2009 ERISA Disclosure Information Report
Provided By Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)
300 East Randolph Street
Chicago, Illinois 60601
EIN # 36 – 1236610

HCSC operates through its Blue Cross and Blue Shield plans in Illinois (BCBSIL), New Mexico (BCBSNM), Oklahoma (BCBSOK), and Texas (BCBSTX), and several subsidiaries to offer a variety of health and life insurance products and related services to group customers and individuals.
Information about the operations and financial relationships of HCSC and its affiliates and subsidiaries is available through many sources, such as:
Home Page -- http://www.hcsc.com/index.html
Affiliates and Subsidiaries -- http://www.hcsc.com/about-hcsc/plans-affiliates.html
Financial Statements -- http://www.hcsc.com/about-hcsc/finance.htm
Annual Statements -- https://external-apps.naic.org/insData/index.jsp
Affiliates Newsroom -- http://www.hcsc.com/newsroom/affiliate-newsroom.html
Blue Cross and Blue Shield Association -- http://www.bcbs.com/
Community Involvement -- http://www.hcsc.com/commitments/community-involvement/community-involvement.html

Eligible indirect compensation ("EIC") that has been or is likely to be received by HCSC and certain of HCSC's vendors in connection with services provided by HCSC to our self-funded group customers for calendar year 2009 is listed below. Please note EIC includes amounts that are not necessarily passed on to our group customers or to members. The financial terms of the services provided by HCSC to our group customers, and additional details about the services, are described in the existing group customer's administrative services agreement(s) and insurance policies with HCSC and/or in other materials we may provide from time-to-time.

The following Disclosure Information is supplemental to, and does not take the place of, any information previously provided to our group customers. Important additional information about separate financial relationships and fees is provided in the administrative services agreement(s) and insurance policies between HCSC and our group customers. Additional information about these types of fees, the amount of these fees and the sources of these fees is available upon request.

Please Note: Not all of the following Disclosure Information will be applicable to every group customer, and not all groups are subject to Schedule C reporting. For groups not subject to Schedule C reporting, this Disclosure Information is provided for informational purposes only. For insured business, the financial arrangements below are taken into account when HCSC calculates insured group premiums, unless indicated otherwise.

Group customers should contact their Blue Cross and Blue Shield of Illinois Account Representative if they have questions related to a unique arrangement with us. Group customers should also consult with their own legal and other advisors.

HCSC Compensation

1. *Separate Financial Arrangements with Providers; ADP* -- In Illinois, HCSC's compensation for the services under its administrative services agreement(s) with certain group customers can include the difference, if any, between the net claim payments reimbursed to HCSC by the group customer and the net amounts paid to health care providers by HCSC, after giving effect to HCSC's separate financial arrangements with health care providers. Currently, these differences may arise through the use of HCSC's Average Discount Price ("ADP"). "ADP" means a percentage discount determined by HCSC, which varies from claim to claim. The ADP reflects HCSC's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with hospitals and other facilities under circumstances similar to those involved in the particular claim, reduced by an amount, not to exceed fifteen percent (15%) of such estimate, to reflect related lost investment earnings and costs (the amount of the reduction is referred to as the "planned retention"). Although the maximum planned retention can be up to 15%, the planned retention is often much lower and will vary from year to year, as more fully described below.

In Illinois, HCSC has negotiated with participating facility providers to pay the providers full billed charges of their claims upfront, and then recover from the providers the actual contractual savings at a later date. In that situation, HCSC has lost the opportunity to invest and earn interest on the amount it advances to the provider. HCSC retains a small percentage of the contractual savings for administrative expense and lost investment income, which is captured in the reduced ADP amounts credited to the group customer. This is because the value of the discount is made immediately available to the group members even though HCSC recovers the actual savings from the provider months later. The planned retention is the sum of the interest rate (prime rate determined at beginning of each quarter) times the collection lag (2/12 months for PPO; 15/12 months for non-PPO), and a flat charge of 0.5% for administration. So, if the prime rate is 3%, then the retention is approximately 1.0%.

The group's liability to HCSC for certain facility claims payment is calculated, in part, based on ADP instead of the actual savings from the contract that HCSC has negotiated with the facility. The difference between the actual discounts and ADPs for any given group customer will vary, depending on the health care services received by the group's members, and can be positive or negative. An estimate of the difference can be calculated by multiplying the Estimated Provider Recoveries Percentage (published quarterly by HCSC) by the group customer's covered charges (provided by HCSC on the monthly invoices to group customers) and then subtracting the ADPs (also on the monthly invoices).

2. *Financial Arrangements with Recovery Vendor* -- If HCSC provides recovery-related services to its self-funded group customers, the fees are set forth in its administrative services agreement(s) with the group customer. HCSC has contracted with Healthcare Recoveries, a division of Trover Solutions, Inc. (HRI) to furnish certain recovery-related services to HCSC such as the leasing of case management software, case identification/investigation service and the transfer of recovery cases to be managed by HRI upon the request of HCSC.

a. Case Identification/Investigation Service. HCSC pays HRI a fee of up to $8.00 for each case that HRI investigates and identifies as a recovery matter.
b. Case Management. The standard administrative fee retained by HCSC is a maximum of 25% of the gross recovery and may be more specifically described in the administrative services agreement(s) with the group customer. In the event HRI manages the case at the request of HCSC, HRI remits the entire gross recovery to HCSC and submits an invoice (in the amount of between 20% -30% of the gross recovery) that is paid by HCSC. HCSC will retain (or absorb) any difference between the fee paid by the group customer to HCSC, and the fee paid by HCSC to HRI, as compensation (or shortfall) for HCSC's services. For 2009, HCSC absorbed a shortfall.
c. Case Management Software. HCSC leases a recovery case management software system from HRI for a per/member/per/year charge of $0.15.

3. Financial Arrangements with Pharmacies and PBMs – Expected Rebate amounts are passed back to our self-funded and cost plus group customers with 100% of the Expected Rebate applied as a Rebate Credit on the monthly billing statement calculated on a per employee per month basis. Based upon HCSC's previous experience with retail and mail order rebates per brand prescription for HCSC's overall commercial business in the applicable state for the prior calendar year (Prior Year's Total Brand Rebates), HCSC projects the average dollar amount of rebates per prescription for each of those group customers (Rebate Factor). One-hundred percent (100%) of the Expected Rebate is shared with the group customers and is projected based upon the Prior Year's Total Brand Rebates, the group customer's benefit design for the

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upcoming plan year, the historic retail and mail order usage rates of the members, and the demographics of the members. The Expected Rebate passed back to the group customer is determined by multiplying the Rebate Factor projected for the group customer for the upcoming contract year times the projected number of prescriptions dispensed for members for the upcoming contract year, then divided by the expected number of employees, then divided by twelve (12) months. The Rebate Credits are fixed amounts, paid prospectively to the group customers without the extended delays that normally occur with billing and collection of actual rebates from pharmaceutical manufacturers. Although no true-up is done at the end of group's contract period, the re-calculation of the Expected Rebate for the renewal period takes into account the prior period's actual demographics, utilization, and aggregate rebates and interest earnings. The Rebate Credits do not continue if the group customer terminates.

The actual rebates are collected by HCSC's pharmacy benefit manager (Prime as described in more detail below) and forwarded to HCSC. If it is determined that Prime has overpaid rebates to HCSC, then HCSC must return such overpayment to Prime (who in turn, refunds such overpayment to the manufacturer), but HCSC is not obligated to compensate Prime or any manufacturer on a time value of money basis. If it is determined that Prime has underpaid rebates to HCSC, then Prime must forward such underpayments to HCSC plus interest and late fees. On an aggregate basis for 2009, the difference between the Expected Rebate and the estimated actual rebates for 2009, is estimated to be an amount not to exceed approximately $0.85 per drug claim. HCSC will retain the actual difference, whether it is eventually higher or lower, as compensation (or shortfall) for its services. HCSC estimated this amount based on its current pricing manuals and Prime's most recent 2009 rebate projections for self-funded and cost-plus business (much of which is not yet collected).

Compensation related to the BlueCard Program

The BlueCard Program is established and operated pursuant to policies established and enforced by the Blue Cross and Blue Shield Association. HCSC is an independent licensee of the Blue Cross Blue Shield Association. Under the BlueCard Program, members receive access to healthcare services outside of the geographic area BCBSIL serves. Typically in that situation, members obtain care from healthcare providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the "Host Blue"). Within that situation, BCBSIL is referred to as the "Home Blue."

1. BlueCard Access Fees--Access Fees are usually charged on a per-claim basis and are charged as a percentage of the savings that a Host Blue passes along to the Home Blue by virtue of its relationships with healthcare providers. These fees are paid by the Home Blue to the Host Blue and are in the amounts set forth below. These fees are charged for making the Host Blue's provider network available to the Home Blue's members.

If the group's BlueCard arrangement with HCSC involves the group's payment of Access Fees, they are calculated based on one or more of the following arrangements, depending on the size and distribution of your group's enrollment:

Access Fees for 2009:

Standard BlueCard Claims
7.16% of savings (max = $2,000 per claim)
Reduced PPO Claims
3.98% of savings (max = $2,000 per claim) – 1000 – 9999 enrolled employees
3.70% of savings (max = $2,000 per claim) – 10,000+ enrolled employees

2. Administrative Expense Allowances (AEA)-- This is usually a flat per-claim fee paid by the Home Blue to the Host Blue. It is paid for administrative services that the Host Blue provides in processing the claim for benefits for a member of the Home Blue.

In 2009 (i) for group customers with fewer than 1000 covered employees, the AEA fee is $11.00 for institutional provider claims and $5.00 for professional provider claims, and (ii) for group customers with 1000 (or more) covered employees, the AEA fee is $9.75 for institutional provider claims and $4.00 for professional provider claims.

Currently, the AEA fees that HCSC pays to Host Blues are not specifically passed through to our group customers as group-specific expenses, but instead HCSC factors these fees into HCSC's determination of the administrative fees that HCSC charges to group customers with BlueCard claims.

3. "Custom" Arrangements with Host Blues-- Home Blues may elect to use a non-standard AEA that is paid on a per contract / per month (PCPM) basis. In such cases, the PCPM-based AEA replaces both the AEA and Access Fees.

4. Use of Estimated or Average Pricing by Host Blues-- As described in your administrative services agreement, some Host Blues use estimated or average prices to determine the negotiated price that is made available to HCSC when plan members access the Host Blue's participating provider network. This may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount paid to the provider by the Host Blue.

The following describes the formula used for determining an estimated or average price:

Estimated: A percentage is used to modify the claim price for covered services. This percentage (either positive or negative) allows Host Blues to incorporate adjustments and actuarial projections prospectively into the final price. The percentage is determined by figuring the aggregate cost to the Host Blue over a look-back period less any initial payments made to providers divided by the total of payments initially made to providers. The aggregate cost in the numerator includes all provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, other non-claim transactions and any positive or negative balance in the variance account. The percentage is then actuarially adjusted for anticipated changes in claims expenses for the prospective period. As of October 13, 2009, the modifying percentage applied to claims from those Host Blues that use estimated pricing ranged from -1.9% to +16.5%.

Average: An average price is determined for a defined category of provider (e.g., institutional, professional, etc.) of a Host Blue in a given geographic area. The average is determined as follows:

Total amount paid to such providers over a look-back period, including initial payments as well as applicable claim and non-claim related transactions, which may include but are not limited to provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, etc., and any positive or negative balance in the variance account divided by the total amount of such providers' corresponding charges for covered services over the same look-back period (claims for non-covered services are not included in the calculation)

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This result is an average price that is applied to each claim for the defined category of provider of the Host Blue in the geographic area and presented as the negotiated price.

Although use of these pricing methods may result in a difference (positive or negative) between the price a group customer pays and the amount actually paid to the provider, the price used to determine your payment is a final price. Any positive or negative differences are accounted for in a variance account held by the Host Blue. Host Blues may prospectively increase or reduce estimated or average prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from group customers. Such payable or receivable funds would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices.

5. Fee for Recovery of Overpayments-- In some cases, a Host Blue will undertake recovery efforts from its participating providers on behalf of Home Blues. These recoveries from a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse investigations, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In addition, the Host Blue may engage a third party vendor to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery and could be up to 35% of the recovered amount or could be assessed at up to 28% of total claims dollars to be audited. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Program Policies, which generally require correction on a claim-by-claim or prospective basis.

6. BlueCard Worldwide Program-- The BlueCard Worldwide Program provides members with access to an international network of inpatient, outpatient and professional providers. Medical assistance and claims support services are also provided under the program by Mondial Assistance. The fees that the Host Blue pays to Mondial are as follows:

Medical Assistance Services	Per Unit Price
General Inbound Calls (questions related to the BlueCard Worldwide Program and related processes; requests for provider information for non-medical situations, etc.)	$10.00 / Call
Phone Translation	$22.50 / Call
Fulfillment	$7.50 / Mailing
Medical Referral	$125.00 / Referral
Misrouted Calls	$3.00 / Call
Medical Monitoring < 3 Days	$295.00 / Case
Medical Monitoring 3 – 10 Days	$485.00 / Case
Medical Monitoring > 10 Days	$550.00 / Case
Plan Claim Inquiry	$15.00 / Case
Medical Evacuation coordination	$2,000.00 / Case
Medical Repatriation coordination	$2,000.00 / Case
Repatriation of Remains coordination	$800.00 / Case

Claims Support Services	Per Unit Price
Claim Preparation – (Image claim, route claim, verify eligibility, conduct provider follow-ups; excluding translation and currency conversion)	$12.75 / Bill
Claim Preparation and Currency Conversion	$16.00 / Bill
Claim Preparation and Translation	$24.00 / Bill
Claim Preparation, Translation, and Currency Conversion	$26.50 / Bill
Check Issuance (receive funds, match to file, purchase currency, issue check)	$12.00 / Bill
Member Returned Claim	$5.75 / Bill
Misrouted Claim (i.e., domestic)	$5.75 / Bill
Void Check Request	$20.00 / Request
Other Document Translation (i.e., medical records)	$25.00 / Page
Currency Reconciliation	At Cost
Outside Translation Costs	At Cost

Pharmacy Benefit Manager's Compensation

HCSC has contracted with Prime Therapeutics LLC (Prime) for Prime to furnish certain pharmacy benefit management and prescription drug services (PBM services), such as formulary, rebate and pharmacy networks management; claims processing; clinical management programs; utilization review; mail order and specialty pharmacy services; e-prescribing; and reporting and account support services for all operating divisions (currently BCBSIL, BCBSTX, BCBSNM and BCBSOK). Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC. HCSC owns approximately 41% of the equity interest in Prime. HCSC has entered into various administrative services agreements with Prime to provide these services. Some of the amounts received by Prime from HCSC, pharmacies, manufacturers or other third parties may be charged each time a claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled (transaction-based fees), and may include, but are not limited to, administrative fees charged by Prime to HCSC, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, the fees that HCSC pays to Prime are not specifically passed through to our group customers as group-specific expenses, but instead HCSC factors these fees into HCSC's determination of the administrative fees and premiums that HCSC charges to group customers with prescription drug benefit coverage administered or insured by HCSC. The amounts that Prime receives from third parties do not accrue to the benefit of group customers, unless otherwise specifically set forth in the administrative services agreement or insurance policy. The amount of compensation received by HCSC from a particular group customer for PBM services is not specifically shared with Prime. Instead, HCSC's agreements with Prime require HCSC to pay Prime various fees, of which the following were considered transaction-based fees for 2009:

1. Pharmacy Program Management Fee (Prime's recommended service code 12) – Prime receives from HCSC a program management fee (a per-claim charge) as compensation for Prime's performance of the following PBM services to HCSC:

a. Electronic claims processing
b. Access to the pharmacy claims processing system
c. Pharmacy Network development, management and oversight
d. Standard Pharmacy Program Reporting
e. PrimeMail Program
f. Triessent Specialty Pharmacy Program

g. Formulary management and printing
h. P&T Committee management and oversight
i. Rebate contracting with pharmaceutical drug manufacturers
j. Call center for member and pharmacy customer service
k. Drug utilization review
l. Drug Recall notifications
m. QI Monitoring
n. RFP, Sales and Group Presentation support
o. Website and on-line tools
p. E-prescribing Program and provider connectivity (downloads of Formulary to PDA (a per-claim charge). In addition to the Pharmacy Program Management fee, HCSC also reimburses Prime for fees charged to Prime by its e-prescribing vendor(s) (per eligibility, formulary and medication history requests)
q. Paper and foreign claims processing (a per-claim charge plus postage)
r. Prior Authorization (clinical appeals and reviews) (a per-review fee).
s. Other services as mutually agreed upon

2. Separately-Priced PBM Services-- (Prime's recommended service code 12) – Prime receives from HCSC the following additional transaction-based fees:

Desktop and on-site audits of Network Pharmacies (flat fee and/or a percentage of the amount recovered not to exceed 25%). Prime may determine, through audit or otherwise, that a pharmacy has been under or overpaid under the Network Agreement. Prime forwards recoveries to HCSC net of Prime's retained recovery fee. For self-funded and cost-plus business, HCSC credits recoveries to the applicable group customer.

In addition, third parties pay Prime various fees that might be considered in connection with services provided by HCSC to our group customers, of which the following were considered transaction-based fees for 2009:

1. PrimeMail and Triessent® Specialty Pharmacy Programs (Prime's recommended service code 99) – Except for mail and specialty drugs, the prices/discounts that Prime has negotiated with pharmacies are passed-through to HCSC (and ultimately to our group customers). For mail and specialty drugs, the difference between Prime's acquisition cost and the negotiated price that Prime charges HCSC is retained by Prime as its fee for the various administrative services provided as part of the mail and specialty PBM program. Prime subcontracts with another pharmacy(ies) to assist with the provision of certain of the specialty pharmacy drugs and related services. The amount that Prime pays such other pharmacy(ies) is independent from and may not be the same as the amount HCSC pays to Prime. When the amount that HCSC pays to Prime is more than the amount that Prime pays such other pharmacy(ies), the difference is retained by Prime as compensation for its mail and specialty pharmacy program services.

2. Float on rebate payment (Prime's recommended service code 62) – Prime contracts with pharmaceutical manufacturers for prescription drug rebates as described in the administrative services agreement. For the number of days between the day that Prime receives manufacturers' rebates and the day that Prime forwards the money to HCSC (approximately 20 days), Prime invests the money and earns float. Prime's float compensation equals the rebate amount multiplied by the interest rate multiplied by the amount of time the money is invested. This compensation is for Prime's rebate administration services. If the manufacturers do not forward rebates to Prime on time, Prime may charge the manufacturers a late fee, which is retained by Prime. If it is determined, through audit or otherwise, that a manufacturer has underpaid rebates to Prime (or Prime has underpaid rebates to HCSC), then Prime must forward to HCSC the underpaid rebates. If it is determined, through audit or otherwise, that a manufacturer has overpaid rebates to Prime (or Prime has overpaid rebates to HCSC), then HCSC must return such overpayment to Prime (who in turn, refunds such overpayment to the manufacturer), but HCSC is not obligated to compensate Prime or any manufacturer on a time value of money basis.

3. Pharmacy transaction fees (Prime's recommended service code 12) – Contracted pharmacies pay Prime a fee for each paid claim processed electronically, for the administration of electronic claims processing.

4. Manufacturer administrative fees (Prime's recommended service code 49) Prime also may provide administrative services, such as invoicing, data analysis and reporting, to pharmaceutical manufacturers, some of which might be construed to be in connection with services to our group customers. The top 10 manufacturers by volume based on rebates, listed in alpha order, are: Abbott Labs, Astra Zeneca, Daiichi Sankyo, GlaxoSmithKline, Johnson & Johnson, Merck & Co, Novartis, Novo Nordisk, Pfizer, and Teva Neuroscience .

5. Float on pharmacy and member claims payments (Prime's recommended service code 62) – For the number of days between the day that Prime receives funds from HCSC for claims payments to pharmacies and members, and the day that Prime pays the pharmacies and members, Prime invests the money and earns float. Prime's float compensation equals the amount of the claims multiplied by the interest rate multiplied by the amount of time it is invested. This compensation is for Prime's administrative services.

The estimated compensation that Prime received from HCSC and sources other than HCSC for 2009, captured as part of supporting the HCSC book-of-business (i.e. all self-funded and insured business), is $66,368,000. On a per claim basis, that translates to approximately $1.26 per claim.

To calculate the above per claim estimate for 2009, Prime used the following methodology:

Step 1. Sum the Prime book-of-business fees earned through October 31, 2009 for the following revenue sources:
- Pharmacy Program Management and Audit Recovery Fees
- Manufacturer Administrative Fees
- Pharmacy Transaction Fees
- Earnings from Triessent business

Step 2. Using year-to-date trends, estimate the fees earned for November and December 2009 on a book-of-business basis for fees earned on a per claim basis (same list as above).
Step 3. Capture total interest income earned through October 31, 2009, and subtract interest attributed to Prime's financial reserves. The remaining interest earned estimates the float earned by Prime through October 31, 2009.
Step 4. Estimate interest rates for November and December 2009, and use year-to-date trend to estimate float income earned in November and December.
Step 5. Sum items 1 through 4 to estimate total 2009 book-of-business earnings that are disclosable via Form 5500.
Step 6. Estimate HCSC book-of-business earnings by dividing the total in item 5 by the percentage of claims estimated for HCSC for the full 2009 plan year as a portion of Prime's book-of-business.
Step 7. To provide a per claim amount, divide the HCSC total from item 6 by the total number of claims estimated for 2009 for HCSC.

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BlueCross BlueShield of Illinois

HCSC EIN # 36 – 1236610

Date: February 22, 2010

ATTN: JANE DOE
SAMPLE IL-AUTO-DISC-RX-No BlueCard
123 MAIN ST
SUITE A
SPRINGFIELD, IL 12345-1234

RE: 2009 ERISA Disclosure Information Report
Account Number: 000000

Dear JANE DOE:

The 2009 ERISA Disclosure Information Report attached to this letter discusses information relating to the Form 5500 regulations promulgated under the Employee Retirement Income Security Act of 1974 (ERISA Form 5500 regulations) as well as the proposed 408(b)(2) service provider regulations.

Because both sets of regulations have a complex disclosure component, we have been and are continuing to conduct an internal assessment of information that is available to you about Health Care Service Corporation (HCSC)*, our corporate structure and the companies we use to help us deliver services to our group health customers. Historically, information has been made available to you through various avenues, such as marketing materials, websites, RFPs, contracts, reports, correspondence and various communications. As a result of our efforts, we are pleased to provide the attached detailed 2009 ERISA Disclosure Information. While some of this information has already been made available through various avenues mentioned above, additional detail may have been added in response to the ERISA regulations. In particular, we have included detailed information that we believe meets the requirements for "Eligible Indirect Compensation Disclosures" for certain services. We are providing this information because a plan sponsor's reporting requirements for Schedule C are streamlined for "Eligible Indirect Compensation (EIC)." Please note that amounts that are EIC are not included in HCSC's Form 5500 Supplemental Information Report which is also included in this packet. HCSC's Form 5500 Information Report that you have received in previous years has not changed. It will be sent to you separately at the usual time.

You may find it appropriate to pass the attached Disclosure Information along to the person or department responsible for completing your company's tax reporting obligations.

If you have any questions about the Disclosure Information, please contact your Blue Cross and Blue Shield of Illinois Account Representative.

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