relevant information to policy makers to ensure that issues important to medical laboratories are reflected in any interoperability standards, HCIT legislation and proposed regulations.

Privacy and Security of Health Information; Standard Transactions

Pursuant to HIPAA, the Secretary of HHS has issued final regulations designed to improve the efficiency and effectiveness of the healthcare system by facilitating the electronic exchange of information in certain financial and administrative transactions while protecting the privacy and security of the information exchanged. Three principal regulations have been issued in final form: privacy regulations, security regulations and standards for electronic transactions.

The HIPAA privacy regulations, which fully came into effect in April 2003, establish comprehensive federal standards with respect to the uses and disclosures of protected health information by health plans, healthcare providers and healthcare clearinghouses. The regulations establish a complex regulatory framework on a variety of subjects, including:

- the circumstances under which uses and disclosures of protected health information are permitted or required without a specific authorization by the patient, including but not limited to treatment purposes, activities to obtain payment for our services and our healthcare operations activities;
- a patient's rights to access, amend and receive an accounting of certain disclosures of protected health information;
- the content of notices of privacy practices for protected health information; and
- administrative, technical and physical safeguards required of entities that use or receive protected health information.

We have implemented practices to meet the requirements of the HIPAA privacy regulations. The HIPAA privacy regulations establish a "floor" and do not supersede state laws that are more stringent. Therefore, we are required to comply with both federal privacy standards and varying state privacy laws. In addition, for healthcare data transfers relating to citizens of other countries, we need to comply with the laws of other countries. The federal privacy regulations restrict our ability to use or disclose patient-identifiable laboratory data, without patient authorization, for purposes other than payment, treatment or healthcare operations (as defined by HIPAA) except for disclosures for various public policy purposes and other permitted purposes outlined in the final privacy regulations. The privacy regulations provide for significant fines and other penalties for wrongful use or disclosure of protected health information, including potential civil and criminal fines and penalties. Although the HIPAA statute and regulations do not expressly provide for a private right of damages, we could incur damages under state laws to private parties for the wrongful use or disclosure of confidential health information or other private personal information.

The final HIPAA security regulations, which establish requirements for safeguarding electronic patient information, were published on February 20, 2003 and became effective on April 21, 2003, although healthcare providers had until April 20, 2005 to comply. We have implemented policies and standards to reasonably and appropriately comply with the requirements of the regulations.

The final HIPAA regulations for electronic transactions, which we refer to as the transaction standards, establish uniform standards for electronic transactions and code sets, including the electronic transactions and code sets used for billing claims, remittance advices, enrollment and eligibility. HHS issued guidance on July 24, 2003 stating that it would not penalize a covered entity for post-implementation date transactions that are not fully compliant with the transactions standards, if the covered entity could demonstrate its good faith efforts to comply with the standards. However, beginning October 1, 2005, CMS no longer processes incoming non-HIPAA compliant electronic Medicare claims.

Many of our payers were not ready to implement the transaction standards by the October 2003 compliance deadline or were not ready to test or trouble-shoot claims submissions. Since that time, significant progress has been made in implementing the transaction standards with our payers. As of December 31, 2005, we are substantially complete with the conversion to the required standard format for our electronic

fee-for-service claim transactions and our electronic fee-for-service remittance transactions. In September 2005, as part of HIPAA Administrative Simplification, HHS published a Notice of Proposed Rulemaking on Standards for Electronic Health Care Claims Attachments. We are commenting on this proposal through ACLA, our industry trade association, and final rule publication from HHS is not anticipated prior to mid-2006. Upon final rule publication, the implementation period for electronic health care claim attachments is anticipated to be two years at a minimum.

The HIPAA transaction standards are complex and subject to differences in interpretation by payers. For instance, some payers may interpret the standards to require us to provide certain types of information, including demographic information not usually provided to us by physicians. We are working closely with our payers to establish acceptable protocols for claims submissions and with our industry trade association and an industry coalition to present issues and problems as they arise to the appropriate regulators and standards setting organizations.

Regulation of Reimbursement for Clinical Laboratory Services

Overview. The healthcare industry has experienced significant changes in reimbursement practices during the past several years. Government payers, such as Medicare (which principally serves patients 65 years and older) and Medicaid (which principally serves indigent patients), as well as private payers and large employers, have taken steps and may continue to take steps to control the cost, utilization and delivery of healthcare services, including clinical laboratory services. If we cannot offset additional reductions in the payments we receive for our services by reducing costs, increasing test volume and/or introducing new procedures, it could have a material adverse impact on our net revenues and profitability.

While the total cost to comply with Medicare administrative requirements is disproportionate to our cost to bill other payers, average Medicare reimbursement rates are not materially different than our overall average reimbursement rate from all payers, making this business generally less profitable. Despite the added cost and complexity of participating in the Medicare and Medicaid programs, we continue to participate in such programs because we believe that our other business may depend, in part, on continued participation in these programs, since certain customers may want a single laboratory capable of performing all of their clinical laboratory testing services, regardless of who pays for such services.

Billing and reimbursement for clinical laboratory testing is subject to significant and complex federal and state regulation. Penalties for violations of laws relating to billing federal healthcare programs and for violations of federal fraud and abuse laws include: (1) exclusion from participation in Medicare/Medicaid programs; (2) asset forfeitures; (3) civil and criminal fines and penalties; and (4) the loss of various licenses, certificates and authorizations necessary to operate some or all of a clinical laboratory's business. Civil monetary penalties for a wide range of violations are not more than $10,000 per violation plus three times the amount claimed and, in the case of kickback violations, not more than $50,000 per violation plus up to three times the amount of remuneration involved. A parallel civil remedy under the federal False Claims Act provides for damages not more than $11,000 per violation plus up to three times the amount claimed.

Reduced Reimbursements. In 1984, Congress established a Medicare fee schedule payment methodology for clinical laboratory services performed for patients covered under Part B of the Medicare program. Congress then imposed a national ceiling on the amount that carriers could pay under their local Medicare fee schedules. Since then, Congress has periodically reduced the national ceilings. The Medicare national fee schedule limitations were reduced in 1996 to 76% of the 1984 national median of the local fee schedules and in 1998 to 74% of the 1984 national median. The national ceiling applies to tests for which limitation amounts were established before January 1, 2001. For more recent tests (tests for which a limitation amount is first established on or after January 1, 2001), the limitation amount is set at 100% of the median of all the local fee schedules established for that test in accordance with the Social Security Act. The MMA eliminated for five years (beginning January 1, 2004) the provision for annual increases to the Medicare national fee schedule based on the consumer price index. Thus, by law an adjustment to the national fee schedule for clinical laboratory services based on the consumer price index cannot occur before January 1, 2009. However, the MMA added coverage for certain cardiovascular screening tests and diabetes screening tests, subject to certain frequency limitations. The MMA evaluates new diagnostic tests for coverage as they are introduced. In addition, the 2005 Physician Fee Schedule rule proposed to lower Medicare's payment rates for flow cytometry services in 2005. Quest Diagnostics believed that CMS failed to properly value these services and commented on this proposed change through ACLA. Pathology services are reimbursed by Medicare according to a Physician Fee Schedule based on a resource-based relative value scale, or RBRVS, that is periodically updated by CMS. On

November 21, 2005, CMS published its Final Physician Fee Schedule Rule (effective January 1, 2006) but did not implement any changes to the Practice Expense values in the new fee schedule, leaving the lower reimbursement for flow cytometry in place for 2006. In addition, the formula used for RBRVS calls for a 4.4% reduction in the 2006 payment level for physicians services, including anatomic pathology services payable to clinical laboratories. In February 2006, Congress eliminated the 4.4% reduction in the 2006 Physician Fee Schedule, keeping the reimbursement for physician services (including anatomic pathology services billed by clinical laboratories) unchanged from 2005. Approximately 1% of our net revenues are derived from pathology services reimbursed by Medicare based on RBRVS.

With regard to the clinical laboratory services performed on behalf of Medicare beneficiaries, we must bill the Medicare program directly and must accept the carrier's fee schedule amount as payment in full. In addition, state Medicaid programs are prohibited from paying more (and in most instances, pay significantly less) than Medicare. Major clinical laboratories, including Quest Diagnostics, typically use two fee schedules for tests billed on a fee-for-service basis:

- "Client" fees charged to physicians, hospitals, and institutions for which a clinical laboratory performs testing services on a wholesale basis and which are billed on a monthly basis. These fees are generally subject to negotiation or discount.
- "Patient" fees charged to individual patients and third-party payers, like Medicare and Medicaid. These fees generally require separate bills for each requisition.

The fee schedule amounts established by Medicare are typically substantially lower than patient fees otherwise charged by us, but are sometimes higher than our fees actually charged to certain clients. During 1992, the OIG of the HHS issued final regulations that prohibited charging Medicare fees substantially in excess of a provider's usual charges. The laboratory industry believes that the term "usual charges" specifically applies to amounts charged to similarly-situated third-party payers and to patients and that client fees should not be included in "usual charges". The OIG, however, declined to provide any guidance concerning interpretation of these rules, including whether or not discounts to non-governmental clients and payers or the dual-fee structure might be inconsistent with these rules.

A proposed rule released in September 1997 would have authorized the OIG to exclude providers from participation in the Medicare program, including clinical laboratories, that charge Medicare and other programs fees that are "substantially in excess of . . . usual charges . . . to any of [their]customers, clients or patients". This proposal was withdrawn by the OIG in 1998. In November 1999, the OIG issued an advisory opinion which indicated that a clinical laboratory offering discounts on client bills may violate the "usual charges" regulation if the "charge to Medicare substantially exceeds the amount the laboratory most frequently charges or has contractually agreed to accept from non-Federal payers". The OIG subsequently issued a letter clarifying that the usual charges regulation is not a blanket prohibition on discounts to private pay customers.

In September 2003, the OIG published a Notice of Proposed Rulemaking that would amend the OIG's exclusion regulations addressing excessive claims. Under the proposed exclusion rule, the OIG would have the authority to exclude a provider for submitting claims to Medicare that contain charges that are substantially in excess of the provider's usual charges. The proposal would define "usual charges" as the average payment from non-government entities, on a test by test basis, excluding capitated payments; and would define "substantially in excess" to be an amount that is more than 20% greater than the usual charge. We believe that the rule is unnecessary for the clinical laboratory industry because Congress has already established fee schedules for the services that the rule proposes to regulate. We also believe that the rule is unworkable and overly burdensome. Through our industry trade association, we filed comments opposing the proposed rule and we are working with our trade association and a coalition of other healthcare providers who also oppose this proposed regulation as drafted. If this regulation is adopted as proposed, it could potentially reduce the amounts we bill and collect from Medicare and other federal payers, affect the fees we charge to other payers, or subject the Company to penalties for non-compliance, and could also be costly for us to administer.

The 1997 Balanced Budget Act permits CMS to adjust statutorily prescribed fees for some medical services, including clinical laboratory services, if the fees are "grossly excessive". In December 2002, CMS issued an interim final rule setting forth a process and factors for establishing a "realistic and equitable" payment amount for all Medicare Part B services (except physician services and services paid under a prospective payment system) when the existing payment amounts are determined to be inherently unreasonable. Payment amounts may be considered unreasonable because they are either grossly excessive or deficient. In December 2005, CMS published the final rule clarifying that if CMS or a carrier determines that an overall

payment adjustment of less than 15% is needed to produce a realistic and equitable payment amount, then the payment amount is not considered "grossly excessive or deficient." However, if a determination is made that a payment adjustment of 15% or more is justified, CMS could provide an adjustment of less than 15%, but not more than 15%, in any given year. We cannot provide any assurances to investors that fees payable by Medicare could not be reduced as a result of the application of this rule or that the government might not assert claims for reimbursement by purporting to retroactively apply this rule or the OIG interpretation concerning "usual charges."

Currently, Medicare does not require the beneficiary to pay a co-payment for clinical laboratory testing. When co-payments were last in effect before adoption of the clinical laboratory services fee schedules in 1984, clinical laboratories received from Medicare carriers only 80% of the Medicare allowed amount and were required to bill Medicare beneficiaries for the unpaid balance of the Medicare allowed amount. If re-enacted, a co-payment requirement could adversely affect the revenues of the clinical laboratory industry, including us, by exposing the testing laboratory to the credit of individuals and by increasing the number of bills. In addition, a laboratory could be subject to potential fraud and abuse violations if adequate procedures to bill and collect the co-payments are not established and followed. The Medicare reform bill approved by the United States Senate in June 2003 included a co-payment provision, under which clinical laboratories would receive from Medicare carriers only 80% of the Medicare allowed amount for clinical laboratory tests and would be required to bill Medicare beneficiaries for the 20% balance of the Medicare allowed amount. The co-payment provision was dropped from the bill as passed (known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003). We cannot provide any assurances to investors that Congress would not seek to re-impose a copayment requirement payable by Medicare beneficiaries for clinical laboratory services. Certain Medicaid programs already require Medicaid recipients to pay co-payment amounts for clinical laboratory testing.

Reduced Utilization of Clinical Laboratory Testing. In recent years, CMS has taken several steps to reduce utilization of clinical laboratory testing. Since 1995, Medicare carriers have adopted policies under which they do not pay for many commonly ordered clinical tests unless the ordering physician has provided an appropriate diagnosis code supporting the medical necessity of the test. Physicians are required by law to provide diagnostic information when they order clinical tests for Medicare and Medicaid patients. However, CMS has not prescribed any penalty for physicians who fail to provide this diagnostic information to laboratories. Moreover, regulations adopted in accordance with HIPAA require submission of diagnosis codes as part of the standard claims transaction.

We are generally permitted to bill patients directly for some statutorily excluded clinical laboratory services. If a patient signs an advance beneficiary notice, or ABN, we are also generally permitted to bill patients for clinical laboratory tests that Medicare does not cover due to "medical necessity" limitations (these tests include limited coverage tests for which the ordering physician did not provide an appropriate diagnosis code and certain tests ordered on a patient at a frequency greater than covered by Medicare). An ABN is a notice signed by the beneficiary which documents the patient's informed decision to personally assume financial liability for laboratory tests which are likely to be denied and not reimbursed by Medicare because they are deemed to be not medically necessary. We do not have any direct contact with most of these patients and, in such cases, cannot control the proper use of the ABN by the physician or the physician's office staff. If the ABN is not timely provided to the beneficiary or is not completed properly, we may end up performing tests that we cannot subsequently bill to the patient if they are not reimbursable by Medicare due to coverage limitations.

Inconsistent Practices. Currently, many different local carriers administer Medicare. They have inconsistent policies on matters such as: (1) test coverage; (2) automated chemistry panels; (3) diagnosis coding; (4) claims documentation; and (5) fee schedules (subject to the national fee schedule limitations). Inconsistent carrier rules and policies have increased the complexity of the billing process for clinical laboratories. As part of the 1997 Balanced Budget Act, HHS was required to adopt uniform policies on the above matters by January 1, 1999, and to replace the current local carriers with no more than five regional carriers. Although HHS has finalized a number of uniform test coverage/diagnosis coding policies, it has not taken any final action to replace the local carriers with five regional carriers.

Carrier Jurisdiction Changes for Lab-to-Lab Referrals. On October 31, 2003, CMS announced its intention to change the manner in which Medicare contractors currently process claims for lab-to-lab referrals of clinical laboratory tests. While laboratories are, under certain criteria, permitted to directly bill Medicare for clinical laboratory tests they refer to other laboratories, they must be reimbursed at the correct fee schedule amount based on the Medicare fee schedule in effect in the Medicare carrier region in which the test was actually performed. Historically, laboratories needed to enroll with and file claims to multiple carriers in order

to bill for such out-of-area test referrals, to ensure receipt of the appropriate payment amount. This has proven to be an administratively difficult process, with many obstacles to obtaining accurate claims payment, including applying the correct fee schedule. On July 1, 2004, CMS implemented a change that mandated that the laboratory's "home" carrier maintain and apply the clinical laboratory fee schedule applicable to the carrier region where the test was performed. This streamlined process allows a laboratory to file all of its clinical laboratory claims to its "home" carrier.

CMS also has announced a parallel change with regard to purchased diagnostic interpretations (pathology services). A previously announced change in Medicare carrier jurisdiction rules required laboratories to bill the carrier where a purchased diagnostic interpretation service was performed. This would have required carriers to issue Medicare provider numbers to the billing laboratory. In October 2004, CMS posted a "change notice" permitting laboratories to temporarily bill their local carriers for purchased diagnostic tests or interpretations regardless of the location where the service was furnished. The final change notice was issued on October 29, 2004, effective April 1, 2005. The final notice requires carriers to implement a new edit to check for duplicate claims for referred clinical diagnostic laboratory and purchased diagnostic services submitted by physicians/suppliers to more than one carrier.

Competitive Bidding. The MMA requires CMS to conduct two demonstration projects of competitive bidding for clinical laboratory tests. CMS awarded the clinical laboratory competitive bidding demonstration design and implementation contract to RTI International, Research Triangle Park, North Carolina, and its subcontractor, Palmetto GBA. Palmetto is a Part B carrier and previously conducted for CMS a competitive bidding demonstration for Durable Medical Equipment (DME). In August 2005, RTI presented its draft design at a public meeting. The RTI proposal incorporated several ACLA recommendations, including having bidders bid on the full range of tests paid under the laboratory fee schedule, utilizing a fee-for-service basis for bidding, and allowing bidders to subcontract. CMS has not made any final decisions on the RTI draft design, but was required to submit its initial report on the competitive bidding proposal by December 31, 2005. CMS' status report is currently in the clearance process at CMS and has not yet been submitted to Congress. The President's 2007 Budget Proposal presented in January 2006 included cost savings from competitive bidding for clinical laboratory services. The budget proposal did not contain substantive details. ACLA, the trade association for the clinical laboratory industry, issued a press release commenting negatively on the budget proposal. Quest Diagnostics and ACLA will monitor the design and implementation phase of the competitive bidding pilot and the Congressional reaction to the 2007 budget proposal. The diagnostic testing industry is concerned that the competitive bidding demonstrations or nation-wide expansion of competitive bidding will not take into account all of the factors involved in the timely delivery of high quality clinical laboratory testing to a broad range of clients in diverse geographic settings.

In December 2004, the State of Florida issued an Invitation to Negotiate (ITN) seeking competitive bids for the provision of clinical laboratory tests on a capitated-basis for some Medicaid recipients and on a reduced fee-for-service basis for other Medicaid recipients. The ITN contemplates that the Florida Medicaid Agency (AHCA) will negotiate with the three highest-scoring bidders for an exclusive statewide contract of at least three years plus a potential renewal period. ACLA, the industry trade association for clinical laboratories, filed two petitions with AHCA challenging the ITN on public policy and legal grounds. In addition, Quest Diagnostics and another large laboratory independently filed bid protests with AHCA. On February 18, 2005, AHCA announced, without further explanation, that it was withdrawing the ITN. AHCA has not yet reissued its ITN. If competitive bidding were implemented on a regional or national basis for clinical laboratory testing, it could materially adversely affect the clinical laboratory industry and us.

Future Legislation. Future changes in federal, state and local regulations (or in the interpretation of current regulations) affecting governmental reimbursement for clinical laboratory testing could adversely affect us. We cannot predict, however, whether and what type of legislative proposals will be enacted into law or what regulations will be adopted by regulatory authorities.

Fraud and Abuse Regulations. Medicare and Medicaid anti-kickback laws prohibit clinical laboratories from making payments or furnishing other benefits to influence the referral of tests billed to Medicare, Medicaid or other federal programs. As noted above, the penalties for violation of these laws may include criminal and civil fines and penalties and/or suspension or exclusion from participation in federal programs. Many of the anti-fraud statutes and regulations, including those relating to joint ventures and alliances, are vague or indefinite and have not been interpreted by the courts. We cannot predict if some of the fraud and abuse rules will be interpreted contrary to our practices.

In November 1999, the OIG issued an advisory opinion concluding that the industry practice of discounting client bills may constitute a kickback if the discounted price is below a laboratory's overall cost (including overhead) and below the amounts reimbursed by Medicare. Advisory opinions are not binding but may be indicative of the position that prosecutors may take in enforcement actions. The OIG's opinion, if enforced, could result in fines and possible exclusion and could require us to eliminate offering discounts to clients below the rates reimbursed by Medicare. The OIG subsequently issued a letter clarifying that it did not intend to imply that discounts are a per se violation of the federal anti-kickback statute, but may merit further investigation depending on the facts and circumstances presented.

In addition, since 1992, a federal anti-"self-referral" law, commonly known as the "Stark" law, prohibits, with certain exceptions, Medicare payments for laboratory tests referred by physicians who have personally, or through a family member, an investment interest in, or a compensation arrangement with, the testing laboratory. Since January 1995, these restrictions have also applied to Medicaid-covered services. Many states have similar anti-"self-referral" and other laws that are not limited to Medicare and Medicaid referrals and could also affect investment and compensation arrangements with physicians. We cannot predict if some of the state laws will be interpreted contrary to our practices.

In April 2003, the OIG issued a Special Advisory Bulletin addressing what it described as "questionable contractual arrangements" in contractual joint ventures. The OIG Bulletin focused on arrangements where a healthcare provider, or Owner, expands into a related healthcare business by contracting with a healthcare provider, or Manager, that already is engaged in that line of business for the Manager to provide related healthcare items or services to the patients of the Owner in return for a share of the profits of the new line of business. While we believe that the Bulletin is directed at "sham" arrangements intended to induce referrals, we cannot predict whether the OIG might choose to investigate all contractual joint ventures, including our joint ventures with various hospitals or hospital systems.

Government Investigations and Related Claims

We are subject to extensive and frequently changing federal, state and local laws and regulations. We believe that, based on our experience with government settlements and public announcements by various government officials, the federal government continues to strengthen its position on healthcare fraud. In addition, legislative provisions relating to healthcare fraud and abuse give federal enforcement personnel substantially increased funding, powers and remedies to pursue suspected cases of fraud and abuse. Many of the regulations applicable to us, including those relating to billing and reimbursement of tests and those relating to relationships with physicians and hospitals, are vague or indefinite and have not been interpreted by the courts. They may be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that could require us to make changes in our operations, including our billing practices. If we fail to comply with applicable laws and regulations, we could suffer civil and criminal damages, fines and penalties, including the loss of licenses or our ability to participate in Medicare, Medicaid and other federal and state healthcare programs and additional liabilities from third party claims. In addition, certain federal and state statues, including the qui tam provisions of the federal False Claim Act, allow private individuals to bring lawsuits against healthcare companies on behalf of government or private payers alleging inappropriate billing practices.

During the mid-1990s, Quest Diagnostics and SBCL settled significant government claims that primarily involved industry-wide billing and marketing practices that both companies believed to be lawful. The federal or state governments may bring additional claims based on new theories as to our practices that we believe to be in compliance with law. The federal government has substantial leverage in negotiating settlements since the amount of potential damages far exceeds the rates at which we are reimbursed, and the government has the remedy of excluding a non-compliant provider from participation in the Medicare and Medicaid programs, which represented approximately 18% of our net revenues during 2005.

We understand that there may be pending qui tam claims brought by former employees or other "whistle blowers" as to which we have not been provided with a copy of the complaint and accordingly cannot determine the extent of any potential liability. We are also aware of certain pending lawsuits related to billing practices filed under the qui tam provisions of the civil False Claims Act and other federal and state statutes. These lawsuits include class action and individual claims by patients arising out of the Company's billing policies. In addition, we are involved in various legal proceedings arising in the ordinary course of business. Some of the proceedings against us involve claims that are substantial in amount.

During the fourth quarter of 2004, Quest Diagnostics Incorporated and Nichols Institute Diagnostics (NID), our test kit manufacturing subsidiary, each received a subpoena from the United States Attorney's Office for the Eastern District of New York. Quest Diagnostics and NID have been cooperating with the United States Attorney's Office. In connection with such cooperation, we have been providing information and producing various business records of NID and Quest Diagnostics, including documents related to testing and test kits manufactured by NID. This investigation by the United States Attorney's Office could lead to civil and criminal damages, fines and penalties and additional liabilities from third party claims. In the second and third quarters of 2005, the FDA conducted an inspection of NID and issued a Form 483 listing the observations made by the FDA during the course of the inspection. NID is cooperating with the FDA and has filed its responses to the Form 483. Noncompliance with the FDA regulatory requirements or failure to take adequate and timely corrective action could lead to regulatory or enforcement action against NID and/or Quest Diagnostics, including, but not limited to, a warning letter, injunction, suspension of production and/or distribution, seizure or recall of products, fines or penalties, denial of pre-market clearance for new or changed products, recommendation against award of government contracts and criminal prosecution.

During the second quarter of 2005, we received a subpoena from the United States Attorney's Office for the District of New Jersey. The subpoena seeks the production of business and financial records regarding capitation and risk sharing arrangements with government and private payers for the years 1993 through 1999. Also, during the third quarter of 2005, we received a subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General. The subpoena seeks the production of various business records including records regarding our relationship with health maintenance organizations, independent physician associations, group purchasing organizations, and preferred provider organizations from 1995 to the present. We are cooperating with the United States Attorney's Office and the Office of the Inspector General.

Although management cannot predict the outcome of such matters, management does not anticipate that the ultimate outcome of such matters will have a material adverse effect on our financial condition, but may be material to our results of operations and cash flows in the period in which the impact of such matters is determined or paid.

As an integral part of our compliance program discussed below, we investigate all reported or suspected failures to comply with federal and state healthcare reimbursement requirements. Any non-compliance that results in Medicare or Medicaid overpayments is reported to the government and reimbursed by us. As a result of these efforts, we have periodically identified and reported overpayments. While we have reimbursed these overpayments and have taken corrective action where appropriate, we cannot assure investors that in each instance the government will necessarily accept these actions as sufficient.

Compliance Program

Compliance with all government rules and regulations has become a significant concern throughout the clinical laboratory industry because of evolving interpretations of regulations and the emerging changes in laboratory science and healthcare technology. We established a compliance program early in 1993.

We emphasize the development of training programs intended to ensure the strict implementation and observance of all applicable laws, regulations and Company policies. Further, we conduct in-depth reviews of procedures, personnel and facilities to assure regulatory compliance throughout our operations. The Quality, Safety & Compliance Committee of the Board of Directors requires periodic reporting of compliance operations from management.

We seek to conduct our business in compliance with all statutes and regulations applicable to our operations. Many of these statutes and regulations have not been interpreted by the courts. We cannot assure investors that applicable statutes or regulations will not be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that would adversely affect us. Potential sanctions for violation of these statutes include significant damages, penalties, and fines, exclusion from participation in governmental healthcare programs and the loss of various licenses, certificates and authorization necessary to operate some or all of our business, which could have a material adverse effect on our business.

Intellectual Property Rights

Other companies or individuals, including our competitors, may obtain patents or other property rights that would prevent, limit or interfere with our ability to develop, perform or sell our tests or operate our business.

As a result, we may be involved in intellectual property litigation and we may be found to infringe on the proprietary rights of others, which could force us to do one or more of the following:

- cease developing, performing or selling products or services that incorporate the challenged intellectual property;
- obtain and pay for licenses from the holder of the infringed intellectual property right;
- redesign or reengineer our tests;
- change our business processes; or
- pay substantial damages, court costs and attorneys' fees, including potentially increased damages for any infringement held to be willful.

Patents generally are not issued until several years after an application is filed. The possibility that, before a patent is issued to a third party, we may be performing a test or other activity covered by the patent is not a defense to an infringement claim. Thus, even tests that we develop could become the subject of infringement claims if a third party obtains a patent covering those tests.

Infringement and other intellectual property claims, regardless of their merit, can be expensive and time-consuming to litigate. In addition, any requirement to reengineer our tests or change our business processes could substantially increase our costs, force us to interrupt product sales or delay new test releases. In the past, we have settled several disputes regarding our alleged infringement of intellectual property rights of third parties. We are currently involved in settling several additional disputes. We do not believe that resolution of these disputes will have a material adverse effect on our results of operations, cash flows or financial condition. However, infringement claims could arise in the future as patents could be issued on tests or processes that we may be performing, particularly in such emerging areas as gene-based testing and other specialty testing.

Insurance

As a general matter, providers of clinical laboratory testing services may be subject to lawsuits alleging negligence or other similar legal claims. Some of these suits involve claims for substantial damages. Any professional liability litigation could also have an adverse impact on our client base and reputation. We maintain various liability insurance coverages for claims that could result from providing or failing to provide clinical laboratory testing services, including inaccurate testing results and other exposures. Our insurance coverage limits our maximum exposure on individual claims; however, we are essentially self-insured for a significant portion of these claims. The basis for claims reserves considers actuarially determined losses based upon our historical and projected loss experience. Management believes that present insurance coverage and reserves are sufficient to cover currently estimated exposures. Although management cannot predict the outcome of any claims made against the Company, management does not anticipate that the ultimate outcome of any such proceedings or claims will have a material adverse effect on our financial condition but may be material to our results of operations and cash flows in the period in which the impact of such claims is determined or paid. Similarly, although we believe that we will be able to obtain adequate insurance coverage in the future at acceptable costs, we cannot assure you that we will be able to do so.

Employees

At December 31, 2005, we employed approximately 41,500 people. This total excludes employees of the joint ventures where we do not have a majority interest. We have no collective bargaining agreements with any unions covering any employees in the United States, and we believe that our overall relations with our employees are good.