BlueCross BlueShield of Texas

BLUE INSIGHT MONTHLY REPORT

ABC Company - Tier 3

04/01/2009 to 12/31/2009

Non-HMO Self Insured

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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CHAPTER DESCRIPTION

The Monthly Report presents key financial and utilization components for the current reporting month as well as renewal year to date. The chapters are intended to highlight key analysis criteria to demonstrate how ABC Company - Tier 3 is doing fiscally, with focus on what is driving their costs. In addition this report highlights what healthcare services are being utilized and how this impacts the overall cost. The report starts with components that provide financial data showing paid claims on a month and year to date (YTD) basis. After the enrollment chapter, components that provide utilization data are shown on an incurred year over year basis. The data in this report can be used to predict how ABC Company - Tier 3 can budget for health costs and what they are facing in the future. In this chapter there is a brief description about the subsequent chapters and key metrics to summarize their findings.

FINANCIAL

The financial overview chapter provides gross financial information for ABC Company - Tier 3 based on paid claims for the current reporting month and for the renewal year to date. The claims have not been aggregated or summarized, so all transactions are reflected based on the paid data and balances back to your Billing and Accounts Receivable System (BARS) bill.

Report Description: This report provides an overview of ABC Company - Tier 3's total health care expenses for the current reporting month and for the year to date.

ABC COMPANY - TIER 3		
TOTAL EXPENSES	DEC'09	YEAR TO DATE
MEDICAL PAID	$141,620	$2,056,381
CAPITATION PAID	$0	$0
PHARMACY PAID	$51,375	$437,687
DENTAL PAID		
TOTAL PAID	$192,995	$2,494,068
RECOVERIES	$-396	$-2,970
PAID + RECOVERIES	$192,599	$2,491,098
FEES & CREDITS	$70,333	$618,841
GROUP LIABILITY	$262,932	$3,109,939

Key Findings: Medical paid made up 73.4% of the total paid amount for the current month. Medical paid made up 82.5% of the total paid amount for the year to date.

MEDICAL CLAIM EXPENSE DISTRIBUTION BY CLAIMANT

Report Description: The distribution of medical paid expense by claimant and the average medical paid per claimant amount are shown for the year to date.

ABC COMPANY - TIER 3

	YEAR TO DATE				
PAID	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT
LESS THAN $200	252	34.3%	$20,067	1.0%	$80
$200 - $1,000	241	32.8%	$118,352	5.8%	$491
$1,000 - $5,000	160	21.8%	$350,067	17.0%	$2,188
$5,000 - $10,000	52	7.1%	$363,355	17.7%	$6,988
$10,000 - $30,000	23	3.1%	$396,812	19.3%	$17,253
SUMMARY LESS THAN $30,000	728	99.0%	$1,248,653	60.7%	$1,715

PAID	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT
$30,000 - $50,000	2	0.3%	$71,924	3.5%	$35,962
$50,000 - $75,000	1	0.1%	$73,892	3.6%	$73,892
$75,000 - $100,000					
$100,000 - $150,000	3	0.4%	$371,560	18.1%	$123,853
$150,000 - $200,000					
$200,000 - $250,000					
$250,000 - $500,000	1	0.1%	$290,353	14.1%	$290,353
GREATER THAN $500,000					
SUMMARY $30,000 OR GREATER	7	1.0%	$807,729	39.3%	$115,390
COMBINED SUMMARY	735	100.0%	$2,056,381	100.0%	$2,798

Key Findings: The proportion of claimants who received less than $200 in services for the year to date was 34.3%. These claimants spent 1.0% of the total paid expenses and the average paid expense per claimant was $80.

1.0% of claimants had expenses over $30,000 for the year to date. These claimants spent 39.3% of the total paid expenses and the average paid expense per claimant was $115,390.

NETWORK SAVINGS ANALYSIS

Report Description: This report displays the covered amount, discount amount, discount percent and paid amount based on paid claims. Displayed by Medicare and non-Medicare primary indicator, and by in and out of network for the year to date. The "Discount %" is calculated as Discount/Covered.

ABC COMPANY - TIER 3							
MEDICARE PRIMARY INDICATOR	NETWORK INDICATOR	SERVICE CATEGORY	COVERED	DISCOUNT	DISCOUNT %	PAID	% OF PAID
NO	IN-NETWORK	INPATIENT FACILITY	$1,419,977	$806,607	56.8%	$559,893	27.2%
		OUTPATIENT FACILITY	$2,191,845	$1,223,906	55.8%	$861,658	41.9%
		PROFESSIONAL	$1,683,054	$897,815	53.3%	$601,875	29.3%
		SUMMARY	$5,294,876	$2,928,327	55.3%	$2,023,427	98.4%
	OUT-OF-NETWORK	INPATIENT FACILITY					
		OUTPATIENT FACILITY	$10,748	$8,945	83.2%	$214	0.0%
		PROFESSIONAL	$84,376	$50,431	59.8%	$19,607	1.0%
		SUMMARY	$95,124	$59,376	62.4%	$19,821	1.0%
	SUMMARY		$5,390,000	$2,987,703	55.4%	$2,043,248	99.4%
YES	IN-NETWORK	INPATIENT FACILITY	$0	$0		$0	0.0%
		OUTPATIENT FACILITY	$21,231	$0	0.0%	$947	0.0%
		PROFESSIONAL	$12,628	$477	3.8%	$12,077	0.6%
		SUMMARY	$33,859	$477	1.4%	$13,024	0.6%
	OUT-OF-NETWORK	INPATIENT FACILITY					
		OUTPATIENT FACILITY					
		PROFESSIONAL	$3,105	$2,558	82.4%	$109	0.0%
		SUMMARY	$3,105	$2,558	82.4%	$109	0.0%
	SUMMARY		$36,964	$3,036	8.2%	$13,133	0.6%
SUMMARY			$5,426,964	$2,990,739	55.1%	$2,056,381	100.0%

Key Findings: ABC Company - Tier 3's overall network savings discount (excluding Medicare) was 55.3% for the year to date.

ENROLLMENT

The enrollment chapter presents descriptive information on ABC Company - Tier 3's subscribers and dependents enrolled in BCBSTX. Information on coverage tier, membership size, age and gender are presented for subscribers and dependents for the current reporting month and the renewal year to date.

Report Description: This report shows the average subscribers, dependents and overall members for ABC Company - Tier 3.

ABC COMPANY - TIER 3		
	DEC'09	YEAR TO DATE
AVERAGE SUBSCRIBERS	571	561
AVERAGE DEPENDENTS	205	210
AVERAGE MEMBERS	776	771
AVERAGE CONTRACT SIZE	1.36	1.37
AVERAGE AGE (YEARS)	38.0	37.8

Key Findings: ABC Company - Tier 3's overall membership was 776 in the current reporting month and 771 for the year to date. The average age of members was 38.0 for the current reporting month and 37.8 for the year to date.

MEDICAL AND PHARMACY PAID CLAIMS BY AGE AND GENDER

Report Description: This report identifies the total medical and pharmacy member counts and their paid claims, by age and gender demographics, and by subscribers and dependents for the year to date. The report compares and analyzes claims vs. member counts within one age band compared to another to identify the members and age group that are driving the costs.

ABC COMPANY - TIER 3

		MALE			FEMALE			TOTAL		
		AVG MEDICAL MEMBERS	AVG PHARMACY MEMBERS	PAID	AVG MEDICAL MEMBERS	AVG PHARMACY MEMBERS	PAID	AVG MEDICAL MEMBERS	AVG PHARMACY MEMBERS	PAID
SUBSCRIBERS	UNDER 20	1	1	$213	1	1	$252	2	2	$465
	20-29	38	38	$19,496	67	67	$206,966	105	105	$226,462
	30-39	57	57	$68,698	83	83	$162,628	140	140	$231,326
	40-49	55	55	$119,050	92	92	$227,604	147	147	$346,654
	50-64	68	68	$546,962	85	85	$661,048	153	153	$1,208,011
	65+	9	9	$33,811	6	6	$11,766	15	15	$45,577
	TOTAL	228	228	$788,231	333	333	$1,270,265	561	561	$2,058,496
DEPENDENTS	UNDER 20	54	54	$30,271	62	62	$70,270	116	116	$100,541
	20-29	8	8	$5,094	11	11	$31,641	19	19	$36,735
	30-39	2	2	$3,380	15	15	$35,048	17	17	$38,427
	40-49	8	8	$10,800	14	14	$41,003	22	22	$51,803
	50-64	8	8	$48,633	20	20	$123,533	29	$29	$172,167
	65+	1	1	$2,966	6	6	$32,932	7	7	$35,898
	TOTAL	82	82	$101,144	128	128	$334,428	210	210	$435,572
TOTAL MEMBERS		309	309	$889,375	462	462	$1,604,693	771	771	$2,494,068

Key Findings: The total subscriber count for males was highest in the 50 - 64 age range. Male subscribers in the 50 - 64 age group had the highest net paid claims. The total subscriber count for females was highest in the 40 - 49 age range. Female subscribers in the 50 - 64 age group had the highest net paid claims.

The total dependent count for males was highest in the Under 20 age range. Male dependents in the 50 - 64 age group had the highest net paid claims. The total dependent count for females was highest in the Under 20 age range. Female dependents in the 50 - 64 age group had the highest net paid claims.

EXPENSE AND UTILIZATION OVERVIEW

The expense and utilization overview chapter is intended to provide key metrics for ABC Company - Tier 3's claims experience. Year-over-year changes and comparisons to the benchmark are provided as well. Data in this chapter is reported based on incurred, 12-month rolling periods with 2 months run-out.

Report Description: This report shows key metrics, paid PMPMs, and paid PEPMs by service category.

	ABC COMPANY - TIER 3				
UTILIZATION	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
INPATIENT ADMISSIONS/1000	86.2	70.8	21.7%	73.1	18.0%
OUTPATIENT VISITS/1000	1,697.2	1,220.2	39.1%	1,260.5	34.6%
PROFESSIONAL SERVICES/1000	19,874.8	17,520.7	13.4%	20,014.9	-0.7%
PHARMACY PRESCRIPTIONS/MEMBER	12.7	12.3	3.2%	11.2	12.9%
DENTAL SERVICES/MEMBER	2.7	2.8	-3.3%	3.3	-20.3%

	ABC COMPANY - TIER 3				
PAID PMPM	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
TOTAL MEDICAL	$299.62	$215.84	38.8%	$235.57	27.2%
CAPITATION	$0.00	$0.00		$0.00	
PHARMACY	$62.59	$59.04	6.0%	$54.29	15.3%
DENTAL	$16.59	$17.38	-4.5%	$19.89	-16.6%
PAID PEPM					
TOTAL MEDICAL	$413.10	$293.97	40.5%	$455.10	-9.2%
CAPITATION	$0.00	$0.00		$0.00	
PHARMACY	$86.29	$80.33	7.4%	$104.69	-17.6%
DENTAL	$22.03	$23.23	-5.2%	$42.35	-48.0%

Key Findings: Utilization for Outpatient had the largest increase in Visits/1000 between the current and prior reporting periods.

Between the current and prior reporting periods, ABC Company - Tier 3's medical PMPM expenses increased 38.8%. The pharmacy paid PMPM increased 6.0%. ABC Company - Tier 3's medical PEPM expenses increased 40.5%. The pharmacy paid PEPM increased 7.4%.

CHAPTER DESCRIPTION

This chapter provides gross financial and membership information for ABC Company - Tier 3 based on paid claims for the current reporting month and for the renewal year to date. The claims have not been aggregated or summarized, so all transactions are reflected based on the paid date for each individual transaction. This means that original claims are reflected based on the original processing date and adjustments are based on the date of the adjustment, even if the original claim was processed at a different time.

Reports in this chapter will include medical amounts only unless specifically indicated as pharmacy or dental amounts.

The first report provides a breakdown of key gross expenditures, from billed amount to paid amount, for the current reporting month and for the year to date. This report may highlight key measures and their potential impact on gross paid expenses.

The second report displays the percentage of the billed amounts accounted for by discounts and the allowed amount. Also presented is the percentage of the allowed amount accounted for by out of pocket, COB, COB Medicare, other reductions, other payments and the paid amount. It is important to monitor how these expense categories impact the overall costs over time. For example, changes to the plan design may be reflected by a change in the proportion of out of pocket to the allowed amount, and ultimately what is the liability of the plan, changes in the percentage of discounts may reflect provider contract changes or shifts in provider-mix, and changes in COB amounts may reflect a change in benefits or a changed focus to capture funds from these sources.

The third report presents gross allowed and paid amounts by service category, along with percentages these amounts by service category are to the total allowed amount and total paid amount. This breakdown provides a high level view of what service categories areas are driving expenses and potentially highlights areas for further attention.

The fourth report focuses on how expenditures are distributed by claimant. The distribution of claimants by paid amount shows the percentage of claimants at different levels of total payments for the current reporting month and for the year to date. Analysis of this report can highlight the impact of high cost claimants on the overall costs.

The distribution of claimants by out of pocket shows the percentage of claimants at different levels of out of pocket expenses. This report helps determine the impact of any changes in plan design on out of pocket.

Completing the chapter are reports that provide information on network savings (for PPO and POS products), and insight into the monthly claim lag and that can help identify Incurred But Not Reported (IBNR).

Data Note

Current reporting month represents claims paid in Dec'09.
Year to date represents claims paid from Apr'09 through Dec'09.
Raw claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

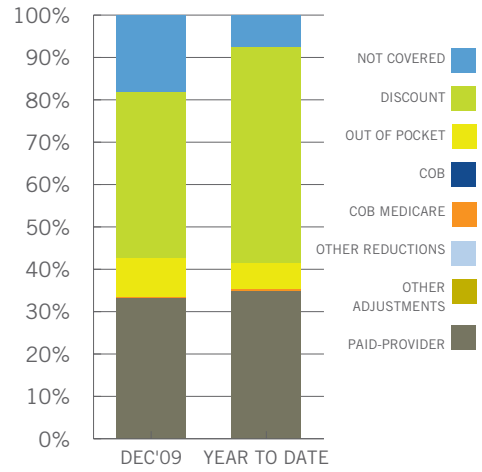
SUMMARY OF FINANCIAL MEASURES

Report Description: This report provides an overview of ABC Company - Tier 3's health care expenses from billed to paid for the current reporting month and for the year to date. Some key financial measures are displayed below. These metrics include plan performance measures, such as the degree of discounts the plan was able to achieve, as well as COB and COB Medicare recoveries that the plan was able to receive based on other insurance contributing to the overall expenses. Information is also provided on the amount of overall health care expenses that the member was directly responsible for, through deductibles, coinsurance or co-payments. Other reductions includes penalties, workers compensation savings, and subrogation savings. Other payments includes Blue Card access fees and surcharges. Also displayed are other adjustments. Finally, the report provides information on the level and percent changes in paid expenses, which represents ABC Company - Tier 3's liability, with a further breakout for Fees and Credits. Definitions of these financial measures can be found in the glossary.

ABC COMPANY - TIER 3		
MEDICAL EXPENSES	DEC'09	YEAR TO DATE
BILLED	$431,254	$5,856,689
NOT COVERED	$77,672	$429,725
COVERED	$353,583	$5,426,964
DISCOUNT	$169,372	$2,990,739
ALLOWED	$184,211	$2,436,225
OUT OF POCKET	$39,429	$363,911
COB	$517	$821
COB MEDICARE	$219	$20,576
OTHER REDUCTIONS	$0	$0
OTHER ADJUSTMENTS	$-0	$-465
PAID-PROVIDER	$144,047	$2,051,382
OTHER PAYMENTS	$-2,426	$4,999
PAID	$141,620	$2,056,381

ABC COMPANY - TIER 3		
TOTAL EXPENSES	DEC'09	YEAR TO DATE
MEDICAL PAID	$141,620	$2,056,381
CAPITATION PAID	$0	$0
PHARMACY PAID	$51,375	$437,687
DENTAL PAID		
TOTAL PAID	$192,995	$2,494,068
RECOVERIES	$-396	$-2,970
PAID + RECOVERIES	$192,599	$2,491,098
FEES & CREDITS	$70,333	$618,841
GROUP LIABILITY	$262,932	$3,109,939

BREAKDOWN OF BILLED AMOUNT



ABC COMPANY - TIER 3		
FEES & CREDITS	DEC'09	YEAR TO DATE
ADMIN FEES	$36,268	$321,964
AGGREGATE STOP LOSS	$1,196	$11,177
RX CREDIT FEES	$-3,787	$-32,866
SPECIFIC STOP LOSS	$36,656	$318,566
SUMMARY	$70,333	$618,841

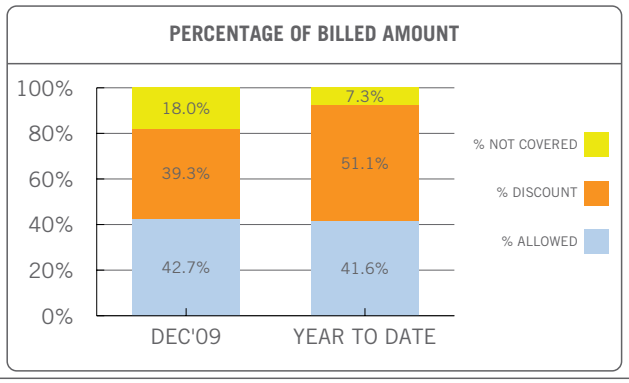
Paid-Provider excludes Other Payments, which are not part of the Billed Amount.

COMPONENTS OF MEDICAL BILLED AND ALLOWED AMOUNTS

Report Description: The breakdown of ABC Company - Tier 3's medical billed and allowed amounts are analyzed below. The discount amount, not covered amount and allowed amount are presented as a percentage of the billed amount for the current reporting month and for the year to date. The out of pocket amount, COB recoveries, other reductions, other adjustments, and paid-provider amount are presented as a percentage of the allowed amount.

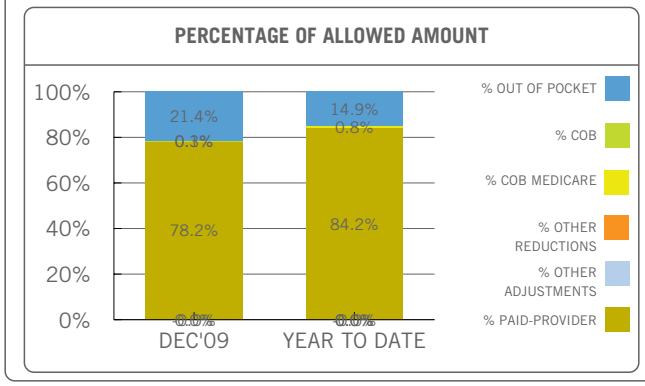
BILLED AMOUNT

ABC COMPANY - TIER 3	DEC'09	YEAR TO DATE
% NOT COVERED	18.0%	7.3%
% DISCOUNT*	39.3%	51.1%
% ALLOWED	42.7%	41.6%



ALLOWED AMOUNT

ABC COMPANY - TIER 3	DEC'09	YEAR TO DATE
% OUT OF POCKET	21.4%	14.9%
% COB	0.3%	0.0%
% COB MEDICARE	0.1%	0.8%
% OTHER REDUCTIONS	0.0%	0.0%
% OTHER ADJUSTMENTS	-0.0%	-0.0%
% PAID-PROVIDER	78.2%	84.2%



Billed Amount: The allowed amount was 42.7% of the billed amount for the current reporting month and 41.6% of the billed amount for the year to date. Discounts were 39.3% of the billed amount for the current reporting month and 51.1% of the billed amount for the year to date. The remaining not covered amount was 18.0% of the billed amount for the current reporting month and 7.3% of the billed amount for the year to date.

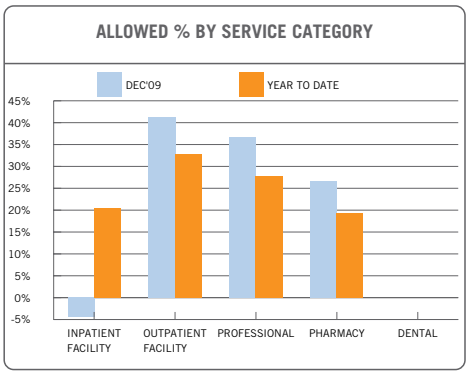
Allowed Amount: Of the allowed amount in the current reporting month, the paid-provider amount was 78.2%, out of pocket was 21.4%, COB was 0.3%, COB Medicare was 0.1%, and other reductions were 0.0%. Other adjustments were -0.0%. For year to date, of the allowed amount, the paid-provider amount was 84.2%, out of pocket was 14.9%, COB was 0.0%, COB Medicare was 0.8%, and other reductions were 0.0%. Other adjustments were -0.0%.

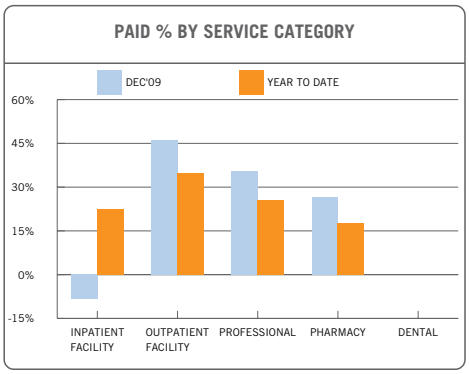
*This reflects the overall discount as a percent of the billed amount. Please refer to page 1.3 'Network Savings Analysis' for your network discount percent based off the Covered amount.

KEY FINANCIAL MEASURES BY SERVICE CATEGORY

Report Description: The percent allowed and paid for each service category (inpatient facility, outpatient facility, professional, pharmacy and dental) is analyzed to determine which service categories have contributed the most in these key financial measures in the current reporting month and for the year to date.

ABC COMPANY - TIER 3			
		DEC'09	YEAR TO DATE
INPATIENT FACILITY	ALLOWED	$-10,620	$613,371
	ALLOWED %	-4.2%	20.3%
	PAID	$-15,555	$559,893
	PAID %	-8.1%	22.4%
OUTPATIENT FACILITY	ALLOWED	$102,962	$990,973
	ALLOWED %	41.1%	32.8%
	PAID	$88,822	$862,820
	PAID %	46.0%	34.6%
PROFESSIONAL	ALLOWED	$91,868	$831,882
	ALLOWED %	36.6%	27.6%
	PAID	$68,353	$633,669
	PAID %	35.4%	25.4%
CAPITATION	PAID	$0	$0
	PAID %	0.0%	0.0%
PHARMACY	ALLOWED	$66,457	$580,839
	ALLOWED %	26.5%	19.3%
	PAID	$51,375	$437,687
	PAID %	26.6%	17.5%
DENTAL	ALLOWED		
	ALLOWED %		
	PAID		
	PAID %		
SUMMARY	ALLOWED	$250,667	$3,017,064
	ALLOWED %	100.0%	100.0%
	PAID	$192,995	$2,494,068
	PAID %	100.0%	100.0%





Summary: Overall allowed expense for the current reporting month made up 8.3% of the year to date allowed expenses. Overall paid expense for the current reporting month made up 7.7% of the year to date paid expenses.

Allowed % by Service Category: In terms of the proportion of overall allowed expenses by service category, Outpatient Facility allowed expenses accounted for the greatest proportion of the overall allowed expenses for the year to date. The next highest service category was Professional, which accounted for 27.6% for the year to date allowed expenses.

Paid % by Service Category: In terms of the proportion of overall paid expenses by service category, Outpatient Facility paid expenses accounted for the greatest proportion of the overall paid expenses for the year to date. The next highest service category was Professional, which accounted for 25.4% for the year to date paid expenses.

OVERALL PAID EXPENSES BY ICD-9 DIAGNOSTIC CATEGORY

Report Description: The table below lists the top 15 overall paid expenses across inpatient facility, outpatient facility, and professional settings by ICD-9 diagnostic categories for the year to date and the respective experience for the current reporting month.

ABC COMPANY - TIER 3				
	DEC'09		YEAR TO DATE	
ICD-9 DIAGNOSTIC CATEGORY	PAID	PAID %	PAID	PAID %
INJURY & POISONING	$4,234	3.0%	$354,354	17.2%
HEALTH SERVICES	$31,418	22.2%	$328,822	16.0%
SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS	$24,579	17.4%	$237,614	11.6%
CIRCULATORY	$15,552	11.0%	$186,100	9.0%
GENITOURINARY	$10,284	7.3%	$147,393	7.2%
DIGESTIVE	$10,026	7.1%	$121,284	5.9%
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$-10,740	-7.6%	$116,408	5.7%
NEOPLASMS	$4,981	3.5%	$88,359	4.3%
COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	$9,216	6.5%	$70,412	3.4%
WITHOUT REPORTED DIAGNOSIS	$4,691	3.3%	$59,526	2.9%
RESPIRATORY	$7,262	5.1%	$59,519	2.9%
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	$8,533	6.0%	$58,528	2.8%
NERVOUS SYSTEM	$3,509	2.5%	$55,568	2.7%
MENTAL HEALTH	$1,164	0.8%	$32,473	1.6%
HEALTH SERVICES: REPRODUCTION AND DEVELOPMENT	$2,442	1.7%	$27,143	1.3%
ALL OTHER	$14,469	10.2%	$112,876	5.5%
SUMMARY	$141,620	100.0%	$2,056,381	100.0%

The top three ICD-9 Diagnostic Categories in the current reporting month based on paid were Health Services, Symptoms, Signs & Ill-Defined Conditions, and Circulatory.

MEDICAL CLAIM EXPENSE DISTRIBUTION BY CLAIMANT

Report Description: The distribution of medical paid expense by claimant and the average medical paid per claimant amount is shown for the year to date. The graphs display the percentage of claimants and paid expenses for the year to date.[1]

ABC COMPANY - TIER 3					
	YEAR TO DATE				
PAID	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT
LESS THAN $200	252	34.3%	$20,067	1.0%	$80
$200 - $1,000	241	32.8%	$118,352	5.8%	$491
$1,000 - $5,000	160	21.8%	$350,067	17.0%	$2,188
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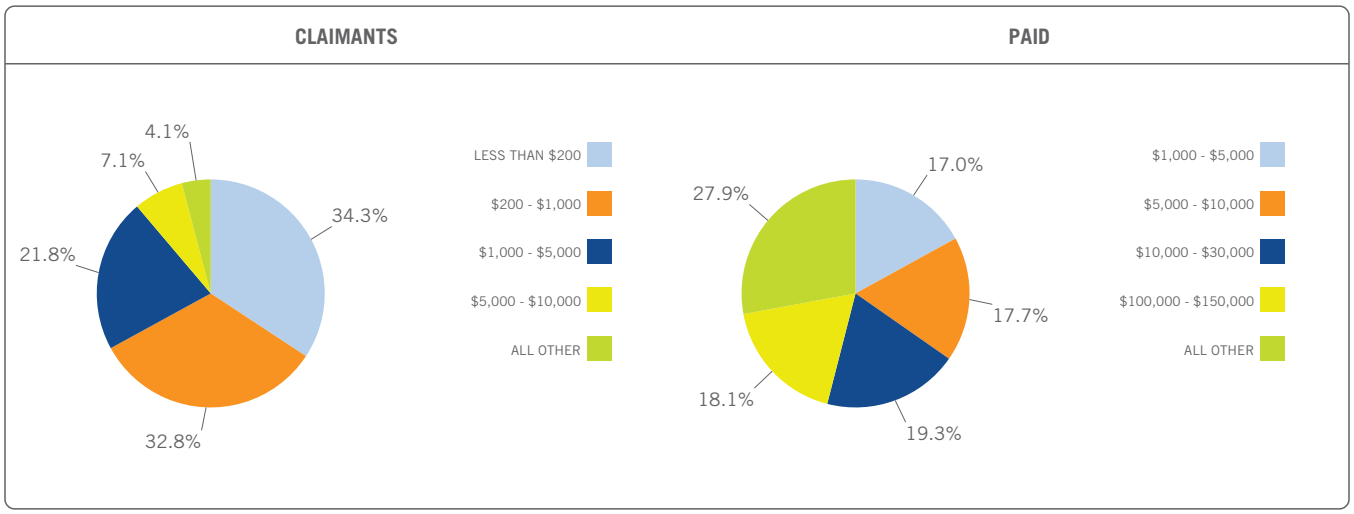
$10,000 - $30,000	23	3.1%	$396,812	19.3%	$17,253
SUMMARY	728	99.0%	$1,248,653	60.7%	$1,715

PAID	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT
$30,000 - $50,000	2	0.3%	$71,924	3.5%	$35,962
$50,000 - $75,000	1	0.1%	$73,892	3.6%	$73,892
$75,000 - $100,000					
$100,000 - $150,000	3	0.4%	$371,560	18.1%	
$150,000 - $200,000					
$200,000 - $250,000					
$250,000 - $500,000	1	0.1%	$290,353	14.1%	$290,353
GREATER THAN $500,000					
SUMMARY	7	1.0%	$807,729	39.3%	$115,390



The proportion of claimants who received less than $200 in services for the year to date was 34.3%. These claimants spent 1.0% of the total paid expenses and the average paid expense per claimant was $80.

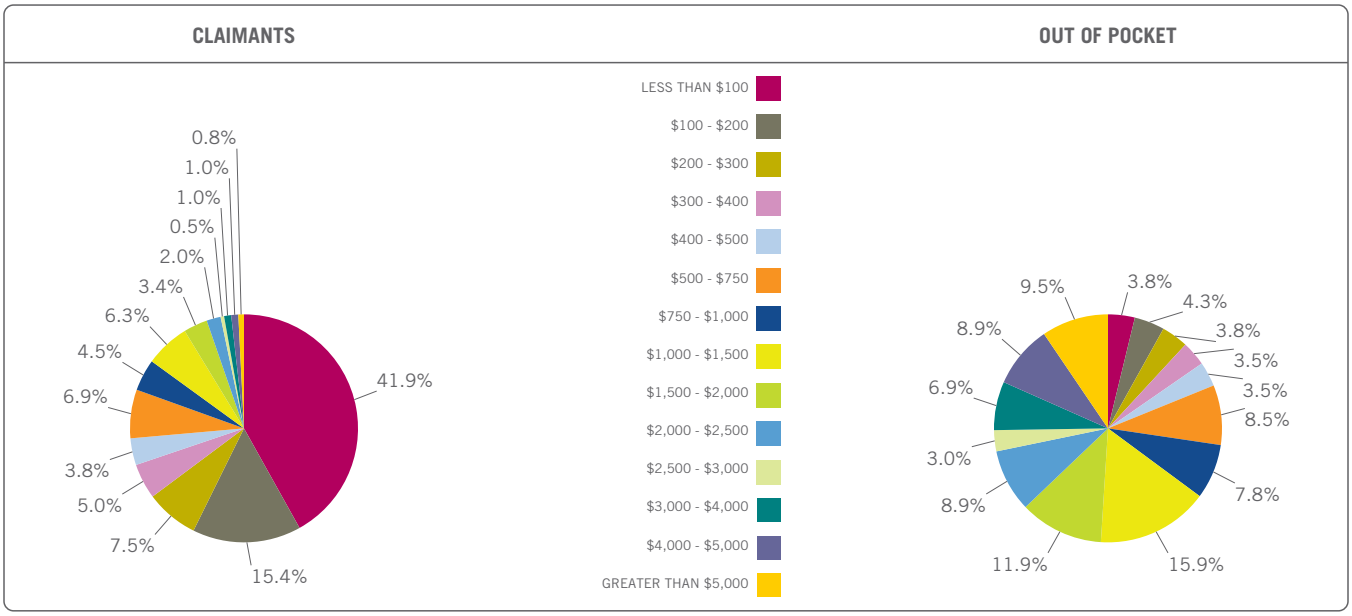
1.0% of claimants had expenses over $30,000 for the year to date. These claimants spent 39.3% of the total paid expenses and the average paid expense per claimant was $115,390.

[1]This is a claimant analysis, where only members who had a claim are included.

MEDICAL OUT OF POCKET DISTRIBUTION BY CLAIMANT

Report Description: The impact of cost sharing provisions is analyzed to determine the overall liability incurred by the member. This report provides a distribution of claimants by their total medical out of pocket expenses for the year to date. If changes have been made to plan design, this report helps analyze what the impacts of those changes have been to the member. The graphs display the percentage of claimants and out of pocket expenses for the year to date.[1]

ABC COMPANY - TIER 3				
	YEAR TO DATE			
OUT OF POCKET	CLAIMANTS	CLAIMANTS %	OUT OF POCKET	OUT OF POCKET %
LESS THAN $100	308	41.9%	$13,896	3.8%
$100 - $200	113	15.4%	$15,542	4.3%
$200 - $300	55	7.5%	$13,665	3.8%
$300 - $400	37	5.0%	$12,642	3.5%
$400 - $500	28	3.8%	$12,580	3.5%
$500 - $750	51	6.9%	$30,840	8.5%
$750 - $1,000	33	4.5%	$28,459	7.8%
$1,000 - $1,500	46	6.3%	$57,688	15.9%
$1,500 - $2,000	25	3.4%	$43,277	11.9%
$2,000 - $2,500	15	2.0%	$32,319	8.9%
$2,500 - $3,000	4	0.5%	$10,874	3.0%
$3,000 - $4,000	7	1.0%	$25,160	6.9%
$4,000 - $5,000	7	1.0%	$32,418	8.9%
GREATER THAN $5,000	6	0.8%	$34,550	9.5%
SUMMARY	735	100.0%	$363,911	100.0%



The average out of pocket expense per claimant was $495 for the year to date. Claimants with under $200 in out of pocket expenses were 57.3% for the year to date. Claimants with out of pocket expenses in the range of less than $100 showed the highest number of claimants for the year to date.

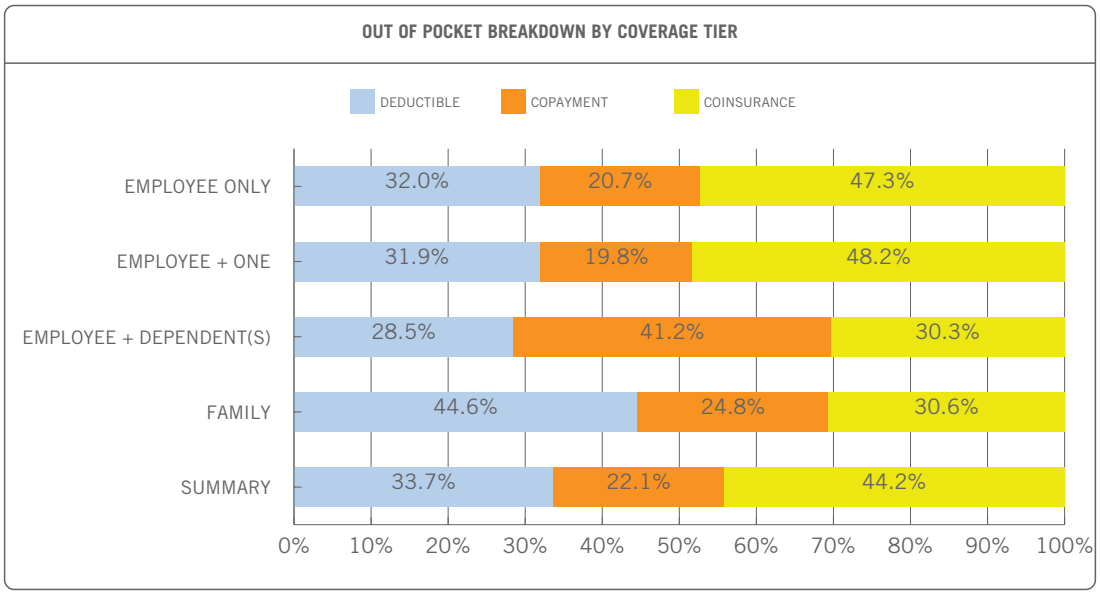
[1]This is a claimant analysis, where only members who had a claim are included.

MEDICAL OUT OF POCKET ANALYSIS

Report Description: This report shows the deductible, copayment, coinsurance, and total out of pocket amounts as a percent of the allowed amount by coverage tier for the year to date. The chart shows the total out of pocket amount broken out by the percent the member paid for deductible, copayment, and coinsurance for claims for the year to date.

ABC COMPANY - TIER 3

	YEAR TO DATE									
COVERAGE TIER	ALLOWED	DEDUCTIBLE	DEDUCT % OF ALLOWED	COPAYMENT	COPAY % OF ALLOWED	COINSURANCE	COINS % OF ALLOWED	OUT OF POCKET	OPX % OF ALLOWED	PAID
EMPLOYEE ONLY	$1,382,694	$70,941	5.1%	$45,734	3.3%	$104,698	7.6%	$221,373	16.0%	$1,164,593
EMPLOYEE + ONE	$770,123	$22,533	2.9%	$14,004	1.8%	$34,057	4.4%	$70,594	9.2%	$679,544
EMPLOYEE + DEPENDENT(S)	$75,602	$4,904	6.5%	$7,095	9.4%	$5,205	6.9%	$17,204	22.8%	$58,576
FAMILY	$207,806	$24,404	11.7%	$13,581	6.5%	$16,756	8.1%	$54,741	26.3%	$153,668
SUMMARY	$2,436,225	$122,782	5.0%	$80,413	3.3%	$160,716	6.6%	$363,911	14.9%	$2,056,381



The overall total out of pocket amount as a percent of allowed for the year to date was 14.9.%. The coverage tier with the highest deductible as a percent of allowed was Family. Copayment as a percent of allowed was highest for Employee + Dependent(s). Coinsurance as a percent of allowed was highest for Family.

Of the total out of pocket amount, 33.7% was attributed to the deductible amount. The copayment amount attributed 22.1%. The remaining 44.2% was attributed to the coinsurance amount.

MEDICAL LAG REPORT

Report Description: This report displays, by paid month, the net medical dollars paid and the corresponding month incurred for a 12 month rolling paid period (or the available data for your account). This report provides insight into the monthly claim lag and can help identify IBNR.

ABC COMPANY - TIER 3

INCURRED MONTH	PAID MONTH												
	JAN'09	FEB'09	MAR'09	APR'09	MAY'09	JUN'09	JUL'09	AUG'09	SEP'09	OCT'09	NOV'09	DEC'09	SUMMARY
ALL PRIOR	$54	$0	$144	$450	$790		$0	$276		$14	$300	$0	$2,029
JAN'08	$49			$149									$198
FEB'08	$533			$206									$739
MAR'08	$4,007	$430	$0	$1,006		$0	$0	$164		$0			$5,608
APR'08				$656		$0		$0				$292	$948
MAY'08	$56			$218	$72		$0			$0			$345
JUN'08	$653	$6,210	$0	$21	$1,036								$7,920
JUL'08	$-399	$6,161	$0	$0	$263	$445			$442	$0		$0	$6,912
AUG'08	$368	$68	$17	$430	$0	$100	$0	$203			$0	$0	$1,186
SEP'08	$400	$-189	$0	$2,994	$857	$0	$553		$0	$0	$0		$4,616
OCT'08	$4,579	$5,639	$484	$14	$111	$183	$927		$0	$0			$11,936
NOV'08	$35,175	$2,030	$240	$35	$1,027	$267	$40	$-272	$137		$67	$0	$38,746
DEC'08	$109,105	$73,673	$88,995	$4,496	$3,407	$55	$209	$0		$91	$0		$280,031
JAN'09	$57,683	$154,786	$17,748	$2,592	$1,206	$352	$90	$122	$156	$12,370	$0	$0	$247,103
FEB'09		$90,900	$80,369	$22,863	$898	$4,103	$113	$44	$10	$2,199	$343		$201,843
MAR'09			$54,021	$179,523	$271,832	$3,548	$2,122	$178	$59	$-25	$342	$57	$511,657
APR'09				$62,046	$75,688	$19,412	$2,271	$844	$16	$57	$234	$0	$160,568
MAY'09					$35,150	$68,952	$14,704	$7,121	$270	$76	$42	$33	$126,349
JUN'09						$80,839	$188,997	$21,148	$4,393	$360	$22	$-24,861	$270,899
JUL'09							$53,764	$81,017	$29,803	$3,508	$859	$676	$169,627
AUG'09								$66,870	$102,270	$30,667	$3,028	$6,510	$209,346
SEP'09									$64,578	$126,247	$6,164	$1,944	$198,932
OCT'09										$88,795	$120,134	$12,628	$221,557
NOV'09											$26,936	$95,993	$122,929
DEC'09												$48,347	$48,347
SUMMARY	$212,263	$339,709	$242,018	$277,699	$392,336	$178,256	$263,791	$177,718	$202,133	$264,358	$158,471	$141,620	$2,850,372

CHAPTER DESCRIPTION

This chapter presents information on key expenses for ABC Company - Tier 3 for the current reporting month and for the year to date.

The first report focuses on ABC Company - Tier 3 inpatient facility admission experience and examines the leading ICD-9 Diagnostic Categories to help pinpoint what conditions are driving ABC Company - Tier 3 inpatient expenses.

The second report analyzes expenses specifically related to services provided in the outpatient facility setting for ABC Company - Tier 3. The report examines the leading ICD-9 Diagnostic Categories to help pinpoint what conditions are driving ABC Company - Tier 3 outpatient expenses. The expenses presented in this report are for facility expenses only and includes service types such as ambulatory surgery, emergency room, radiology, dialysis and observation room.

The third report encompasses all the services for ABC Company - Tier 3 provided by physicians and other clinicans, ancillary services and supplies. The report examines the leading ICD-9 Diagnostic Categories to help pinpoint what conditions are driving ABC Company - Tier 3 professional expenses. Physician and other clinician services, include surgical procedures, evaluation and management (E&M) services, anesthesia services, physical/occupational/speech therapy services and other medical services. Ancillary services include radiology and laboratory/pathology services. Medical services and supplies are also included in the professional service category. This service type represents services that have been submitted with a HCPCS (Healthcare Common Procedure Coding System) code.

Data Note

Current reporting month represents claims paid in Dec'09.

Year to date represents claims paid from Apr'09 through Dec'09.

Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

INPATIENT FACILITY PAID EXPENSES BY ICD-9 DIAGNOSTIC CATEGORY

Report Description: The table below lists the top 15 inpatient facility paid expenses by ICD-9 diagnostic categories for the year to date and the respective experience for the current reporting month.

ABC COMPANY - TIER 3				
	DEC'09		YEAR TO DATE	
ICD-9 DIAGNOSTIC CATEGORY	PAID	PAID %	PAID	PAID %
INJURY & POISONING			$277,477	49.6%
CIRCULATORY			$81,570	14.6%
DIGESTIVE	$2,918	-18.8%	$44,086	7.9%
COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	$8,316	-53.5%	$31,574	5.6%
GENITOURINARY			$29,852	5.3%
SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS			$24,216	4.3%
MENTAL HEALTH			$16,769	3.0%
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$-28,640	184.1%	$13,053	2.3%
RESPIRATORY			$10,487	1.9%
NERVOUS SYSTEM			$9,121	1.6%
NEOPLASMS			$5,585	1.0%
HEALTH SERVICES			$5,170	0.9%
BLOOD AND BLOOD-FORMING ORGANS			$4,558	0.8%
LIVEBORN INFANTS	$1,851	-11.9%	$4,150	0.7%
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES			$2,226	0.4%
SUMMARY	$-15,555	100.0%	$559,893	100.0%

The top three ICD-9 Diagnostic Categories in the current reporting month based on paid were Complications Of Pregnancy, Childbirth, And The Puerperium, Digestive, and Liveborn Infants.

OUTPATIENT FACILITY PAID EXPENSES BY ICD-9 DIAGNOSTIC CATEGORY

Report Description: The table below lists the top 15 outpatient facility paid expenses by ICD-9 diagnostic categories for the year to date and the respective experience for the current reporting month.

ABC COMPANY - TIER 3				
	DEC'09		YEAR TO DATE	
ICD-9 DIAGNOSTIC CATEGORY	PAID	PAID %	PAID	PAID %
HEALTH SERVICES	$31,044	35.0%	$320,750	37.2%
SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS	$16,581	18.7%	$112,773	13.1%
GENITOURINARY	$6,231	7.0%	$72,340	8.4%
DIGESTIVE	$2,951	3.3%	$43,638	5.1%
NEOPLASMS			$40,728	4.7%
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$8,211	9.2%	$38,180	4.4%
INJURY & POISONING	$2,028	2.3%	$36,858	4.3%
CIRCULATORY	$9,324	10.5%	$33,000	3.8%
NERVOUS SYSTEM	$2,016	2.3%	$28,203	3.3%
WITHOUT REPORTED DIAGNOSIS	$2,404	2.7%	$24,617	2.9%
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	$1,824	2.1%	$22,587	2.6%
COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM			$19,737	2.3%
RESPIRATORY	$2,392	2.7%	$17,165	2.0%
OTHER CIRCUMSTANCES	$0	0.0%	$10,752	1.2%
EYES	$132	0.1%	$7,942	0.9%
ALL OTHER	$3,683	4.1%	$33,552	3.9%
SUMMARY	$88,822	100.0%	$862,820	100.0%

The top three ICD-9 Diagnostic Categories in the current reporting month based on paid were Health Services, Symptoms, Signs & Ill-Defined Conditions, and Circulatory.

PROFESSIONAL PAID EXPENSES BY ICD-9 DIAGNOSTIC CATEGORY

Report Description: The table below lists the top 15 professional paid expenses by ICD-9 diagnostic categories for the year to date and the respective experience for the current reporting month.

ABC COMPANY - TIER 3				
	DEC'09		YEAR TO DATE	
ICD-9 DIAGNOSTIC CATEGORY	PAID	PAID %	PAID	PAID %
SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS	$7,998	11.7%	$100,625	15.9%
CIRCULATORY	$6,229	9.1%	$71,530	11.3%
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$9,688	14.2%	$65,175	10.3%
GENITOURINARY	$4,053	5.9%	$45,202	7.1%
NEOPLASMS	$4,981	7.3%	$42,047	6.6%
INJURY & POISONING	$2,206	3.2%	$40,019	6.3%
WITHOUT REPORTED DIAGNOSIS	$2,287	3.3%	$34,910	5.5%
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	$6,709	9.8%	$33,715	5.3%
DIGESTIVE	$4,157	6.1%	$33,561	5.3%
RESPIRATORY	$4,870	7.1%	$31,868	5.0%
HEALTH SERVICES: REPRODUCTION AND DEVELOPMENT	$2,316	3.4%	$22,817	3.6%
COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	$900	1.3%	$19,101	3.0%
NERVOUS SYSTEM	$1,493	2.2%	$18,245	2.9%
EYES	$1,802	2.6%	$17,937	2.8%
MENTAL HEALTH	$1,164	1.7%	$11,462	1.8%
ALL OTHER	$7,500	11.0%	$45,457	7.2%
SUMMARY	$68,353	100.0%	$633,669	100.0%

The top three ICD-9 Diagnostic Categories in the current reporting month based on paid were Musculoskeletal And Connective Tissue, Symptoms, Signs & Ill-Defined Conditions, and Endocrine, Nutritional And Metabolic Diseases.

CHAPTER DESCRIPTION

Pharmacy includes all outpatient, non-professional prescription drug services provided to ABC Company - Tier 3's members. This report provides a breakdown of key pharmacy expenditures, from billed amount to paid amount, for the current reporting month and for the year to date on a paid basis. This report will balance back to billing and accounts receivable system (BARS).

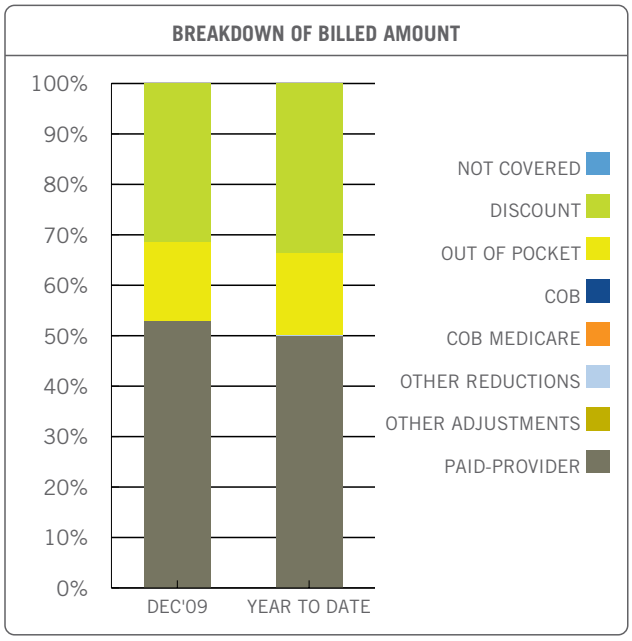
Data Note

Current reporting month represents claims paid in Dec'09.
Year to date represents claims paid from Apr'09 through Dec'09.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

SUMMARY OF PHARMACY FINANCIAL MEASURES

Report Description: This report provides an overview of ABC Company - Tier 3's pharmacy expenses from billed to paid for the current reporting month and for the year to date. These key financial measures are on a paid basis and balance back to your billing and accounts receivable system (BARS). These metrics include plan performance measures, such as the degree of discounts the plan was able to achieve, as well as COB and COB Medicare recoveries that the plan was able to receive based on other insurance contributing to the overall expenses. Information is also provided on the amount of overall health care expenses that the member was directly responsible for, through deductibles, coinsurance or co-payments. Other reductions include penalties, workers compensation savings, and subrogation savings. Other payments includes Blue Card access fees and surcharges. Also displayed are other adjustments. Definitions of these financial measures can be found in the glossary.

ABC COMPANY - TIER 3		
PHARMACY EXPENSES	DEC'09	YEAR TO DATE
BILLED	$96,885	$874,285
NOT COVERED	$0	$0
COVERED	$96,885	$874,285
DISCOUNT	$30,428	$293,446
ALLOWED	$66,457	$580,839
OUT OF POCKET	$15,017	$142,401
COB	$0	$0
COB MEDICARE	$0	$0
OTHER REDUCTIONS	$64	$752
OTHER ADJUSTMENTS	$0	$0
PAID-PROVIDER	$51,375	$437,687
OTHER PAYMENTS	$0	$0
PAID	$51,375	$437,687



Paid-Provider excludes Other Payments, which are not part of the Billed Amount.

CHAPTER DESCRIPTION

This chapter provides dental financial information for ABC Company - Tier 3.

The report displays financial information for ABC Company - Tier 3 based on paid claims for the curent reporting month and for the year to date. Also presented are the amounts accounted for by out of pocket, COB, other reductions, other payments and the paid amount.

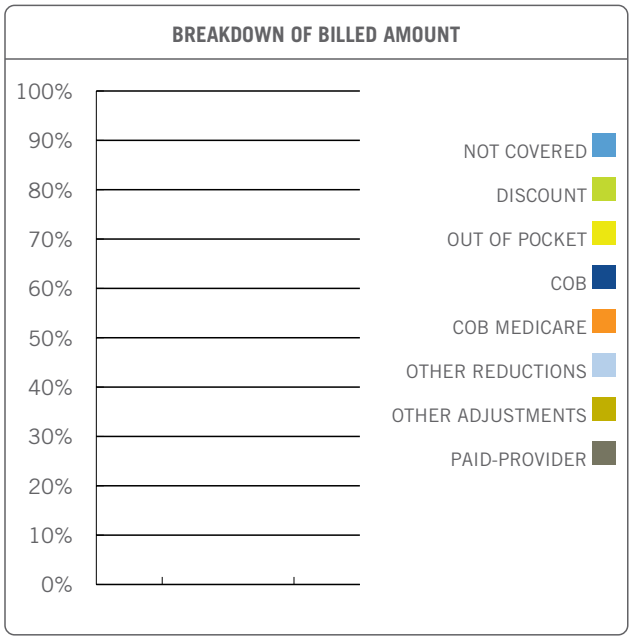
Data Note

Current reporting month represents claims paid in Dec'09.
Year to date represents claims paid from Apr'09 through Dec'09.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

SUMMARY OF DENTAL FINANCIAL MEASURES

Report Description: This report provides an overview of ABC Company - Tier 3's dental expenses from billed to paid for the current reporting month and for the year to date. Some key financial measures are displayed below including discounts, COB, and dental expenses that the member was directly responsible for through deductibles, coinsurance or co-payments.[1]

ABC COMPANY - TIER 3		
DENTAL EXPENSES		
BILLED		
NOT COVERED		
COVERED		
DISCOUNT		
ALLOWED		
OUT OF POCKET		
COB		
COB MEDICARE		
OTHER REDUCTIONS		
OTHER ADJUSTMENTS		
PAID-PROVIDER		
OTHER PAYMENTS		
PAID		



[1]Financials may vary from other Financial Reporting provided by the plan.

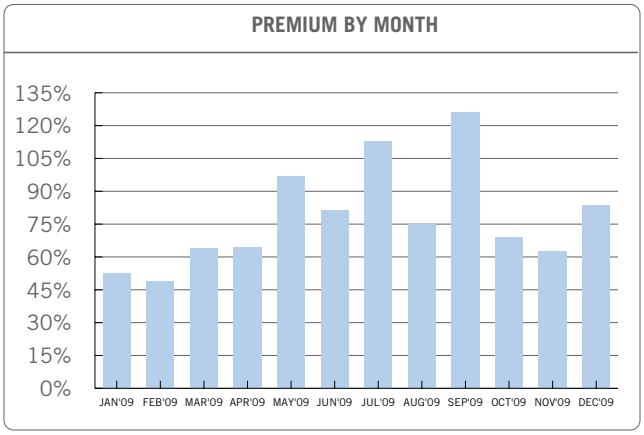
CHAPTER DESCRIPTION

This chapter provides informaton for ABC Company - Tier 3 based on paid claims, membership and premium for the most recent twelve reporting months. Premium is reported on an incurred month basis. Paid claims and premium include only dental dollars.

SUMMARY OF DENTAL LOSS RATIO

Report Description: This report provides an overview of ABC Company - Tier 3's membership, premium, and dental loss ratio and paid claims for the most recent twelve months. Definitions of these financial measures can be found in the glossary.

MONTH	DENTAL SUBSCRIBERS	DENTAL MEMBERS
JAN'09	558	957
FEB'09	545	924
MAR'09	543	919
APR'09	555	936
MAY'09	541	914
JUN'09	542	922
JUL'09	529	892
AUG'09	521	875
SEP'09	307	493
OCT'09	355	559
NOV'09	360	565
DEC'09	361	570
SUMMARY	5,717	9,526



MONTH	PREMIUM	DENTAL PAID CLAIMS	DENTAL LOSS RATIO
JAN'09	$21,216	$11,142	52.5%
FEB'09	$20,654	$10,127	49.0%
MAR'09	$20,535	$13,140	64.0%
APR'09	$21,500	$13,867	64.5%
MAY'09	$20,913	$20,244	96.8%
JUN'09	$21,040	$17,056	81.1%
JUL'09	$20,331	$22,964	112.9%
AUG'09	$19,902	$14,861	74.7%
SEP'09	$10,576	$13,332	126.1%
OCT'09	$12,055	$8,286	68.7%
NOV'09	$12,121	$7,553	62.3%
DEC'09	$12,250	$10,240	83.6%
SUMMARY	$213,092	$162,811	76.4%

SUMMARY OF FINDINGS

The dental loss ratio for the current month was 7.2% higher than the average of the most recent twelve months, which was 76.4%.

Data Note
Reporting is based on paid, 12-month rolling periods.
Current reporting period represents claims paid from Jan'09 through Dec'09.
Paid claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

CHAPTER DESCRIPTION

The enrollment chapter presents descriptive information on ABC Company - Tier 3's subscribers and dependents enrolled in BCBSTX. The ability to track changes in the characteristics of ABC Company - Tier 3's enrolled population is critical information for effective plan management. Information on membership size, age and gender are presented for subscribers and dependents for the current reporting month and for the year to date. Enrollment by age band is shown for both subscribers and dependents for the current reporting month and for the year to date. Additionally, the proportion of ABC Company - Tier 3's enrollment by coverage tier is presented. The final report provides an analysis of enrollment/disenrollment to provide detailed information necessary to understand monthly count variances.

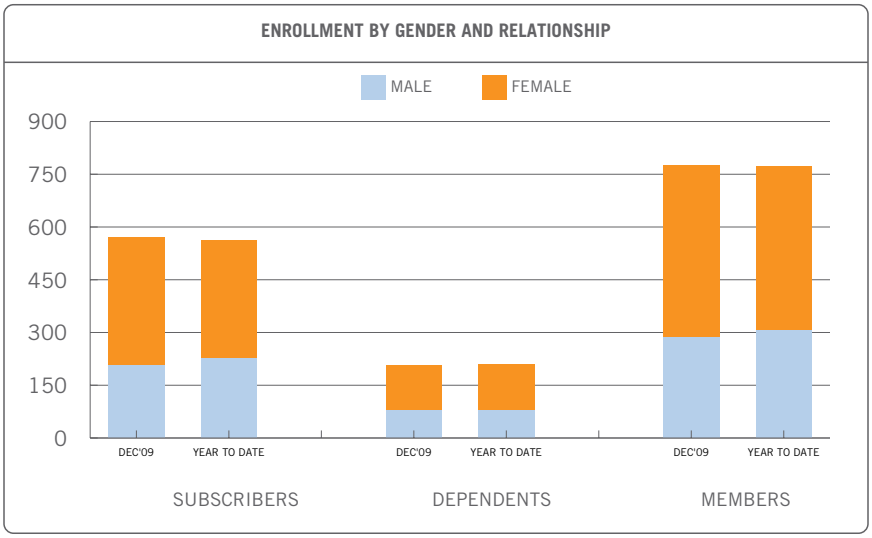
Data Note

Current reporting month represents members enrolled in Dec'09.
Year to date represents average membership enrolled from Apr'09 through Dec'09.
Enrollment for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

ENROLLMENT OVERVIEW

Report Description: For medical membership only, the average number of subscribers, dependents, members and average contract size for ABC Company - Tier 3 are shown below in addition to the average age, overall proportion of males, females, and females 20-44 years.

ABC COMPANY - TIER 3		
	DEC'09	YEAR TO DATE
AVERAGE SUBSCRIBERS	571	561
AVERAGE DEPENDENTS	205	210
AVERAGE MEMBERS	776	771
AVERAGE CONTRACT SIZE	1.36	1.37
AVERAGE AGE (YEARS)	38.0	37.8
PROPORTION OF MALES	37.1%	40.1%
PROPORTION OF FEMALES	62.9%	59.9%
PROPORTION OF FEMALES (20-44 YEARS)	30.4%	29.7%



Size: ABC Company - Tier 3's overall membership was 776 in the current reporting month and 771 for the year to date.

Gender: The average proportion of males was 37.1% in the current reporting month and 40.1% for the year to date.

Relationship:

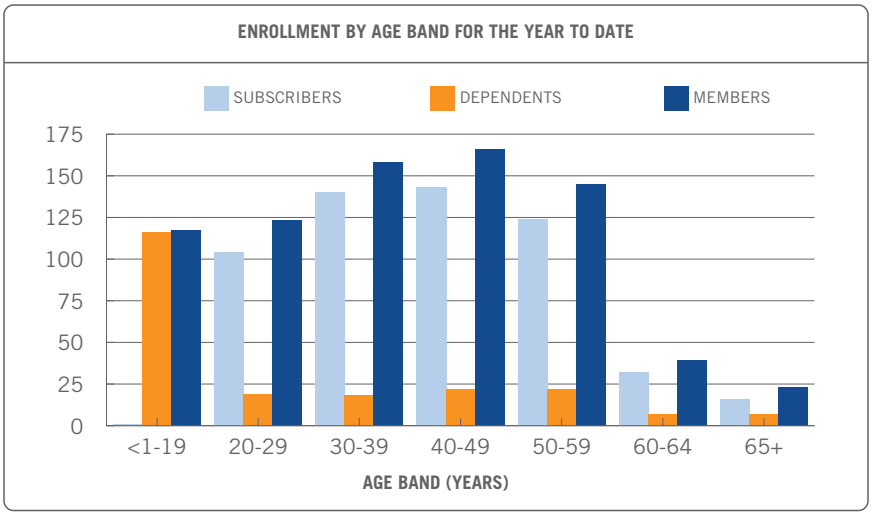
Subscribers - For the current reporting month, 36.4% of subscribers were male and 63.6% were female. For the year to date, 40.6% of subscribers were male and 59.4% were female.

Dependents - For the current reporting month, 39.0% of dependents were male and 61.0% were female. For the year to date, 39.0% of dependents were male and 61.0% were female.

ENROLLMENT BY AGE AND GENDER

Report Description: For medical membership only, ABC Company - Tier 3's average age of subscribers (employees), dependents (spouse and/or children) and total members are displayed in the table below, as well as the average age by gender for the current reporting month and for the year to date. The graph shows various age bands for the year to date, broken down by subscribers, dependents and total members.

ABC COMPANY - TIER 3						
AVERAGE AGE (IN YEARS) BY GENDER						
	DEC'09			YEAR TO DATE		
	MALE	FEMALE	SUMMARY	MALE	FEMALE	SUMMARY
SUBSCRIBERS	43.7	42.2	42.7	43.7	41.8	42.6
DEPENDENTS	21.9	26.7	24.9	20.0	28.3	25.1
MEMBERS	37.7	38.2	38.0	37.4	38.1	37.8



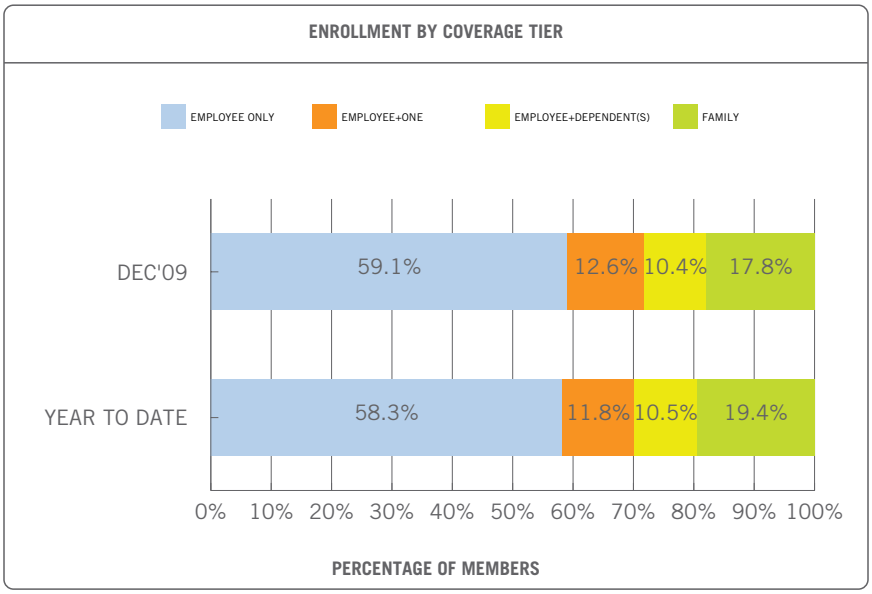
Subscriber Age: The average age for subscribers was 42.7 for the current reporting month and 42.6 for the year to date. In the current reporting month, males were older than females and most subscribers fell into the 40-49 age band.

Dependent Age: The average age for dependents was 24.9 for the current reporting month and 25.1 for the year to date. In the current reporting month, males were younger than females and most dependents fell into the <1-19 age band.

ENROLLMENT BY COVERAGE TIER

Report Description: The average number of medical members and proportion of medical members in each coverage tier are displayed in the table and chart below as well as the average contract size for the current reporting month and for the year to date.

ABC COMPANY - TIER 3						
MEDICAL MEMBERS	DEC'09			YEAR TO DATE		
COVERAGE TIER	AVERAGE MEMBERS	% MEMBERS	AVERAGE CONTRACT SIZE	AVERAGE MEMBERS	% MEMBERS	AVERAGE CONTRACT SIZE
EMPLOYEE ONLY	459	59.1%	1.00	450	58.3%	1.00
EMPLOYEE+ONE	98	12.6%	2.00	91	11.8%	2.00
EMPLOYEE+DEPENDENT(S)	81	10.4%	2.79	81	10.5%	2.87
FAMILY	138	17.8%	4.06	150	19.4%	3.96
SUMMARY	776	100.0%	1.36	771	100.0%	1.37



Employee Only: Made up 59.1% of the overall membership in the current reporting month and 58.3% for the year to date.

Employee + One: Made up 12.6% of the overall membership in the current reporting month and 11.8% for the year to date.

Employee + Dependent(s): Made up 10.4% of the overall membership in the current reporting month and 10.5% for the year to date.

Family: Made up 17.8% of the overall membership in the current reporting month and 19.4% for the year to date.

ENROLLMENT/DISENROLLMENT

Report Description: This report displays monthly medical subscriber and member enrollment and disenrollment counts for the current policy year. This report breaks by Medicare and non-Medicare eligibility and enables you to identify significant monthly count variances soon after they occur. This report is filtered to display Plan Eligibility only.

ABC COMPANY - TIER 3

TOTAL MEDICAL SUBSCRIBERS

	MEDICARE NON-ELIGIBLE			MEDICARE ELIGIBLE			
MONTH	NEW ENROLLMENT	DISENROLLMENT	SUBSCRIBER VARIANCE	NEW ENROLLMENT	DISENROLLMENT	SUBSCRIBER VARIANCE	TOTAL SUBSCRIBERS
APR'09	21	5	16	0	0	0	579
MAY'09	9	1	8	0	0	0	565
JUN'09	12	4	8	0	0	0	567
JUL'09	9	14	-5	0	1	-1	552
AUG'09	7	7	0	0	1	-1	546
SEP'09	8	26	-18	0	2	-2	523
OCT'09	52	4	48	3	0	3	574
NOV'09	19	8	11	0	1	-1	572
DEC'09	10	2	8	0	0	0	571
JAN'10							
FEB'10							
MAR'10							
SUMMARY	147	71	76	3	5	-2	561

ABC COMPANY - TIER 3

TOTAL MEDICAL MEMBERS

	MEDICARE NON-ELIGIBLE			MEDICARE ELIGIBLE			
MONTH	NEW ENROLLMENT	DISENROLLMENT	MEMBER VARIANCE	NEW ENROLLMENT	DISENROLLMENT	MEMBER VARIANCE	TOTAL MEMBERS
APR'09	38	17	21	0	0	0	800
MAY'09	11	8	3	0	0	0	781
JUN'09	21	5	16	0	0	0	791
JUL'09	10	26	-16	0	2	-2	764
AUG'09	14	23	-9	0	1	-1	749
SEP'09	14	36	-22	0	4	-4	720
OCT'09	64	8	56	4	0	4	780
NOV'09	28	17	11	0	1	-1	778
DEC'09	12	5	7	0	0	0	776
JAN'10							
FEB'10							
MAR'10							
SUMMARY	212	145	67	4	8	-4	771

ENROLLMENT BY TYPE OF COVERAGE

Report Description: This report provides a high-level view of ABC Company - Tier 3's membership, broken down by employee status. These numbers show if a certain employee status was a key driver to any changes in overall membership for the current reporting month and for the year to date.

ABC COMPANY - TIER 3			
AVERAGE ENROLLED MEMBERSHIP BY EMPLOYEE STATUS FOR DEC'09			
EMPLOYEE STATUS	MEDICAL	PHARMACY	DENTAL
ACTIVE	776	776	419
RETIREE UNDER 65			
RETIREE 65 AND OVER			
COBRA			
SUMMARY	776	776	419

ABC COMPANY - TIER 3			
AVERAGE ENROLLED MEMBERSHIP BY EMPLOYEE STATUS FOR YEAR TO DATE			
EMPLOYEE STATUS	MEDICAL	PHARMACY	DENTAL
ACTIVE	771	771	571
RETIREE UNDER 65			
RETIREE 65 AND OVER			
COBRA			
SUMMARY	771	771	571

CHAPTER DESCRIPTION

The expense and utilization overview chapter is intended to provide key metrics for ABC Company - Tier 3's claims and eligibility experience. Year-over-year changes and comparisons to the benchmark are provided as well. Typically, when analyzing the health plan's overall performance in the last year, two sets of questions are asked:

1. What is the percent change in membership and paid expenses?

2. How does ABC Company - Tier 3's experience compare to the benchmark?

The report provides a high-level breakdown of year-over-year expense and utilization changes and comparisons to the benchmark. The Key Indicators table provides information related to the demographic make-up of ABC Company - Tier 3 and how paid expenses are distributed across all service categories. Demographic information is calculated using medical enrollment only. All per 1000, per employee, and per member measures are calculated using medical, dental, or pharmacy enrollment as appropriate. Graphs are also provided that show the proportion of paid by service category and the percent changes in expenses and utilization by service category.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.
Current reporting period represents claims incurred Nov'08 through Oct'09 and paid through Dec'09.
Prior reporting period represents claims incurred Nov'07 through Oct'08 and paid through Dec'08.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).
Benchmarks are based on BCBSTX's non-HMO book of business. The book of business includes groups between approximately 50 and 500 subscribers.

SUMMARY OF FINDINGS

Overall membership increased 5.8%. Contract size remained stable and the average age remained stable.

Overall medical paid PMPM increased 38.8%. Paid PMPM for pharmacy increased 6.0%. Dental paid PMPM decreased slightly. For medical paid PMPM by service category, inpatient facility increased 25.0%, outpatient facility increased 78.6% and professional increased 14.7%.

KEY INDICATORS

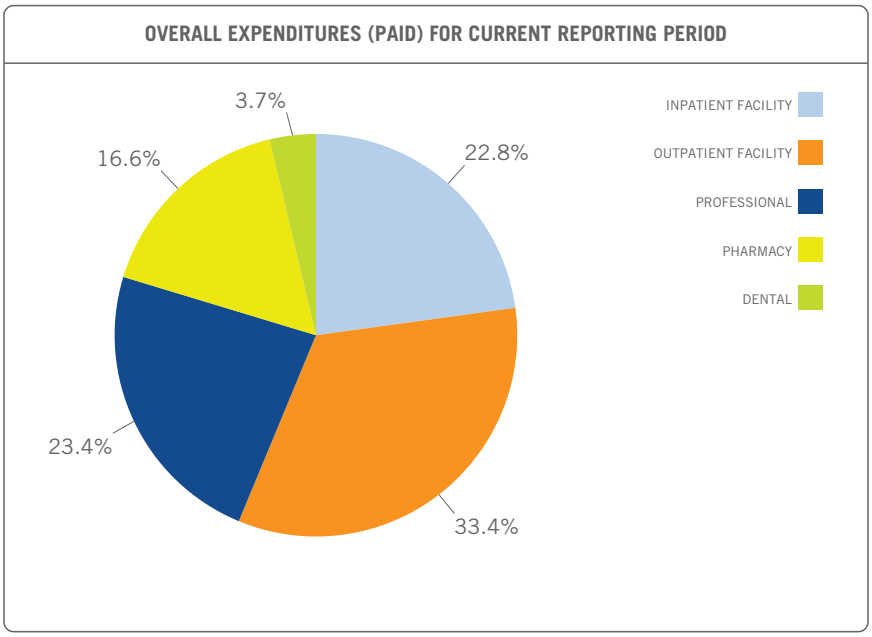
	ABC COMPANY - TIER 3				
	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK[1]	% VARIANCE
DEMOGRAPHICS (MEDICAL ONLY)					
AVERAGE SUBSCRIBERS	564	539	4.5%		
AVERAGE DEPENDENTS	214	195	9.4%		
AVERAGE MEMBERS	777	734	5.8%		
AVERAGE CONTRACT SIZE	1.38	1.36	1.2%	1.93	-28.6%
AVERAGE AGE (YEARS)	37.9	38.5	-1.7%		
PROPORTION OF MALES	41.7%	43.4%	-3.9%	52.2%	-20.0%
PROPORTION OF FEMALES	58.3%	56.6%	3.0%	47.8%	21.8%
PROPORTION OF FEMALES (20-44 YEARS)	29.3%	27.8%	5.1%	18.4%	59.4%
OVERALL EXPENSES (PAID PMPM)					
INPATIENT FACILITY	$85.90	$68.70	25.0%	$70.76	21.4%
OUTPATIENT FACILITY	$125.69	$70.39	78.6%	$71.18	76.6%
PROFESSIONAL	$88.03	$76.75	14.7%	$93.63	-6.0%
TOTAL MEDICAL	$299.62	$215.84	38.8%	$235.57	27.2%
CAPITATION	$0.00	$0.00		$0.00	
PHARMACY	$62.59	$59.04	6.0%	$54.29	15.3%
DENTAL	$16.59	$17.38	-4.5%	$19.89	-16.6%
OVERALL EXPENSES (PAID PEPM)					
INPATIENT FACILITY	$118.43	$93.57	26.6%	$136.70	-13.4%
OUTPATIENT FACILITY	$173.30	$95.87	80.8%	$137.51	26.0%
PROFESSIONAL	$121.37	$104.53	16.1%	$180.89	-32.9%
TOTAL MEDICAL	$413.10	$293.97	40.5%	$455.10	-9.2%
CAPITATION	$0.00	$0.00		$0.00	
PHARMACY	$86.29	$80.33	7.4%	$104.69	-17.6%
DENTAL	$22.03	$23.23	-5.2%	$42.35	-48.0%

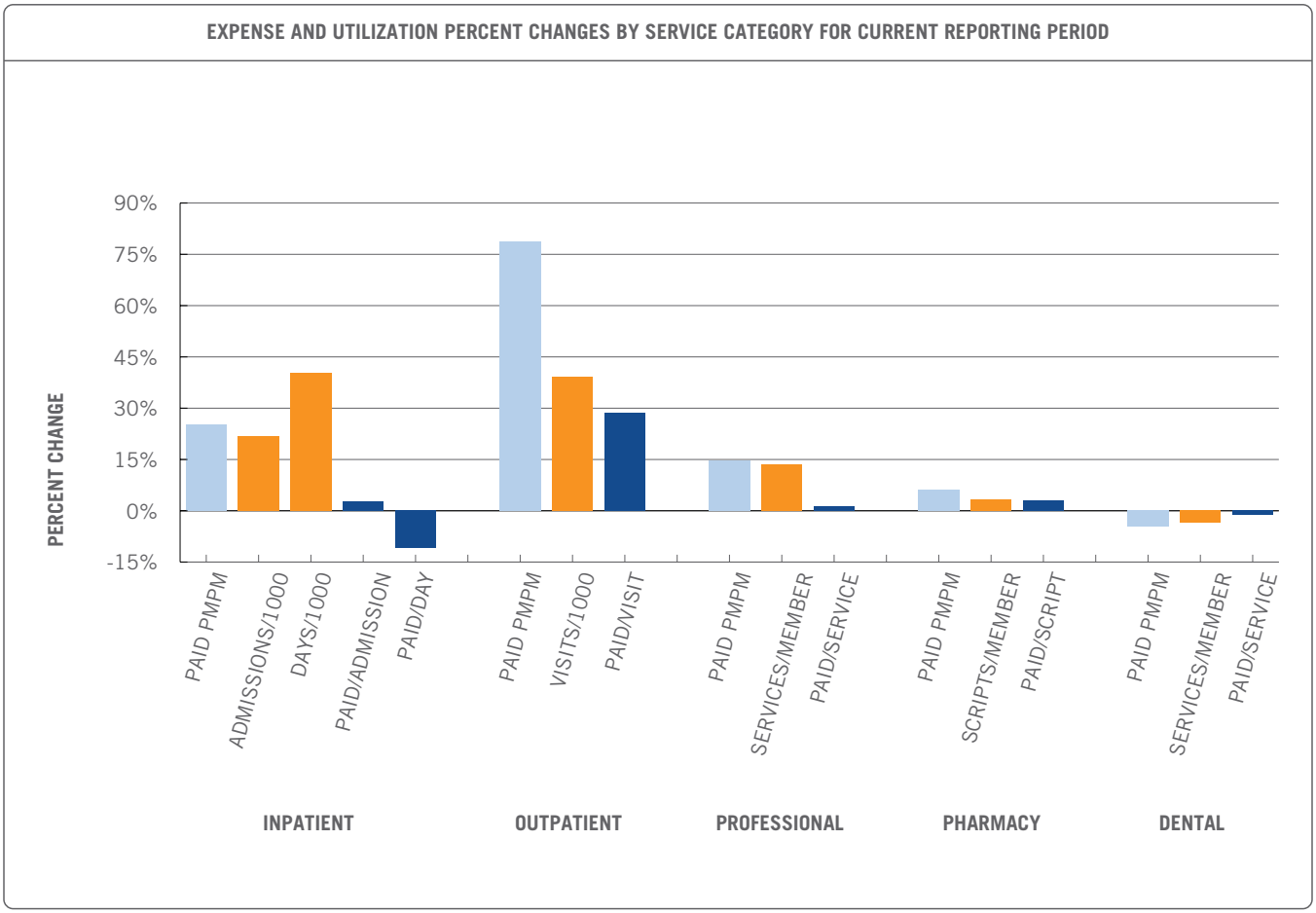
[1]The benchmark is age/gender adjusted.

KEY INDICATORS, CONTINUED

	ABC COMPANY - TIER 3				
	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
INPATIENT FACILITY UTILIZATION					
ADMISSIONS/1000	86.2	70.8	21.7%	73.1	18.0%
DAYS/1000	383.4	273.7	40.1%	322.5	18.9%
AVERAGE LENGTH OF STAY (ALOS)	4.4	3.9	15.1%	4.4	0.8%
PAID/ADMISSION	$11,956	$11,642	2.7%	$11,618	2.9%
PAID/DAY	$2,688	$3,012	-10.8%	$2,633	2.1%
IN-NETWORK PAID %	100.0%	89.3%	12.0%	98.6%	1.4%
OUTPATIENT FACILITY UTILIZATION					
VISITS/1000	1,697.2	1,220.2	39.1%	1,260.5	34.6%
PAID/VISIT	$889	$692	28.4%	$678	31.2%
IN-NETWORK PAID %	99.9%	89.7%	11.4%	98.6%	1.3%
EMERGENCY ROOM VISITS/1000	258.6	249.2	3.8%	219.3	17.9%
EMERGENCY ROOM PAID/VISIT	$913	$773	18.2%	$797	14.5%
PROFESSIONAL UTILIZATION					
VISITS/MEMBER	8.0	7.1	12.0%		
SERVICES/MEMBER	19.9	17.5	13.4%	20.0	-0.7%
PAID/VISIT	$132	$129	2.4%		
PAID/SERVICE	$53	$53	1.1%	$56	-5.3%
IN-NETWORK PAID %	97.4%	98.5%	-1.2%	98.7%	-1.3%
OFFICE VISITS/MEMBER	6.0	5.5	9.1%		
OFFICE SERVICES/MEMBER	14.8	13.4	10.8%	15.9	-7.1%
OFFICE PAID/VISIT	$106	$99	6.8%		
OFFICE PAID/SERVICE	$43	$40	5.2%	$45	-5.6%
PHARMACY UTILIZATION					
PRESCRIPTIONS/MEMBER	12.7	12.3	3.2%	11.2	12.9%
GENERIC DISPENSING RATE	63.0%	61.0%	3.4%	63.0%	0.1%
PAID/PRESCRIPTION	$59	$58	2.8%	$58	2.1%
DENTAL UTILIZATION					
SERVICES/MEMBER	2.7	2.8	-3.3%	3.3	-20.3%
PAID/SERVICE	$75	$76	-1.2%	$72	4.7%

KEY INDICATORS, CONTINUED





CHAPTER DESCRIPTION

This chapter presents information on key expense and utilization metrics for ABC Company - Tier 3, how they changed over time and how they compare with the benchmark.

This first group of reports focuses on ABC Company - Tier 3 inpatient facility admission experience. The first inpatient report details key statistics for maternity and non-maternity admissions (medical, surgical, mental health/substance abuse and non-acute) with percent change and benchmark comparisons. The second inpatient report lists the top ten inpatient providers ranked by number of admissions and by paid PMPM.

The second group of reports analyzes expense and utilization specifically related to visits provided in the outpatient facility setting for ABC Company - Tier 3. The first report presents outpatent expense and utilization by visit type with percent change and benchmark comparisions. The second report examines the top ten most frequent reasons for an outpatient emergency room visit, surgical procedure, and radiology service.

The last report encompasses all the services for ABC Company - Tier 3 provided by physicians and other clinicians, ancillary services and supplies. This report analyzes the expense and utilization of professional services by service type with percent change and benchmark comparisons.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.
Current reporting period represents claims incurred Nov'08 through Oct'09 and paid through Dec'09.
Prior reporting period represents claims incurred Nov'07 through Oct'08 and paid through Dec'08.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).
Benchmarks are based on BCBSTX's non-HMO book of business. The book of business includes groups between approximately 50 and 500 subscribers.

INPATIENT ADMISSION ANALYSIS

Report Description: Expense and utilization measures are displayed in the table below for the following admission categories: maternity, medical, mental health/substance abuse, non-acute, and surgical. Current reporting period, prior reporting period, and benchmark measures are analyzed in the table. Non-acute refers to admissions for rehabilitation, skilled nursing facilities, and hospice care. The paid amount is based on the inpatient facility component only. Inpatient professional statistics are not reported.

		ABC COMPANY - TIER 3				
SERVICE TYPE		NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
MEDICAL	ADMISSIONS/1000	29.6	24.5	20.7%	29.8	-0.5%
	DAYS/1000	96.5	88.5	9.0%	135.8	-28.9%
	AVERAGE LENGTH OF STAY	3.3	3.6	-9.7%	4.6	-28.5%
	PAID PMPM	$10.77	$10.82	-0.5%	$23.10	-53.4%
	PAID/ADMISSION	$4,366	$5,297	-17.6%	$9,317	-53.1%
	PAID/DAY	$1,339	$1,467	-8.7%	$2,042	-34.4%
SURGICAL	ADMISSIONS/1000	32.2	27.2	18.1%	24.1	33.6%
	DAYS/1000	189.1	130.7	44.7%	104.2	81.5%
	AVERAGE LENGTH OF STAY	5.9	4.8	22.5%	4.3	35.9%
	PAID PMPM	$65.13	$52.61	23.8%	$40.24	61.8%
	PAID/ADMISSION	$24,297	$23,179	4.8%	$20,055	21.2%
	PAID/DAY	$4,132	$4,829	-14.4%	$4,635	-10.8%
MATERNITY	ADMISSIONS/1000	18.0	15.0	20.3%	14.2	26.4%
	DAYS/1000	57.9	35.4	63.5%	37.7	53.7%
	AVERAGE LENGTH OF STAY	3.2	2.4	36.0%	2.6	21.5%
	PAID PMPM	$7.19	$3.97	81.3%	$4.65	54.6%
	PAID/ADMISSION	$4,793	$3,179	50.7%	$3,919	22.3%
	PAID/DAY	$1,491	$1,345	10.8%	$1,482	0.6%
MENTAL HEALTH/ SUBSTANCE ABUSE	ADMISSIONS/1000	5.1	1.4	278.0%	3.6	42.2%
	DAYS/1000	32.2	2.7	1081.1%	25.8	24.9%
	AVERAGE LENGTH OF STAY	6.3	2.0	212.5%	7.1	-12.2%
	PAID PMPM	$2.25	$0.12	1771.4%	$1.26	77.8%
	PAID/ADMISSION	$5,244	$1,059	395.1%	$4,191	25.1%
	PAID/DAY	$839	$530	58.4%	$589	42.4%
NON-ACUTE	ADMISSIONS/1000	1.3	2.7	-52.8%	1.4	-6.9%
	DAYS/1000	7.7	16.3	-52.8%	19.1	-59.6%
	AVERAGE LENGTH OF STAY	6.0	6.0	0.0%	13.8	-56.6%
	PAID PMPM	$0.55	$1.18	-53.2%	$1.50	-63.0%
	PAID/ADMISSION	$5,170	$5,220	-1.0%	$12,995	-60.2%
	PAID/DAY	$862	$870	-1.0%	$940	-8.3%
SUMMARY	ADMISSIONS/1000	86.2	70.8	21.7%	73.1	18.0%
	DAYS/1000	383.4	273.7	40.1%	322.5	18.9%
	AVERAGE LENGTH OF STAY	4.4	3.9	15.1%	4.4	0.8%
	PAID PMPM	$85.90	$68.70	25.0%	$70.76	21.4%
	PAID/ADMISSION	$11,956	$11,642	2.7%	$11,618	2.9%
	PAID/DAY	$2,688	$3,012	-10.8%	$2,633	2.1%

INPATIENT ADMISSION ANALYSIS, CONTINUED

Medical: Over the two reporting periods, ABC Company - Tier 3's expense (paid PMPM) remained stable, utilization (admissions/1,000) increased 20.7% and paid per admission decreased 17.6% for medical admissions. In addition, the average length of stay decreased 9.7%. Compared to the benchmark, ABC Company - Tier 3 had lower expenses, similar utilization, lower paid per admission and shorter length of stay.

Surgical: Over the two reporting periods, ABC Company - Tier 3's expense (paid PMPM) increased 23.8%, utilization (admissions/1,000) increased 18.1% and paid per admission increased 4.8% for surgical admissions. In addition, the average length of stay increased 22.5%. Compared to the benchmark, ABC Company - Tier 3 had higher expenses, higher utilization, higher paid per admission and longer length of stay.

Maternity: Over the two reporting periods, ABC Company - Tier 3's expense (paid PMPM) increased 81.3%, utilization (admissions/1,000) increased 20.3% and paid per admission increased 50.7% for maternity admissions. In addition, the average length of stay increased 36.0%. Compared to the benchmark, ABC Company - Tier 3 had higher expenses, higher utilization, higher paid per admission and longer length of stay.

Mental Health/Substance Abuse: Over the two reporting periods, ABC Company - Tier 3's expense (paid PMPM) increased 1771.4%, utilization (admissions/1,000) increased 278.0% and paid per admission increased 395.1% for mental health/substance abuse admissions. In addition, the average length of stay increased 212.5%. Compared to the benchmark, ABC Company - Tier 3 had higher expenses, higher utilization, higher paid per admission and shorter length of stay.

Non-Acute: Over the two reporting periods, ABC Company - Tier 3's expense (paid PMPM) decreased 53.2%, utilization (admissions/1,000) decreased 52.8% and paid per admission remained relatively stable for non-acute admissions. In addition, the average length of stay remained relatively stable. Compared to the benchmark, ABC Company - Tier 3 had lower expenses, lower utilization, lower paid per admission and shorter length of stay.

INPATIENT PROVIDER SUMMARY

Report Description: The provider listings below include top ten inpatient facility providers ranked by admissions and by paid for the current reporting period. Expense and utilization measures are featured in both listings.

TOP 10 INPATIENT FACILITY PROVIDERS BY ADMISSIONS FOR ABC COMPANY - TIER 3

PROVIDER NAME	PROVIDER STATE	ADMISSIONS	% OF TOTAL ADMISSIONS	DAYS	AVG LENGTH OF STAY	PAID/ ADMISSION	PAID	% OF TOTAL PAID
Provider 0000000961	XX	14	20.9%	70	5.0	$7,220	$101,079	12.6%
Provider 0000001173	XX	13	19.4%	38	2.9	$5,422	$70,485	8.8%
Provider 0000000738	XX	5	7.5%	54	10.8	$57,853	$289,263	36.1%
Provider 0000001058	XX	5	7.5%	13	2.6	$6,116	$30,578	3.8%
Provider 0000001591	XX	4	6.0%	16	4.0	$12,812	$51,246	6.4%
Provider 0000000517	XX	3	4.5%	8	2.7	$5,937	$17,811	2.2%
Provider 0000000577	XX	2	3.0%	5	2.5	$4,652	$9,304	1.2%
Provider 0000000737	XX	2	3.0%	8	4.0	$4,421	$8,842	1.1%
Provider 0000000751	XX	2	3.0%	8	4.0	$8,872	$17,744	2.2%
Provider 0000001715	XX	2	3.0%	19	9.5	$4,370	$8,740	1.1%
ALL OTHER		15	22.4%	59	3.9	$13,065	$195,978	24.5%
SUMMARY		67	100.0%	298	4.4	$11,956	$801,070	100.0%

TOP 10 INPATIENT FACILITY PROVIDERS BY PAID FOR ABC Company - Tier 3

PROVIDER NAME	PROVIDER STATE	ADMISSIONS	% OF TOTAL ADMISSIONS	DAYS	AVG LENGTH OF STAY	PAID/ ADMISSION	PAID	% OF TOTAL PAID
Provider 0000000738	XX	5	7.5%	54	10.8	$57,853	$289,263	36.1%
Provider 0000000961	XX	14	20.9%	70	5.0	$7,220	$101,079	12.6%
Provider 0000001417	XX	1	1.5%	23	23.0	$85,009	$85,009	10.6%
Provider 0000001173	XX	13	19.4%	38	2.9	$5,422	$70,485	8.8%
Provider 0000001591	XX	4	6.0%	16	4.0	$12,812	$51,246	6.4%
Provider 0000000750	XX	1	1.5%	3	3.0	$35,637	$35,637	4.4%
Provider 0000001058	XX	5	7.5%	13	2.6	$6,116	$30,578	3.8%
Provider 0000000517	XX	3	4.5%	8	2.7	$5,937	$17,811	2.2%
Provider 0000000751	XX	2	3.0%	8	4.0	$8,872	$17,744	2.2%
Provider 0000000536	XX	1	1.5%	1	1.0	$14,889	$14,889	1.9%
ALL OTHER		18	26.9%	64	3.6	$4,852	$87,329	10.9%
SUMMARY		67	100.0%	298	4.4	$11,956	$801,070	100.0%

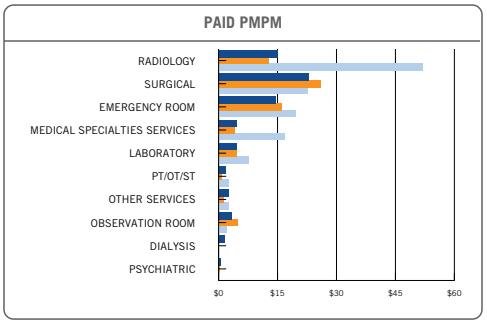
The top three inpatient facility providers that comprised 47.8% of the total admissions were Provider 0000000961, Provider 0000001173, and Provider 0000000738.

The top three inpatient facility providers that comprised 59.3% of the total paid were Provider 0000000738, Provider 0000000961, and Provider 0000001417.

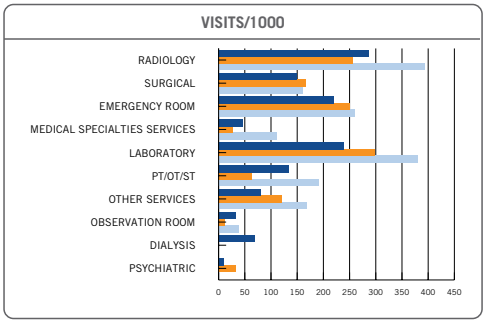
OUTPATIENT FACILITY VISIT TYPE ANALYSIS

Report Description: Outpatient facility expense and utilization measures are displayed in the table below by visit type. Current reporting period, prior reporting period, and benchmark measures are analyzed in the table. The visit type Other Services refers to all visits that could not be classified into other visit types that are displayed below.

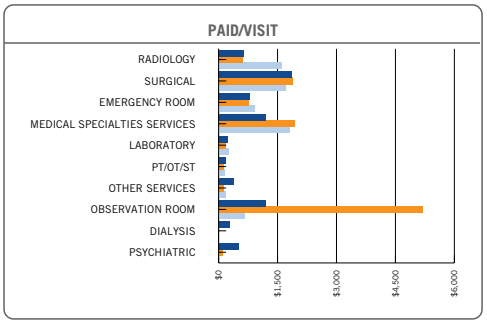
	ABC COMPANY - TIER 3				
PAID PMPM	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
RADIOLOGY	$51.98	$12.67	310.4%	$14.98	247.1%
SURGICAL	$22.63	$25.93	-12.7%	$23.00	-1.6%
EMERGENCY ROOM	$19.68	$16.04	22.7%	$14.57	35.1%
MEDICAL SPECIALTIES SERVICES	$16.70	$4.14	303.6%	$4.54	267.6%
LABORATORY	$7.62	$4.61	65.2%	$4.49	69.5%
PT/OT/ST	$2.53	$0.70	260.4%	$1.88	34.9%
OTHER SERVICES	$2.50	$1.34	87.1%	$2.50	0.2%
OBSERVATION ROOM	$2.04	$4.71	-56.6%	$3.25	-37.0%
DIALYSIS				$1.57	
PSYCHIATRIC		$0.25		$0.40	
SUMMARY	$125.69	$70.39	78.6%	$71.18	76.6%



	ABC COMPANY - TIER 3				
VISITS/1000	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
RADIOLOGY	392.5	254.7	54.1%	285.8	37.3%
SURGICAL	159.6	166.1	-4.0%	148.2	7.7%
EMERGENCY ROOM	258.6	249.2	3.8%	219.3	17.9%
MEDICAL SPECIALTIES SERVICES	110.7	25.9	327.7%	45.7	141.9%
LABORATORY	379.6	298.2	27.3%	237.6	59.7%
PT/OT/ST	190.4	62.6	204.0%	134.3	41.8%
OTHER SERVICES	168.6	119.8	40.7%	79.4	112.2%
OBSERVATION ROOM	37.3	10.9	242.5%	32.7	14.0%
DIALYSIS				67.8	
PSYCHIATRIC		32.7		9.6	
SUMMARY	1,697.2	1,220.2	39.1%	1,260.5	34.6%



	ABC COMPANY - TIER 3				
PAID/VISIT	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
RADIOLOGY	$1,590	$597	166.3%	$629	152.8%
SURGICAL	$1,702	$1,873	-9.1%	$1,863	-8.7%
EMERGENCY ROOM	$913	$773	18.2%	$797	14.5%
MEDICAL SPECIALTIES SERVICES	$1,811	$1,919	-5.6%	$1,192	52.0%
LABORATORY	$241	$186	29.8%	$227	6.1%
PT/OT/ST	$160	$135	18.6%	$168	-4.9%
OTHER SERVICES	$178	$134	33.0%	$378	-52.8%
OBSERVATION ROOM	$657	$5,183	-87.3%	$1,190	-44.8%
DIALYSIS				$278	
PSYCHIATRIC		$93		$496	
SUMMARY	$889	$692	28.4%	$678	31.2%



NOV'08-OCT'09 NOV'07-OCT'08 BENCHMARK

OUTPATIENT FACILITY VISIT TYPE ANALYSIS, CONTINUED

Expense: Overall, ABC Company - Tier 3's change in paid PMPM for outpatient facility visits was 78.6%, which was 76.6% above the benchmark. A comparison of paid PMPM by visit type shows that ambulatory surgery was comparable to the benchmark, emergency room was 35.1% above the benchmark and radiology was 247.1% above the benchmark.

Utilization: The change in outpatient facility visits/1,000 was 39.1%, which was 34.6% higher than the benchmark. A comparison of visits/1,000 by visit type shows that ambulatory surgery was 7.7% higher than the benchmark, emergency room was 17.9% higher than the benchmark and radiology was 37.3% higher than the benchmark.

Paid per Visit: The overall change in the paid per visit was 28.4% and was 31.2% higher than the benchmark. Paid per visit for emergency room was 14.5% higher than the benchmark, 8.7% lower than the benchmark for ambulatory surgery and 152.8% higher than the benchmark for radiology.

OUTPATIENT FACILITY VISIT TYPE DETAIL FOR EMERGENCY ROOM, AMBULATORY SURGERY AND RADIOLOGY

Report Description: In the first table, key utilization and expense metrics are displayed for the ten most frequent emergency room diagnoses in the current reporting period. The ambulatory surgery table shows key utilization and expense metrics for the ten most frequent diagnostic categories in the current reporting period. The last table displays key utilization and expense metrics for the most frequent outpatient radiology services in the current reporting period.

EMERGENCY ROOM - TOP 10 DIAGNOSIS BY VISITS FOR ABC COMPANY - TIER 3 FOR THE CURRENT REPORTING PERIOD

3-DIGIT PRINCIPAL DIAGNOSIS	VISITS/1000	% OF TOTAL VISITS/1000	PAID/VISIT	PAID PMPM	% OF TOTAL PAID PMPM
786 SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	23.2	9.0%	$1,210	$2.34	11.9%
789 OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	12.9	5.0%	$2,417	$2.59	13.2%
558 OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS	9.0	3.5%	$828	$0.62	3.2%
784 SYMPTOMS INVOLVING HEAD AND NECK	9.0	3.5%	$923	$0.69	3.5%
780 GENERAL SYMPTOMS	7.7	3.0%	$1,229	$0.79	4.0%
873 OTHER OPEN WOUND OF HEAD	7.7	3.0%	$952	$0.61	3.1%
346 MIGRAINE	6.4	2.5%	$908	$0.49	2.5%
535 GASTRITIS AND DUODENITIS	6.4	2.5%	$885	$0.47	2.4%
682 OTHER CELLULITIS AND ABSCESS	6.4	2.5%	$469	$0.25	1.3%
724 OTHER AND UNSPECIFIED DISORDERS OF BACK	6.4	2.5%	$718	$0.38	2.0%
ALL OTHER	163.4	63.2%	$767	$10.44	53.0%
SUMMARY	258.6	100.0%	$913	$19.68	100.0%

AMBULATORY SURGERY - TOP 10 DIAGNOSIS BY VISITS FOR ABC COMPANY - TIER 3 FOR THE CURRENT REPORTING PERIOD

ICD-9 DIAGNOSTIC CATEGORY	VISITS/1000	% OF TOTAL VISITS/1000	PAID/VISIT	PAID PMPM	% OF TOTAL PAID PMPM
DIGESTIVE	27.0	16.9%	$1,477	$3.33	14.7%
NEOPLASMS	19.3	12.1%	$2,353	$3.78	16.7%
GENITOURINARY	18.0	11.3%	$2,564	$3.85	17.0%
EYES	12.9	8.1%	$1,204	$1.29	5.7%
INJURY & POISONING	12.9	8.1%	$573	$0.61	2.7%
MUSCULOSKELETAL AND CONNECTIVE TISSUE	12.9	8.1%	$2,049	$2.20	9.7%
WITHOUT REPORTED DIAGNOSIS	9.0	5.6%	$1,010	$0.76	3.4%
CIRCULATORY	7.7	4.8%	$3,541	$2.28	10.1%
HEALTH SERVICES	6.4	4.0%	$2,645	$1.42	6.3%
BLOOD AND BLOOD-FORMING ORGANS	5.1	3.2%	$796	$0.34	1.5%
ALL OTHER	28.3	17.7%	$1,175	$2.77	12.2%
SUMMARY	159.6	100.0%	$1,702	$22.63	100.0%

OUTPATIENT FACILITY VISIT TYPE DETAIL FOR EMERGENCY ROOM, AMBULATORY SURGERY AND RADIOLOGY, CONTINUED

RADIOLOGY SERVICE CATEGORIES BY VISITS FOR ABC COMPANY - TIER 3 FOR THE CURRENT REPORTING PERIOD					
DETAILED SERVICE TYPE	VISITS/1000	% OF TOTAL VISITS/1000	PAID/VISIT	PAID PMPM	% OF TOTAL PAID PMPM
OTHER IMAGING	141.5	36.1%	$315	$3.72	7.1%
DIAGNOSTIC RADIOLOGY: OTHER	135.1	34.4%	$454	$5.11	9.8%
THERAPEUTIC RADIOLOGY	45.0	11.5%	$8,917	$33.46	64.4%
CT SCAN	43.7	11.1%	$1,515	$5.52	10.6%
MRI	20.6	5.2%	$1,548	$2.66	5.1%
NUCLEAR MEDICINE	5.1	1.3%	$1,569	$0.67	1.3%
ALL OTHER	1.3	0.3%	$7,863	$0.84	1.6%
SUMMARY	392.5	100.0%	$1,590	$51.98	100.0%

The top three diagnoses in terms of total ER visits were 786 Symptoms Involving Respiratory System And Other Chest Symptoms, 789 Other Symptoms Involving Abdomen And Pelvis, and 558 Other Noninfectious Gastroenteritis And Colitis. These diagnoses accounted for 17.4% of the total ER visits evaluated in this analysis.

The top five paid ambulatory surgical procedures accounted for 53.2% of the total ambulatory surgical visits and for 68.2% of the total ambulatory surgical expenses.

The top five paid radiology services accounted for 98.3% of the total radiology visits and for 97.1% of the total radiology expenses.

PROFESSIONAL SERVICE TYPE ANALYSIS

Report Description: Expense and utilization measures for professional services by service type are displayed in the table below. Current reporting period, prior reporting period, and benchmark measures are analyzed in the table.

	ABC COMPANY - TIER 3				
PAID PMPM	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
EVALUATION & MANAGEMENT	$21.57	$18.75	15.1%	$24.94	-13.5%
SURGICAL	$19.06	$17.43	9.4%	$15.20	25.4%
MEDICAL	$15.20	$9.15	66.1%	$14.76	3.0%
RADIOLOGY	$9.10	$8.69	4.7%	$9.05	0.6%
PATHOLOGY & LABORATORY	$8.55	$6.55	30.6%	$8.22	4.0%
MEDICAL SERVICES & SUPPLIES (HCPCS II)	$8.46	$10.48	-19.3%	$14.02	-39.7%
ANESTHESIA	$4.78	$4.33	10.5%	$4.90	-2.3%
PT/OT/ST	$1.26	$1.37	-8.4%	$2.51	-49.8%
OTHER	$0.04			$0.04	10.6%
SUMMARY	$88.03	$76.75	14.7%	$93.63	-6.0%

	ABC COMPANY - TIER 3				
SERVICES/1000	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
EVALUATION & MANAGEMENT	4,591.0	4,052.7	13.3%	4,606.1	-0.3%
SURGICAL	1,354.9	1,341.4	1.0%	1,424.0	-4.9%
MEDICAL	3,001.9	2,338.2	28.4%	3,399.8	-11.7%
RADIOLOGY	1,777.0	1,630.0	9.0%	1,548.8	14.7%
PATHOLOGY & LABORATORY	6,797.8	5,703.1	19.2%	6,176.9	10.1%
MEDICAL SERVICES & SUPPLIES (HCPCS II)	1,464.3	1,406.7	4.1%	1,376.7	6.4%
ANESTHESIA	164.7	152.5	8.0%	147.8	11.5%
PT/OT/ST	719.3	896.1	-19.7%	1,325.6	-45.7%
OTHER	3.9			9.3	-58.5%
SUMMARY	19,874.8	17,520.7	13.4%	20,014.9	-0.7%

	ABC COMPANY - TIER 3				
PAID/SERVICE	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE	BENCHMARK	% VARIANCE
EVALUATION & MANAGEMENT	$56	$56	1.6%	$65	-13.2%
SURGICAL	$169	$156	8.3%	$128	31.8%
MEDICAL	$61	$47	29.3%	$52	16.7%
RADIOLOGY	$61	$64	-3.9%	$70	-12.4%
PATHOLOGY & LABORATORY	$15	$14	9.6%	$16	-5.5%
MEDICAL SERVICES & SUPPLIES (HCPCS II)	$69	$89	-22.5%	$122	-43.3%
ANESTHESIA	$348	$341	2.3%	$398	-12.4%
PT/OT/ST	$21	$18	14.1%	$23	-7.4%
OTHER	$131			$49	166.7%
SUMMARY	$53	$53	1.1%	$56	-5.3%

Expense: Over the current reporting period, ABC Company - Tier 3's top three paid service types were Evaluation & Management, Surgical and Medical.

Utilization: The highest utilized service type was Pathology & Laboratory which was 10.1% higher than the benchmark. Next was Evaluation & Management which was comparable to the benchmark, followed by Medical.

Paid per Service: The most expensive service type was Anesthesia which was 12.4% lower than the benchmark. Next was Surgical which was 31.8% higher than the benchmark, followed by Other.

CHAPTER DESCRIPTION

Pharmacy includes all outpatient, non-professional prescription drug services provided to ABC Company - Tier 3's members. These services are categorized into generic, brand formulary, brand non-formulary, specialty drugs, and self-administered drugs. Once the patent for a brand drug expires, a generic version of the drug which is the same chemically as the brand version can be available at cheaper prices. Generic drugs are less expensive because generic manufacturers do not have the investment expenses of a new drug developer. When appropriate, plan sponsors encourage the use of generics over brand drugs. Formulary brand drugs are those that appear on the plan's approved list of brands. Non-formulary brand drugs are all other brand drugs which generally have equally effective and less expensive generic equivalents and/or have one or more formulary options. Specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies.

This chapter presents information on key expense and utilization metrics for prescription drugs. These metrics are provided on a paid basis with compression logic applied, consequently the report will not balance back to BARS. When available, metrics for the current reporting month are compared to the year to date.

Prescription drugs are classified by therapeutic class. Number of prescriptions, total paid by plan, and whether generic or formulary is presented for the top 25 therapeutic drug classes. Descriptive information on the top 25 prescription drugs is also provided based on number of prescriptions, total paid by plan, and whether generic or formulary.

A report on Specialty drugs is included showing key expense and utilization metrics.

Data Note

Current reporting month represents claims paid in Dec'09.
Year to date represents claims paid from Apr'09 through Dec'09.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).

SUMMARY OF FINDINGS

Generic drugs were dispensed at a(n) 62.2% rate in the current reporting month. Increasing the generic dispensing rate by 2% points would result in a savings of $22,320 for ABC Company - Tier 3 for the year to date.

Multisource brand (brands with an exact generic equivalent) utilization was 2.1% for the year to date.

The top therapeutic classes, based on total ingredient cost in the year to date were Proton Pump Inhibitors, HMG CoA Reductase Inhibitors, and Antihypertensive Combinations. The top prescription drugs, based on total ingredient cost, were Enbrel, Avonex, and Crestor in the year to date. These drugs accounted for 11.7% of the total ingredient cost amount.

The number of members utilizing specialty medication for the year to date was 7. These 7 members received 41 specialty medications which represented 15.4% of the total pharmacy paid amount for the year to date. The top specialty drugs, based on total ingredient cost were Enbrel, Avonex, and Simponi in the year to date. These drugs accounted for 87.1% of the total ingredient cost amount. The top specialty pharmacy drug classes represented were Arthritis & Skin, Multiple Sclerosis, and High Cost Others for the year to date.

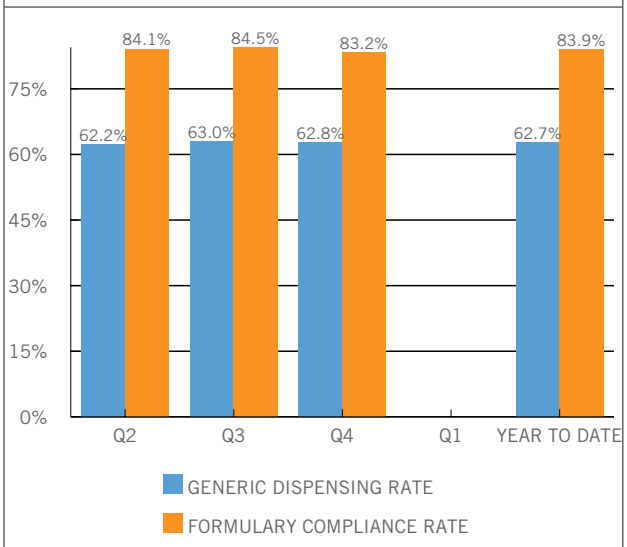
KEY INDICATORS SUMMARY

Report Description: This report provides an overview of ABC Company - Tier 3's prescription expenses and utilization as well as providing percent change in these expenses between the current reporting month and year to date periods.

ABC COMPANY - TIER 3

KEY INDICATORS SUMMARY	DEC'09	YEAR TO DATE
UNIQUE PHARMACY MEMBERS	776	977
CLAIMANTS	318	664
PERCENT OF UTILIZING MEMBERS	41.0%	68.0%
PRESCRIPTIONS	829	7,530
PRESCRIPTIONS PMPM	1.1	1.1
PAID	$52,239	$440,261
PAID PMPM	$67.32	$63.45
AVERAGE INGREDIENT COST/PRESCRIPTION	$80.20	$75.93
GENERIC DISPENSING RATE	62.2%	62.7%
FORMULARY COMPLIANCE RATE	83.0%	83.9%
GENERIC SUBSTITUTION RATE	97.2%	96.8%
OUT OF POCKET PERCENT OF ALLOWED	22.9%	24.5%
RETAIL AS A PERCENT OF PRESCRIPTIONS	99.5%	99.8%
MAIL ORDER AS A PERCENT OF PRESCRIPTIONS	0.5%	0.2%
SPECIALTY AS A PERCENT OF PAID	16.9%	15.4%

GENERIC DISPENSING AND FORMULARY COMPLIANCE RATES[1]



ABC COMPANY - TIER 3

SAVINGS SUMMARY	DEC'09			YEAR TO DATE		
	RETAIL	MAIL ORDER	SUMMARY	RETAIL	MAIL ORDER	SUMMARY
TOTAL PHARMACY DISCOUNT	$30,502	$326	$30,829	$293,673	$1,550	$295,223
MAC PROGRAM SAVINGS	$23,778	$119	$23,896	$219,097	$341	$219,438
PHARMACY DISCOUNT %	31.2%	38.3%	31.2%	33.6%	36.8%	33.6%

ABC COMPANY - TIER 3

COST SHARING DISTRIBUTION	DEC'09		YEAR TO DATE	
	RETAIL	MAIL ORDER	RETAIL	MAIL ORDER
MEMBER: OUT OF POCKET	22.8%	36.3%	24.4%	36.3%
PLAN: PAID	77.1%	63.7%	75.4%	63.7%

[1]When displaying quarterly information, the first and last month of the reported quarters may have incomplete quarterly data.

KEY INDICATORS SUMMARY, CONTINUED

During the current reporting month there were 829 prescriptions dispensed for ABC Company - Tier 3's members. The total amount paid for these prescriptions was $52,239.

Overall current reporting month pharmacy paid PMPM was $67.32. Pharmacy paid PMPM was $63.45 for the year to date.

ABC Company - Tier 3's overall ingredient cost per prescription was $80.20 in the current reporting month. The year to date ingredient cost per prescription was $75.93.

Generic drugs represented 62.2% of all claims in the current reporting month and 62.7% for the year to date. Formulary drugs represented 83.0% for the current reporting month and 83.9% for the year to date.

For the curent reporting month, members' out of pocket contribution was 22.9% to their prescription drug costs through any applicable copay, coinsurance or deductible amounts. For the year to date the members' out of pocket contribution was 24.5%. At retail the members' share is 22.8% during the current reporting month, while at mail it is 36.3%. For the year to date at retail the members' share is 24.4%, while at mail it is 36.3%.

Mail Order claims represent 0.5% of total prescriptions for the current reporting month and 0.2% for the year to date.

Specialty pharmacy claims represented 16.9% of amount paid during the current reporting month and 15.4% for the year to date.

GENERIC VERSUS FORMULARY EXPERIENCE

Report Description: For the year to date, ABC Company - Tier 3's prescription drug expenses are displayed below for retail and mail order providers and broken out by drug type and formulary indicator. The brand type is broken down by single-source and multi-source. In addition, the total expense for each category is shown by the member and the plan.

			TOTAL EXPENSE		MEMBER EXPENSE		PLAN EXPENSE	
RETAIL PRESCRIPTIONS	PRESCRIPTIONS	% OF TOTAL PRESCRIPTIONS	ALLOWED	ALLOWED/ PRESCRIPTION	OUT OF POCKET	OUT OF POCKET/ PRESCRIPTION	PAID	PAID/ PRESCRIPTION
GENERIC	4,710	62.7%	$104,828	$22.26	$40,363	$8.57	$64,464	$13.69
BRAND	2,806	37.3%	$476,497	$169.81	$101,644	$36.22	$374,101	$133.32
SUMMARY	7,516	100.0%	$581,325	$77.34	$142,007	$18.89	$438,566	$58.35
BRAND TYPE BREAKDOWN:								
SINGLE SOURCE BRAND	2,651	35.3%	$461,390	$174.04	$96,562	$36.42	$364,828	$137.62
MULTI-SOURCE BRAND	155	2.1%	$15,107	$97.46	$5,082	$32.79	$9,273	$59.83
MULTI-SOURCE BRAND W/DAW1	58	0.8%	$7,078	$122.04	$1,960	$33.80	$5,118	$88.24
BRAND FORMULARY	1,600	21.3%	$320,116	$200.07	$47,657	$29.79	$272,341	$170.21
BRAND NON-FORMULARY	1,206	16.0%	$156,381	$129.67	$53,986	$44.76	$101,760	$84.38

			TOTAL EXPENSE		MEMBER EXPENSE		PLAN EXPENSE	
MAIL ORDER PRESCRIPTIONS	PRESCRIPTIONS	% OF TOTAL PRESCRIPTIONS	ALLOWED	ALLOWED/ PRESCRIPTION	OUT OF POCKET	OUT OF POCKET/ PRESCRIPTION	PAID	PAID/ PRESCRIPTION
GENERIC	8	57.1%	$155	$19.32	$126	$15.72	$29	$3.59
BRAND	6	42.9%	$2,506	$417.70	$840	$140.00	$1,666	$277.70
SUMMARY	14	100.0%	$2,661	$190.05	$966	$68.99	$1,695	$121.07
BRAND TYPE BREAKDOWN:								
SINGLE SOURCE BRAND	6	42.9%	$2,506	$417.70	$840	$140.00	$1,666	$277.70
MULTI-SOURCE BRAND								
MULTI-SOURCE BRAND W/DAW1								
BRAND FORMULARY								
BRAND NON-FORMULARY	6	42.9%	$2,506	$417.70	$840	$140.00	$1,666	$277.70

			TOTAL EXPENSE		MEMBER EXPENSE		PLAN EXPENSE	
TOTAL PRESCRIPTIONS	PRESCRIPTIONS	% OF TOTAL PRESCRIPTIONS	ALLOWED	ALLOWED/ PRESCRIPTION	OUT OF POCKET	OUT OF POCKET/ PRESCRIPTION	PAID	PAID/ PRESCRIPTION
GENERIC	4,718	62.7%	$104,982	$22.25	$40,489	$8.58	$64,493	$13.67
BRAND	2,812	37.3%	$479,003	$170.34	$102,484	$36.45	$375,767	$133.63
SUMMARY	7,530	100.0%	$583,986	$77.55	$142,973	$18.99	$440,261	$58.47
BRAND TYPE BREAKDOWN:								
SINGLE SOURCE BRAND	2,657	35.3%	$463,896	$174.59	$97,402	$36.66	$366,495	$137.94
MULTI-SOURCE BRAND	155	2.1%	$15,107	$97.46	$5,082	$32.79	$9,273	$59.83
MULTI-SOURCE BRAND W/DAW1	58	0.8%	$7,078	$122.04	$1,960	$33.80	$5,118	$88.24
BRAND FORMULARY	1,600	21.2%	$320,116	$200.07	$47,657	$29.79	$272,341	$170.21
BRAND NON-FORMULARY	1,212	16.1%	$158,887	$131.10	$54,826	$45.24	$103,426	$85.34

TOP THERAPEUTIC DRUG CLASSES

Report Description: The top 25 therapeutic drug classes for the year to date are displayed below ranked by ingredient cost.

ABC COMPANY - TIER 3

TOP 25 THERAPEUTIC DRUG CLASSES BY INGREDIENT COST

	PLAN THERAPEUTIC CLASS	PRESCRIPTIONS	INGREDIENT COST	% OF TOTAL INGREDIENT COST	AVG INGREDIENT COST/ PRESCRIPTION	% FORMULARY	% GENERIC	RANK BY VOLUME
1	PROTON PUMP INHIBITORS	241	$36,916	6.5%	$153.18	70.1%	29.5%	6
2	HMG COA REDUCTASE INHIBITORS	408	$34,904	6.1%	$85.55	76.0%	39.0%	1
3	ANTIHYPERTENSIVE COMBINATIONS	386	$25,578	4.5%	$66.26	74.1%	50.5%	2
4	SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS	15	$24,201	4.2%	$1,613.40	100.0%	0.0%	93
5	MULTIPLE SCLEROSIS AGENTS	10	$23,739	4.2%	$2,373.88	100.0%	0.0%	111
6	INSULIN	89	$21,168	3.7%	$237.84	97.8%	0.0%	26
7	HEPARINS AND HEPARINOID-LIKE AGENTS	8	$14,177	2.5%	$1,772.09	100.0%	0.0%	118
8	PLATELET AGGREGATION INHIBITORS	76	$13,858	2.4%	$182.34	100.0%	0.0%	33
9	ANTI-TNF-ALPHA - MONOCLONOAL ANTIBODIES	7	$12,423	2.2%	$1,774.73	0.0%	0.0%	121
10	AMPHETAMINES	78	$12,337	2.2%	$158.17	46.2%	46.2%	31
11	SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)	88	$11,820	2.1%	$134.32	27.3%	3.4%	27
12	COMBINATION CONTRACEPTIVES - ORAL	280	$11,669	2.0%	$41.67	87.1%	68.6%	4
13	SYMPATHOMIMETICS	119	$11,395	2.0%	$95.76	81.5%	15.1%	17
14	ANGIOTENSIN II RECEPTOR ANTAGONISTS	139	$10,730	1.9%	$77.19	52.5%	0.0%	13
15	INSULIN SENSITIZING AGENTS	47	$10,054	1.8%	$213.92	100.0%	0.0%	42
16	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	215	$10,013	1.8%	$46.57	99.5%	57.2%	7
17	HEPATITIS AGENTS	10	$8,897	1.6%	$889.66	100.0%	10.0%	110
18	LEUKOTRIENE MODULATORS	64	$8,562	1.5%	$133.78	100.0%	0.0%	35
19	ANTIDIABETIC COMBINATIONS	89	$8,417	1.5%	$94.58	67.4%	56.2%	25
20	ANTIPSORIATICS	9	$8,246	1.4%	$916.21	100.0%	0.0%	114
21	NON-BARBITURATE HYPNOTICS	84	$8,103	1.4%	$96.47	39.3%	39.3%	30
22	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	200	$7,940	1.4%	$39.70	97.5%	81.0%	9
23	FIBRIC ACID DERIVATIVES	84	$7,333	1.3%	$87.29	91.7%	28.6%	29
24	ANTICONVULSANTS - MISC.	106	$7,238	1.3%	$68.28	76.4%	71.7%	20
25	CALCIUM REGULATORS - MISC.	23	$7,134	1.2%	$310.18	91.3%	39.1%	71
	ALL OTHER	4,655	$214,888	37.6%	$46.16	87.5%	76.6%	
	SUMMARY	7,530	$571,739	100.0%	$75.93	83.9%	62.7%	

The top three therapeutic drug classes based on ingredient cost for ABC Company - Tier 3 were Proton Pump Inhibitors, HMG CoA Reductase Inhibitors, and Antihypertensive Combinations. Together these therapeutic classes accounted for 17.0% of the total ingredient cost and 13.7% of all prescriptions for year to date.

The top three therapeutic drug classes based on volume for ABC Company - Tier 3 were HMG CoA Reductase Inhibitors, Antihypertensive Combinations, and Opioid Combinations. Together these prescription drugs accounted for 15.2% of all prescriptions for the year to date.

TOP PRESCRIPTION DRUGS

Report Description: The top 25 prescription drugs for the year to date are displayed below ranked by ingredient cost.

ABC COMPANY - TIER 3

TOP 25 PRESCRIPTION DRUGS BY INGREDIENT COST

	BRAND NAME	PLAN THERAPEUTIC CLASS	PRESCRIPTIONS	INGREDIENT COST	% OF TOTAL INGREDIENT COST	AVG INGREDIENT COST/ PRESCRIPTION	FORMULARY INDICATOR	GENERIC INDICATOR	RANK BY VOLUME
1	ENBREL	SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS	15	$24,201	4.2%	$1,613.40	YES	NO	132
2	AVONEX	MULTIPLE SCLEROSIS AGENTS	10	$23,739	4.2%	$2,373.88	YES	NO	178
3	CRESTOR	HMG COA REDUCTASE INHIBITORS	150	$18,747	3.3%	$124.98	YES	NO	3
4	NEXIUM	PROTON PUMP INHIBITORS	98	$17,516	3.1%	$178.74	YES	NO	8
5	LOVENOX	HEPARINS AND HEPARINOID-LIKE AGENTS	8	$14,177	2.5%	$1,772.09	YES	NO	220
6	PLAVIX	PLATELET AGGREGATION INHIBITORS	76	$13,858	2.4%	$182.34	YES	NO	14
7	SIMPONI	ANTI-TNF-ALPHA - MONOCLONOAL ANTIBODIES	7	$12,423	2.2%	$1,774.73	NO	NO	244
8	LIPITOR	HMG COA REDUCTASE INHIBITORS	90	$11,113	1.9%	$123.48	NO	NO	12
9	ACTOS	INSULIN SENSITIZING AGENTS	44	$9,457	1.7%	$214.92	YES	NO	33
10	LEXAPRO	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	91	$8,670	1.5%	$95.28	YES	NO	11
11	SINGULAIR	LEUKOTRIENE MODULATORS	64	$8,562	1.5%	$133.78	YES	NO	17
12	SORIATANE CK	ANTIPSORIATICS	9	$8,246	1.4%	$916.21	YES	NO	209
13	CYMBALTA	SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)	51	$7,373	1.3%	$144.56	NO	NO	21
14	ACIPHEX	PROTON PUMP INHIBITORS	34	$6,932	1.2%	$203.89	NO	NO	59
15	PANTOPRAZOLE SODIUM	PROTON PUMP INHIBITORS	63	$6,577	1.2%	$104.40	YES	YES	18
16	SEROQUEL	DIBENZAPINES	21	$6,352	1.1%	$302.48	YES	NO	100
17	AMBIEN CR	NON-BARBITURATE HYPNOTICS	42	$6,331	1.1%	$150.73	NO	NO	36
18	JANUVIA	DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS	35	$6,245	1.1%	$178.43	NO	NO	56
19	CELEBREX	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	33	$6,051	1.1%	$183.37	YES	NO	61
20	FORTEO	CALCIUM REGULATORS - MISC.	7	$5,836	1.0%	$833.75	YES	NO	231
21	BARACLUDE	HEPATITIS AGENTS	8	$5,823	1.0%	$727.91	YES	NO	214
22	ADVAIR DISKUS	SYMPATHOMIMETICS	29	$5,805	1.0%	$200.18	YES	NO	73
23	TRICOR	FIBRIC ACID DERIVATIVES	46	$5,473	1.0%	$118.97	YES	NO	28
24	AMLODIPINE BESYLATE-BENAZEPRIL	ANTIHYPERTENSIVE COMBINATIONS	50	$5,443	1.0%	$108.85	YES	YES	22
25	BYETTA	INCRETIN MIMETIC AGENTS	20	$5,009	0.9%	$250.47	NO	NO	105
	ALL OTHER	ALL OTHER	6,429	$321,780	56.3%	$50.05			
	SUMMARY		7,530	$571,739	100.0%	$75.93			

The top three prescription drugs based on ingredient cost for ABC Company - Tier 3 were Enbrel, Avonex, and Crestor. Together these prescription drugs accounted for 11.7% of the total ingredient cost and 2.3% of all prescriptions for the year to date.

The top three prescription drugs based on volume for ABC Company - Tier 3 were Hydrocodone-Acetaminophen, Lisinopril, and Crestor. Together these prescription drugs accounted for 7.9% of all prescriptions for the year to date.

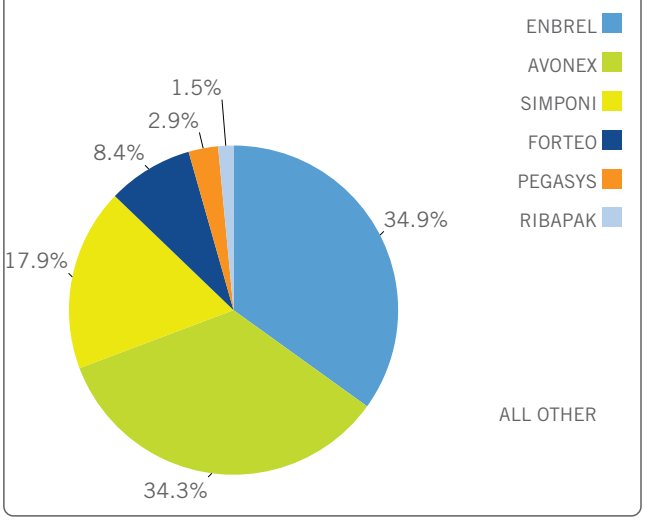
SPECIALTY DRUG ANALYSIS

Report Description: Specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies. The report below shows ABC Company - Tier 3's prescription drug utilization and expenses for the current reporting month and year to date.

ABC COMPANY - TIER 3

KEY INDICATORS SUMMARY	DEC'09	YEAR TO DATE
UNIQUE PHARMACY MEMBERS	776	977
SPECIALTY CLAIMANTS	5	7
PERCENT OF UTILIZING MEMBERS	0.6%	0.7%
PRESCRIPTIONS	5	41
PRESCRIPTIONS PMPM	0.0	0.0
PERCENT OF TOTAL PRESCRIPTIONS PAID	0.6%	0.5%
PLAN EXPENSE: PAID	$8,826	$68,014
PLAN EXPENSE: PAID PMPM	$11.37	$9.80
AVERAGE INGREDIENT COST/PRESCRIPTION	$1,797	$1,690
MEMBER EXPENSE: OUT OF POCKET	$165	$1,305
MEMBER EXPENSE: OUT OF POCKET PMPM	$0.21	$0.19
OUT OF POCKET PERCENT OF ALLOWED	1.8%	1.9%

TOP SPECIALTY DRUGS BY INGREDIENT COST FOR THE YEAR TO DATE



ABC COMPANY - TIER 3

TOP 10 SPECIALTY DRUGS BY INGREDIENT COST FOR THE YEAR TO DATE

BRAND NAME	SPECIALTY CLASS	INGREDIENT COST	PRESCRIPTIONS	AVG INGREDIENT COST/ PRESCRIPTION	SPECIALTY CLAIMANTS
ENBREL	ARTHRITIS & SKIN	$24,201	15	$1,613	3
AVONEX	MULTIPLE SCLEROSIS	$23,739	10	$2,374	1
SIMPONI	ARTHRITIS & SKIN	$12,423	7	$1,775	1
FORTEO	HIGH COST OTHERS	$5,836	7	$834	1
PEGASYS	HEPATITIS C	$2,037	1	$2,037	1
RIBAPAK	HEPATITIS C	$1,036	1	$1,036	1
ALL OTHER	ALL OTHER				
SUMMARY		$69,272	41	$1,690	7

The number of members utilizing specialty medication for the year to date was 7. These 7 members received 41 specialty medications which represented 15.4% of the total pharmacy paid amount for the year to date. The overall specialty pharmacy paid PMPM was $11.37 for the current reporting month and $9.80 for the year to date. The average cost of a specialty medication was $1,797 during the current reporting month and $1,690 for the year to date.

The top three specialty drugs based on ingredient cost for ABC Company - Tier 3 were Enbrel, Avonex, and Simponi. Together these specialty drugs accounted for 87.1% of the total ingredient cost and 78.0% of all specialty prescriptions in the year to date.

CHAPTER DESCRIPTION

This chapter provides dental utilization and enrollment information for ABC Company - Tier 3.The report presents services/1,000, paid PMPM amounts and paid per service by dental service type based on 12-month rolling incurred periods. This breakdown provides a high level view of what service types are driving expenses and potentially highlights areas for further attention. In addition to showing ABC Company - Tier 3's percent change for the two reporting periods, benchmark data for the service types is also included.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.
Current reporting period represents claims incurred Nov'08 through Oct'09 and paid through Dec'09.
Prior reporting period represents claims incurred Nov'07 through Oct'08 and paid through Dec'08.
Claims for active, retiree under 65, retiree 65 and over, and COBRA members are reported (if available).
Benchmarks are based on BCBSTX's non-HMO book of business. The book of business includes groups between approximately 50 and 500 subscribers.

SUMMARY OF FINDINGS

Overall total payments decreased 5.4% from the prior reporting period.

40.5% of paid expenses were concentrated in preventive and diagnostic procedures categories. 14.7% of paid expenses were preventive and 25.8% were diagnostic.

The average claim payment was $75, compared to the prior reporting period average of $76.

DENTAL SERVICE TYPE ANALYSIS

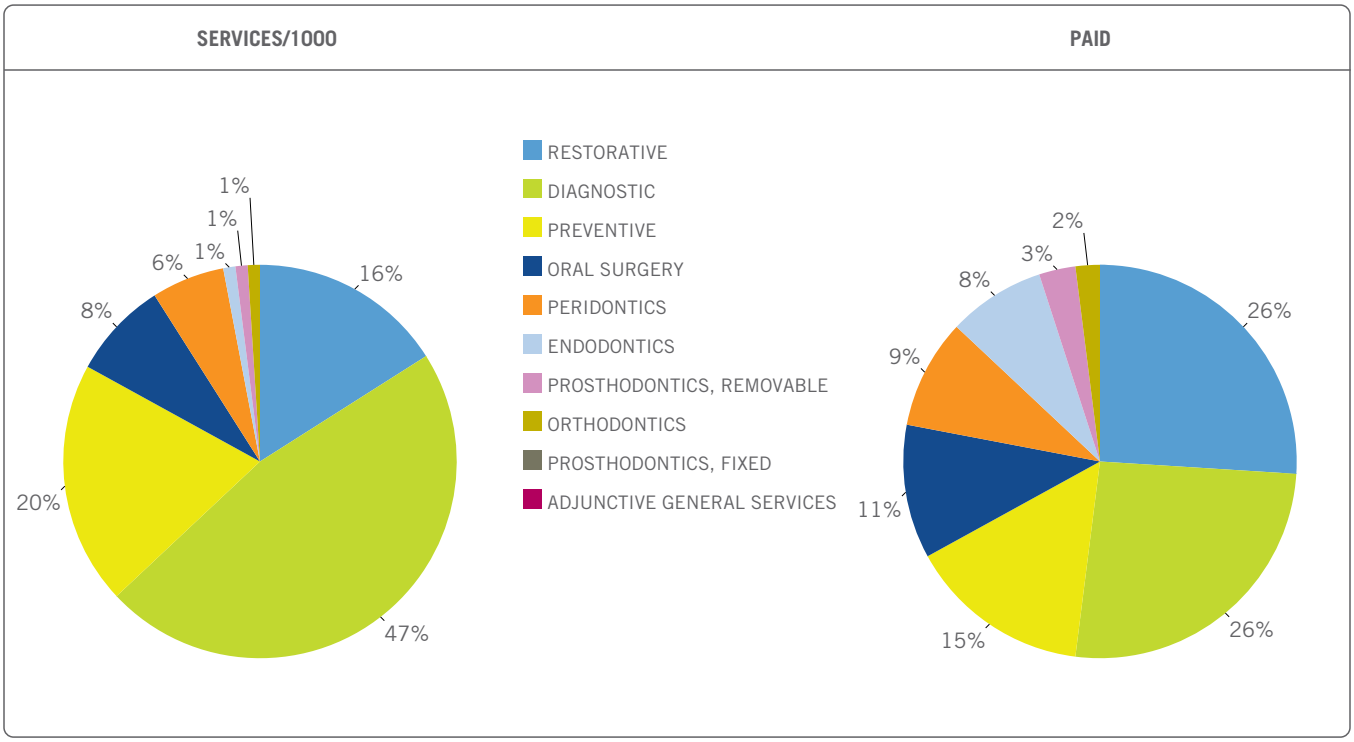
Report Description: Overall expense and utilization are displayed below for the top 10 dental service types by paid PMPM for the current and prior reporting periods. An analysis of percent change and comparison to the benchmark are provided for each dental service type. The pie graphs display the percentage of services/1,000 and paid amount for the current reporting period.

ABC COMPANY - TIER 3			
	NOV'08-OCT'09	NOV'07-OCT'08	% CHANGE
AVERAGE DENTAL MEMBERS	660	666	-1.0%

	ABC COMPANY - TIER 3									
	NOV'08-OCT'09		NOV'07-OCT'08		% CHANGE		BENCHMARK		% VARIANCE	
SERVICE TYPE	SERVICES/ 1000	PAID/ SERVICE	SERVICES/ 1000	PAID/ SERVICE	SERVICES/ 1000	PAID/ SERVICE	SERVICES/ 1000	PAID/ SERVICE	SERVICES/ 1000	PAID/ SERVICE
RESTORATIVE	422.9	$123	507.4	$119	-16.7%	3.1%	512.6	$133	-17.5%	-7.1%
DIAGNOSTIC	1,238.5	$42	1,250.6	$41	-1.0%	1.8%	1,508.4	$38	-17.9%	8.4%
PREVENTIVE	521.5	$56	468.4	$55	11.3%	1.5%	852.1	$53	-38.8%	6.4%
ORAL SURGERY	203.1	$112	195.2	$88	4.1%	26.9%	148.3	$115	37.0%	-2.9%
PERIDONTICS	169.8	$102	192.2	$102	-11.6%	0.1%	118.5	$107	43.3%	-4.1%
ENDODONTICS	36.4	$452	36.0	$511	1.0%	-11.5%	44.1	$383	-17.5%	18.2%
PROSTHODONTICS, REMOVABLE	28.8	$202	28.5	$286	1.0%	-29.3%	12.6	$290	128.8%	-30.3%
ORTHODONTICS	22.7	$170	61.6	$88	-63.1%	92.8%	101.5	$122	-77.6%	39.1%
PROSTHODONTICS, FIXED	4.5	$36	6.0	$375	-24.3%	-90.4%	10.6	$255	-57.1%	-85.9%
ADJUNCTIVE GENERAL SERVICES	10.6	$5	4.5	$0	135.6%		27.6	$71	-61.5%	-92.7%
ALL OTHER							1.8	$428		
SUMMARY	2,658.9	$75	2,750.4	$76	-3.3%	-1.2%	3,338.1	$72	-20.3%	4.7%

	ABC COMPANY - TIER 3							
	NOV'08-OCT'09		NOV'07-OCT'08		% CHANGE		BENCHMARK	% VARIANCE
SERVICE TYPE	PAID	PAID PMPM	PAID	PAID PMPM	PAID	PAID PMPM	PAID PMPM	PAID PMPM
RESTORATIVE	$34,355	$4.34	$40,370	$5.05	-14.9%	-14.1%	$5.66	-23.4%
DIAGNOSTIC	$33,918	$4.28	$33,971	$4.25	-0.2%	0.8%	$4.82	-11.0%
PREVENTIVE	$19,283	$2.44	$17,233	$2.16	11.9%	13.0%	$3.74	-34.9%
ORAL SURGERY	$14,945	$1.89	$11,426	$1.43	30.8%	32.1%	$1.42	33.0%
PERIDONTICS	$11,474	$1.45	$13,096	$1.64	-12.4%	-11.5%	$1.06	37.4%
ENDODONTICS	$10,850	$1.37	$12,260	$1.53	-11.5%	-10.6%	$1.41	-2.5%
PROSTHODONTICS, REMOVABLE	$3,841	$0.49	$5,433	$0.68	-29.3%	-28.6%	$0.30	59.5%
ORTHODONTICS	$2,556	$0.32	$3,622	$0.45	-29.5%	-28.8%	$1.04	-68.8%
PROSTHODONTICS, FIXED	$108	$0.01	$1,500	$0.19	-92.8%	-92.7%	$0.23	-94.0%
ADJUNCTIVE GENERAL SERVICES	$36	$0.00	$0	$0.00			$0.16	-97.2%
ALL OTHER							$0.06	
SUMMARY	$131,365	$16.59	$138,911	$17.38	-5.4%	-4.5%	$19.89	-16.6%

DENTAL SERVICE TYPE ANALYSIS, CONTINUED



Expense: Overall, ABC Company - Tier 3's change in paid PMPM for dental service visits was -4.5% and was lower than the benchmark. A comparison of paid PMPM by dental visit type showed that Restorative was lower than the benchmark, Diagnostic was lower than the benchmark, and Preventive was lower than the benchmark.

Utilization: The change in overall dental services/1,000 was -3.3% and was lower than the benchmark. A comparison of services/1,000 by service type showed that Restorative was lower than the benchmark, Diagnostic was lower than the benchmark, and Preventive was lower than the benchmark.

Allowed: Amount considered eligible for payment by the plan

Allowed/Claimant: Amount considered eligible for payment by the plan per claimant. It is calculated as: Allowed / Claimants

Allowed/Day: Amount considered eligible for payment by the plan per inpatient day. It is calculated as: Allowed / Days

Allowed/Service: Amount considered eligible for payment per admit (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: Allowed / Services

Average Contract Size: The average number of members per subscriber. It is calculated as: Medical Members / Medical Subscribers

Average Length of Stay: Admit last date of service minus admit first date of service (plus 1 if last day=first day). It is calculated as: Days / Services

Benchmark: Represents the BCBSTX book of business that is loaded into Blue Insight. Benchmark utilization and expense rates have been age/gender adjusted to reflect the potential difference in the age/gender distribution between the individual company and BCBSTX book of business. The age/gender adjustment factors are built using the paid claims and enrollment information over a 3 year period from BCBSTX book of business.

Billed: Amount submitted for payment by the provider

Blue Card Access Fee: Interplan Teleprocessing Services fee charged on out-of-state claims for accessing the local plan's provider network

Capitation: A method of payment, exclusively for HMO members, where a physician or hospital is paid a fixed amount for each enrolled member for healthcare services regardless of the actual number or nature of services provided to each individual

Claimants: Number of individual members submitting a claim

COB: Portion of amount considered eligible for payment that has been paid by another insurance company (Coordination of Benefits)

COB Medicare: Portion of amount considered eligible for payment that has been paid by Medicare

Coinsurance: Portion of covered amount member is responsible to pay for the claim

Co-payment: Flat rate that the member is responsible to pay for the claim

Days/1000: Number of inpatient days per 1,000 members. It is calculated as: (Days / Member Months) * 1000 * 12

Deductible: Portion of annual deductible amount member is responsible to pay applied to the claim

Dental Loss Ratio: Calculated as the Dental Paid Claims Amount divided by the Billed Dental Premium Amount

Dental Paid Claims: An amount paid to cover the Health Plan's liability for dental services provided to members for claims that have been processed and approved for payment

Discount: Amount of reduction from billed amount that has been negotiated with the provider

Dispensing Rate: The proportion of total drugs claims a certain drug or drug type is being dispensed

Effective Discount %: The effective discount percentage is calculated as: Discount / (Discount + Paid)

Females (20-44 years): The total number of members who are women between the ages of 20 and 44 years. The proportion of females (20-44 years) is calculated as: Member Months for Women between 20-44 years / Member Months

HCC: High Cost Claimant, a claimant with total paid amount over a specified threshold (e.g., $30,000 or $50,000) within the twelve month reporting period

In-Network Paid %: Percent of total paid expenses for in-network claims. It is calculated as: In-Network Paid / Paid

IP Paid PEPM: Inpatient facility paid amount per employee per month

IP Paid PMPM: Inpatient facility paid amount per member per month

Leading ICD-9 Diagnostic Category: For each patient, summarize total paid amount for each diagnosis and its corresponding MDC. The MDC with the greatest paid amount for the patient becomes the Leading ICD-9 Diagnostic Category for the reporting period (HDMS Generated)

Management Services: A combination of Capitation, Fees & Credits and Recoveries for medical services applied to the Employer Group's account

Medical Paid Claims: An amount paid to cover the Health Plan's liability for medical (healthcare) services provided to members for claims that have been processed and approved for payment

Medical/Pharmacy Loss Ratio: Calculated as the combined Medical and Pharmacy Paid Claims Amount plus Capitation divided by the total Billed Premium Amount for Medical and Pharmacy, where appropriate

Member Months: Count of months of eligibility for members

Network Indicator: An indicator that shows whether the claim was processed as in-network (e.g., in the Preferred Provider Organization network) or out-of-network and paid accordingly

Not Covered: Amount considered not eligible for payment by the plan (excludes the discount amount)

OP Paid PEPM: Outpatient facility paid amount per employee per month

OP Paid PMPM: Outpatient facility paid amount per member per month

Other Adjustments: Minor payments or credits not captured in other specific expense measures

Other Payments: Combination of Blue Card access fees and surcharge expenses

Other Reductions: Combination of maximum reductions, penalties, workers compensation savings, and subrogation savings

Out of Pocket: Total amount that is the responsibility of the claimant. It is calculated as: (Copay + Deductible + Coinsurance)

Paid: Total amount paid by the plan, including access fees, adjustments, and surcharges

Paid PEPM: Amount paid to the provider by the plan per employee per month. It is calculated as: Paid / Subscriber Member Months

Paid PMPM: Amount paid to the provider by the plan per member per month. It is calculated as: Paid / Member Months

Paid/Claimant: Amount paid to the provider by the plan per claimant. It is calculated as: Paid / Claimants

Paid/Day: Amount paid to the provider by the plan per inpatient day. It is calculated as: Paid / Days

Paid/Service: Amount paid to the provider by the plan per admission (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: Paid / Services

Paid/Visit: Amount paid to the plan per professional visit. It is calculated as: Paid / Visits

Paid-Provider: Amount paid to the provider by the plan

Penalty: Amount charged to the user of health care services for a non-approved contractual service

PEPM: Per employee per month

Pharmacy Paid Claims: An amount paid to cover the Health Plan's liability for pharmacy services provided to members for claims that have been processed and approved for payment

Pharmacy Tier: An indicator on each Rx claim that tells whether a prescription is generic, preferred brand, non-preferred brand, specialty, or other

Place of Service: An indicator of whether the professional services were rendered during an inpatient admission, outpatient visit, office visit, or other

Plan Eligibility: Eligibility derived directly from the plan's enrollment system. It excludes eligibility created during data processing for claims without matching records in the enrollment system.

PMPM: Per member per month

PR Paid PEPM: Professional paid amount per employee per month

PR Paid PMPM: Professional paid amount per member per month

Premium: An agreed upon fee paid to the Health Plan for coverage of medical and/or dental benefits for an established benefit period and set intervals

Reporting Period: The date range for which the report was run. When data is not available for the complete reporting period, partial totals will be displayed and comparisons may be inconclusive.

Rx Paid PEPM: Prescription drug paid amount per employee per month

Rx Paid PMPM: Prescription drug paid amount per member per month

Service Category: A classification based on claim type

Service Type: HDMS classification based on principal diagnosis or ICD-9 Procedure Code (HDMS Generated)

Services: Number of admissions (inpatient facility), number of visits (outpatient facility), number of claim lines (professional), or number of scripts (prescription Rx)

Services/1000: Number of services per 1,000 members. It is calculated as: (Services / Member Months) * 1000 * 12

Services/Member: Number of services per member. It is calculated as: (Services / Member Months) * 12

Subrogation Savings: Portion of amount eligible for payment originally paid by the plan but that has since been recovered through a legal action

Surcharge: Amount charged as a tax by certain States on facility claims

Total Paid: The total amount of medical, pharmacy and capitation dollars, where appropriate, paid to cover healthcare services provided to members for claims that have been processed and approved for payment

Visits: Number of professional visits, where a visit is defined as a set of all professional services that occur on the same date for the same claimant and the same professional provider. A visit relates to a physician interaction with a patient and the place of service can be the office, inpatient facility or outpatient facility.

Visits/1000: Number of professional visits per 1,000 members. It is calculated as: (Visits / Member Months) * 1000 * 12

Workers Compensation Savings: Portion of amount eligible for payment that has been paid a third party Workers Compensation carrier