Payers and Customers

We provide testing services to a broad range of healthcare providers. We consider a "payer" as the party that reimburses us 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.

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 2006 applicable to each payer group:

	Requisition Volume as % of Total Volume	Net Revenues as % of Total Clinical Laboratory Testing Net Revenues
Patients	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%

Healthcare insurers, including managed care organizations and other healthcare insurance providers, which typically reimburse us as a contracted provider on behalf of their members for clinical laboratory testing services performed, represent approximately one-half of our consolidated net revenues from clinical laboratory testing. During 2006, only three healthcare insurers, including UNH, accounted for 5% or more of our net revenues. Reimbursement from these three largest payers totaled approximately 19% of our net revenues in 2006. UNH, which accounted for approximately 7% of our net revenues for 2006, was our largest payer.

During 2006, no single customer accounted for more than 1.5% of our consolidated 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.

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 clinical testing volumes and one-half of our net revenues from our clinical testing. 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 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.

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. Our cost to perform work reimbursed under capitated payment arrangements is not materially different from our cost to perform work reimbursed under other arrangements with healthcare insurers. Since average reimbursement rates under capitated payment arrangements are typically less than our overall average reimbursement rate, the testing services reimbursed under capitated payment arrangements are generally less profitable. In 2006, we derived approximately 16% of our testing volume and 7% of our net revenues from capitated payment arrangements.

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. 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. 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 the general trend of increased choice for patients in selecting a healthcare provider, recent experience indicates that some healthcare insurers may actively seek to limit the choice of patients and physicians if they feel it will give them increased leverage to negotiate lower fees, by consolidating services with a single or limited network of contracted providers. Historically, healthcare insurers, which had limited their network of laboratory service providers, encouraged their members, and sometimes offered incentives, to utilize only contracted providers. In addition, patients who use a non-contracted provider may have a higher co-insurance responsibility, which may result in physicians referring testing to contracted providers to minimize the expense to their patients. In cases where members choose to use a non-contracted provider due to service quality or convenience, the non-contracted provider would be reimbursed at rates considered "reasonable and customary". Contracted rates are generally lower than "reasonable and customary" rates because of the potential for greater volume as a contracted provider. However, a non-contracted laboratory service provider with quality and service preferred by physicians and patients to that of contracted providers, could potentially realize greater profits than if it was a contracted provider, provided that physicians and patients continue to have choice in selecting their provider. Physicians requiring testing for patients are the primary referral source of our clinical laboratory testing volume, and often refer work to us as a non-contracted provider. Recent experience indicates that at least one large healthcare insurer, UNH, is looking to restrict or eliminate the choice of physicians, and in turn their patients, by threatening to impose financial penalties on physicians for referring patients to non-contracted laboratory service providers. If this approach is successful in influencing physicians to no longer use non-contracted laboratories, it could make it substantially more difficult for a laboratory service provider to sufficiently differentiate itself based on quality and service in order to profitably operate as a non-contracted provider, could lead to other healthcare insurers using similar tactics, and could materially impact our financial condition, results of operations and cash flows.

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 we may begin to experience a shift of traditional Medicare beneficiaries to private Medicare Advantage programs.

We offer QuestNet™, a service whereby we develop and administer customized networks of clinical laboratory providers for healthcare insurers. Through QuestNet™, physicians and patients are provided multiple choices for clinical laboratory testing while healthcare insurers realize cost reductions from reducing testing

performed by non-contracted providers and simplified administration of payment for clinical laboratory testing services.

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 11% 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. Hospitals can have greater leverage with healthcare insurers than do commercial clinical laboratories, particularly hospitals that have a significant market share; hospitals thus are frequently able to negotiate higher reimbursement rates with healthcare insurers than commercial clinical laboratories for comparable clinical laboratory testing services.

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, decreased slightly in 2006, due to our no longer serving certain low-priced business and some reduction in hiring activity among some large retail customers. 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 and our Focus Diagnostics infectious and immunologic disease testing laboratory. 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