Impact of Affiliation Approval Timing on BCBSD Planning & Costs

EXHIBIT
JOINT-69

BCBSD 2010 Capability Gap Closure Costing Detail

Area	Description	One Time Cost Range	Duration	Ongoing Cost Range
Pricing/ Underwriting Workflow and Rating Engine	• Implement workflow system • Implement rating engine to automate pricing and underwriting processes	$2M - $5M	9-15 months	System Maintenance 18%

Sales and Marketing	• Implement CRM System (vendor-provided software)
	  • Marketing (Marketing Resource Management, Campaign Management)
	  • Sales Force Automation (Lead / Opportunity Management)
		$4M - $8M	12-30 months	System Maintenance / Ongoing Administration (1-2 FTEs) 18%

Network and Medical Management	• Implement a provider profiling system and pay-for-performance capabilities and integrate with new core admin system • Fully integrate iExchange with new core admin system to automate pre-authorizations	$4M - $8M	18-24 months	System Maintenance 18%
Web Portals	• Enhance or replace member / plan sponsor / broker / provider portals (e.g., CDH member tools, transactional capabilities)	$8M - $10M	18-24 months	System Maintenance 18%
Health Care Reform and Compliance	• *ICD-10 Remediation*	$10M - $15M	36 months	System Maintenance 18%
	• *ACO / Payment Reform Administrative Capabilities*	$2M - $5M	12-18 mos	System Maintenance 18%
	• *Implement Health Insurance Exchange Integration*	$3M - $6M	24-36 months	System Maintenance 18% - Ops TBD
	• *MLR Reporting / Pool Management / Rebate Administration Capabilities*	$1M - $3m	9-15 months	System Maintenance 18% - New Ops Function

BCBSD 2010 Capability Gap Closure Costing Detail (continued)

Area	Description	One Time Cost Range	Duration	Ongoing Cost Range
Core Administration Replacement	• Perform full core administrative system replacement (TBS to third party software package replacement) impacting all core operations areas (i.e., Claims, Membership, case installation, billing, provider, accounts receivable, service) • Migrate CDH products to the future core administration system and build more advanced CDH tools • *Support Health Care Reform Administrative Simplification Compliance mandates*	$35M - $50M	24-48 months	System Maintenance and Config 18%
Membership and Billing	• Implement online bill presentment and payment (for group and individual)	$2M - $3M	12-18 months	System Maintenance 18%
Service Oriented Architecture (SOA) / Enterprise Service Bus	• Build out TIBCO integration / workflow / SOA infrastructure and deploy capabilities • Leverage integration infrastructure to support core administration platform replacement	$3M - $5M	12-24 months	System Maintenance 18%
Informatics / Data Warehousing	• Implement an Enterprise Data Warehouse: Establish an enterprise data warehouse (EDW), ETL, ODS, Analytics. Operational and Mgmt Reporting, and Ad Hoc Reporting	$9M - $13M	24-36 months	System Maintenance 18% Operational Support TBD
	• Implement External Client Reporting: Implement interactive and robust plan sponsor reporting capabilities	$3-5M	12 months	System Maintenance 18%
	• Implement a management decision support information system (EIS / Dashboards)	$2M - $4M	12-18 months	System Maintenance 18%

The Healthcare Insurance BPO Market Is Ready to Take Off

Maureen O'Neil

EXHIBIT
JOINT-70

Gartner

No longer just about reducing transaction costs, BPO enables healthcare insurers to run, grow and transform their business

Running, Growing and Transforming the Business with BPO

- Front-end processes
- Core administrative functions
- Customer service

- Provider management
- Care management
- Underwriting support
- CRM
- Communication processes

- Standardized benefit products
- "Utility" delivery systems
- Medical home
- International market position

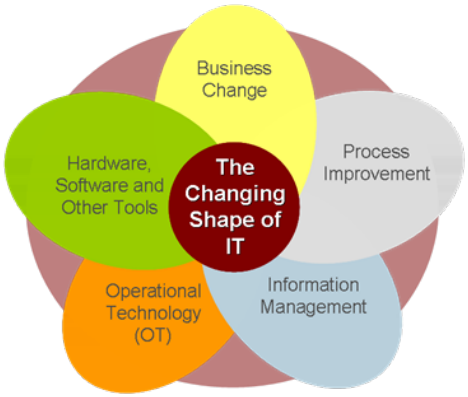
Gartner

Key Issues

1. What healthcare insurance challenges have caused insurers to reassess their use of BPO?
2. How have new trends in healthcare insurance BPO affected insurers' sourcing strategies?
3. What does an analysis of the healthcare insurance BPO market reveal?

Powerful Environmental Forces Are Driving Healthcare IT Dynamics

Economic Climate



Increased Regulation

Healthcare Reform

Gartner

Healthcare Payer IT Budget and Staffing Survey, 2009

Business Initiatives	Cost Control and Staff Reductions
	Business Process Improvement
	Care Management
	Business Intelligence
	Customer Service
	EMR, EHR
IT Initiatives	Cost Cutting and Control
	Consolidation of Servers and Software
	Virtualization and Application Integration
	Modernize Core Administrative Systems
	Business Intelligence
	Customer Relationship Management

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Drivers and Inhibitors of Healthcare Insurance BPO

- Focus on core competencies
- ICD-10 compliance
- M&A and consolidation
- Lack of resources
- Speed to market for new products
- End-of-license and maintenance contracts

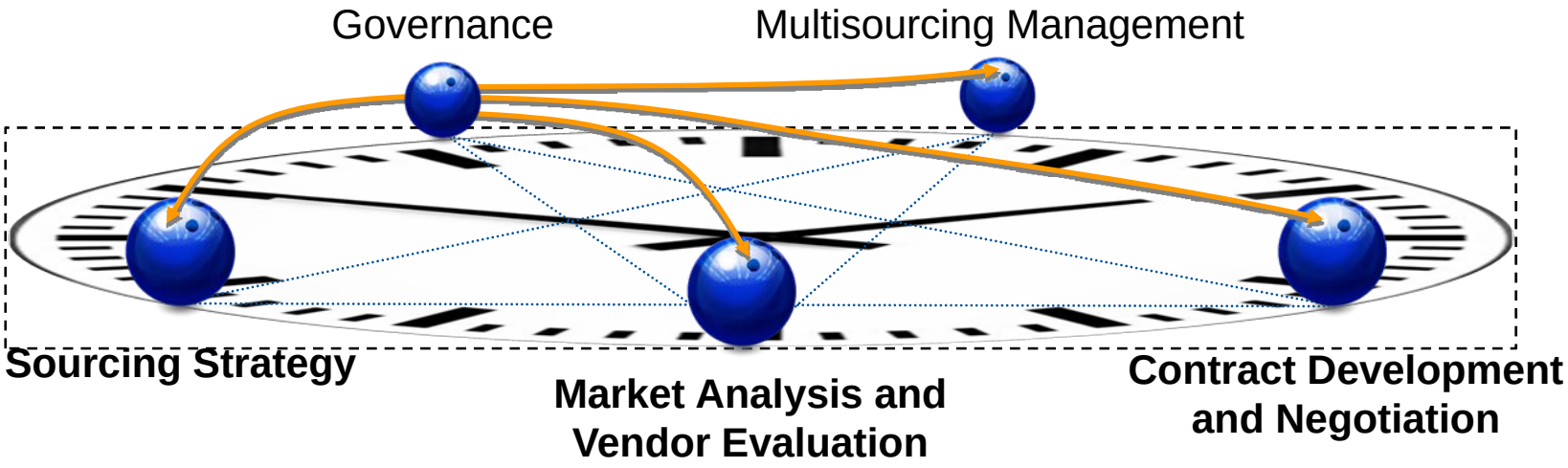
- Outsourcing adverse culture
- Increasing market and product volatility
- IT department seen as core competency
- Lack of strong proven solutions and ROI

Gartner

Key Issues

1. What healthcare insurance challenges have caused insurers to reassess their use of BPO?
2. How have new trends in healthcare insurance BPO affected insurers' sourcing strategies?
3. What does an analysis of the healthcare insurance BPO market reveal?

Healthcare Insurers Need to Develop a Sourcing Strategy



- The multisourcing core elements are complex and can consume many resources.
- Not many companies treat sourcing strategy as an ongoing task, and there are still many companies that do not have a solid sourcing strategy.
- A lot of time is spent in the market analysis, vendor selection and contracting phase — each time when entering a deal.

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Healthcare Insurance Sourcing Options

Business Process Utility
BPU

BPO with standardized processes and a unified, one-to-many technology platform. The provider manages and executes business processes and inputs.

Knowledge Process Outsourcing
KPO

KPO is a term that has emerged to distinguish a specific type of BPO when service offering as higher-value-added or differentiating.

IT Outsourcing
ITO

ITO is a service that is bought through a multiyear contract with an external service provider or outsourcer for day-to-day management of IT operations.

Business Process Outsourcing
BPO

Gartner defines BPO as the delegation of an IT-enabled business process to a third party that owns, administers and manages the process according to a defined set of metrics.

Gartner

BPO Functionality for Healthcare Services

Front-End Processes	Core Admin. Functions	Customer Service	Provider Management
Claims data entry Imaging Mailroom services	Member enrollment Benefit management Claims adjudication Billing and capitation	Full spectrum	Provider setup Credentialing Performance analysis Provider directories

Care Management	Underwriting Support	CRM	Comm. Processes
Precertification Referral authorization Discharge planning Case management	Quote generation Compilation of claims history, employee census files and medical history data	Member acquisition Retention and service	Production delivery and management of consumer campaigns to drive health behavior

These functions have been adopted in many outsourcing deals as stand-alone services or in combination with each other.

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Speed Up the Strategy Process and the Risks May Outweigh Any Reward

- Companies will be in a rush from 2009 to 2013
- Narrow focus on problem solving versus holistic consideration
- 80% rule: Evaluation of options and alternatives

Risks to consider:

- Sourcing strategy not fully aligned to business strategy
- Business outcome not ensured and deal is inflexible
- Organizations that do not screen the market only get the standard options

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Key Issues

1. What healthcare insurance challenges have caused insurers to reassess their use of BPO?
2. How have new trends in healthcare insurance BPO affected insurers' sourcing strategies?
3. What does an analysis of the healthcare insurance BPO market reveal?

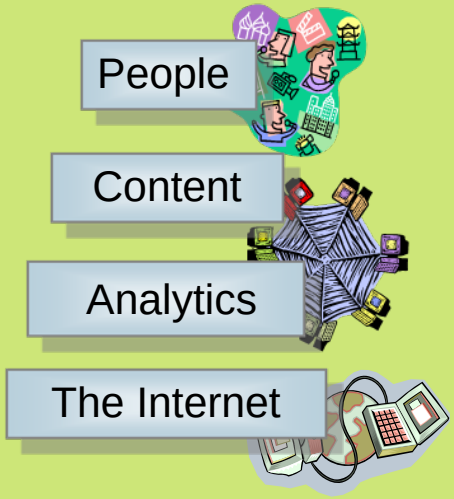
BPO Provider Market Analysis

Mergers and Acquisition

Mergers and acquisitions enable providers to achieve economies of scale and transform discrete-service providers into offering full-service capabilities.

New Service Models

U.S. healthcare insurers' preference for onshore BPO services has influenced the previous onshore/offshore model.



Internet-Based Applications and Other Tools

Utilization of the Internet and introduction of new monitoring tools also differentiate BPO providers.

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BPO Competitive Landscape

- Accenture
- ACS (Xerox pending)
- Antares
- Apollo Health Street
- Cognizant
- Connextions
- Convergys
- CSC
- DST
- Genpact
- HP Services (formerly EDS)
- IBM
- Infosys
- MphasiS
- Patni
- Perot (Dell pending)
- Silverlink
- Syntel
- TMG Health
- TriZetto
- Wipro

Note: This is not a definitive list.

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Customized to Standardized Healthcare Benefit Products — Can BPO Bridge the Gap?

- Hyperefficient processes?
- Drastically lower-cost processes?
- Both more efficient and lower-cost processes?
- Totally standardized processes?
- Very flexible processes?

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Do Your Homework

Can they be creative; do they offer innovative deals and pricing models?

Are global centers readily available?

What is the cultural match between the BPO provider and the insurer?

Will they care about me? Will I be a "small fish in big pond"?

What systems are used (such as system of choice versus taking over my legacy system) and what are the conversion tools?

Does the BPO provider incorporate BPM methodologies and tools?

What is the ratio of experienced versus trained people? Where were they trained? How is the staff managed?

Do It Right or Don't Do It at All.

Your Action Plan

Health insurance CIOs should:

- **Monday Morning**
  - Appoint a dedicated IT manager to be part of the BPO management team
  - Create a BPO management center in the IT organization
- **Your Next 90 Days**
  - Advise the business team on the implications of various governance and support issues
  - Create an IT project team to support the BPO transition program
  - Add the BPO service to the task list for the IT security team
  - Add the BPO service to the task list for the business continuity management team
- **Your Next 12 Months**
  - Ensure that full IT budget impact estimates are prepared and tracked by key teams in the IT organization
  - Ensure all IT help desk services are fully engaged in the BPO future requirements

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Related Gartner Research

- ***Healthcare Insurance BPO Market Ready to Take Off***
  Maureen O'Neil, February 26, 2009, G00165054

- ***CRM BPO Is Emerging Into the Health Insurer Market***
  Joanne Galimi, April 27, 2009, G00167420

- ***Healthcare Insurer Business Process Outsourcing Trends***
  Joanne Galimi, January 23, 2009, G00164744

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TĒLA

Making the Case for Health Plans' Use of Offshore Business Process Outsourcing

A THOUGHT LEADERSHIP WHITE PAPER PUBLISHED BY TĒLA SOURCING, LLC

This paper provides information for healthcare organizations currently exploring offshore business process outsourcing (BPO) and for professionals who want a better understanding of the issues involved in offshore BPO within the healthcare payer and benefits administration environment. It explains the financial implications and potential benefits of using offshore BPO and can be used as a tool to evaluate offshore BPO's impact on administrative cost structures. Finally, it is a valuable resource for entities acting as third-party administrators (TPAs), for administrative services outsourcers (ASOs) and other vendors providing these services in the U.S.

As the cost of healthcare rises from $1.5 trillion in 2002 to a projected $2.6 trillion in 2010, health plans will face increasing pressure on already limited resources. Offshore BPO can save health plans in excess of 40% of total administrative costs. These significant savings can lead to better allocation of capital and resources for pressing business needs.

"Health plans process an estimated 30 billion healthcare transactions each year. 26 billion of these transactions are handled by paper, fax, call centers, or other manual methods. These 26 billion transactions result in a significant burden."

—IBM Research

OVERVIEW—THE NEED FOR OUTSOURCING IN HEALTH INSURANCE

The future and economic role of the U.S. health insurance industry is at a crossroads. It is facing a number of cost-related challenges, including regulatory compliance and rising medical costs due to the environmental factors in the industry. Many organizations are trying to streamline processes, increase automation and reduce administration costs to boost profitability.

Today, on average, 40% to 60% of a health plan's employee base is involved in back-office tasks that add no strategic value—representing a substantial drain on management resources.

As a result of the driving need to reduce administrative costs, onshore outsourcing has become an established industry practice with proven results. While cost is a dominant factor in choosing an outsourcing provider, health plans are also seeking higher quality of service levels that can be offered by selective offshore providers.

THE ADVANTAGES OF OFFSHORE OUTSOURCING

Recently many health plans have begun expanding their BPO strategies by going offshore, increasing savings by as much as 30% to 40%. Companies such as Aetna, Humana and Uniprise have set a historical precedent by actively exploring relationships with BPO service providers in countries like India.

Although BPO is not a recent phenomenon, today's renewed vigor and interest in BPO has arisen from one overriding need—the need to become more competitive.

Offshore outsourcing represents a unique opportunity for the healthcare industry:

1. Moving a large number of back-office or non-critical processes offshore positively impacts the bottom line and shareholder value.
2. Cost savings present a competitive advantage by introducing health plans at a lower price point. Since offshore outsourcing reduces overall cost, it allows the healthcare organization to reduce the premiums and funnel more funds into care management.
3. It gives health plans an opportunity to re-engineer processes, increase technology automation and take advantage of time zone differences, thereby increasing productivity and reducing turnaround times.

When health plans begin to determine which processes to move offshore in order to yield the highest ROI and have the greatest positive impact on the operational bottom line, three processes emerge. The offshoring of these processes can carry a certain degree of risk, which should be carefully evaluated relative to the overall benefits and current cost to the health plans. The processes that can be taken offshore with the least degree of risk and highest degree of ROI include:

PROCESS	RISK	COST SAVINGS	COMPLEXITY	ROI
Claims Administration	Medium	High	High	High
Customer Service	Medium	Medium	Medium	High
Member Management	Low	High	Low	Medium

The above represents research conducted by Tēla Sourcing to identify areas where ROI has vastly improved. For some processes, the risk of outsourcing is high because of the complex nature of particular activities. At the same time, claims administration and customer service, while complex in nature, carry high infrastructure costs. Moving these functions offshore will clearly result in a more positive impact on the bottom line. The risk is mitigated by adopting a robust, proven migration strategy and transitioning to an effective management model.

POTENTIAL BENEFITS FOR A HEALTH PLAN

Presented below is a case study for a health plan that is benefiting from adjudicating claims in an offshore environment.

CURRENT ADMINISTRATIVE COSTS FOR A HEALTH PLAN			
Number of members	160,000	Number of claims manually adjudicated	600,000
Number of annual claims	2,000,000	Total claims adjudication cost	$4,300,800
Auto adjudication rate	70%	Cost of manually adjudicating a claim	$7.168

ADMINISTRATIVE COSTS WITH OFFSHORE OUTSOURCING			
PRICING SCENARIOS	**SCENARIO I**	**SCENARIO II**	**SCENARIO III**
Per claim cost to adjudicate offshore	$1.00	$2.00	$3.00
Number of claims adjudicated	600,000	600,000	600,000
Adjudication cost	**$600,000**	**$1,200,000**	**$1,800,000**
Remaining onshore cost (20%) Project oversight/management	$860,160	$860,160	$860,160
Total cost	$1,460,160	$2,060,160	$2,660,160
Total cost savings	**$2,840,640**	**$2,240,640**	**$1,640,640**
Savings as a % of original cost	66%	52%	38%

Each of the three scenarios represents the average price options offered by offshore providers. Savings will vary based on the plan's current transaction cost. In each case, the significant savings support the decision to go offshore. Outsourcing just one process can yield up to 66% of the original cost.

CONCLUSION

According to a recent Gartner study, 50% of health plans surveyed currently outsource all or part of their IT/back-office business processes. Already, offshore outsourcing has gained significant momentum, resulting in proven benefits for those organizations leading the charge. The next few years promise to be exciting as offshore BPO evolves and ultimately transforms the healthcare insurance segment. With the right approach and successful execution, offshore BPO is likely to play an integral role in this industry and become a key strategic initiative for most health plans, TPAs and onshore BPO vendors.

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ABOUT TELA

Tēla Sourcing provides offshore business process outsourcing (BPO) that will help you focus on providing cost-effective care for your members, as well as strategic and financial initiatives that will ultimately allow you to optimize your bottom line while creating a stronger competitive advantage for your health plan.

Tēla's services are highly customized to meet the diverse administrative and operational needs of U.S. health plans. With an efficient and scalable service delivery center in Pune, India, Tēla can guarantee dramatically reduced costs.

Tēla Sourcing is uniquely positioned to offer both offshore and onshore BPO services that will yield timely, real results:

Focused ONLY on the U.S. Healthcare Payer Industry
Because of our solel focus on healthcare, we are uniquely suited to meet the outsourcing needs of health plans, TPAs and other onshore healthcare organizations wanting to migrate administrative processes offshore. We leverage our deep domain expertise and industry knowledge to provide cost-effective and efficient offshore BPO services.

Offers Onshore Delivery Capabilities
We understand your need to outsource complete business functions. Purely administrative processes are good candidates for offshore outsourcing. Processes dependent on frequently changing regulations, unique business rules or physical infrastructure will do better remaining onshore. We offer value-added onshore BPO services in addition to our core offshore offering, and will work with you to determine the optimal balance for your organization.

Provides End-to-End Services Across the Healthcare Value Chain
Our long-term healthcare focus has given us the expertise to offer you an enterprisewide outsourcing solution—a range of valuable, distinct services, as well as the integration required between offshore and onshore services.

Employs a U.S.-Based Management Team
We are one of only a few service providers to offer a U.S.-based management team well-versed in U.S. and Indian law, thereby creating a single point of accountability and contact. This ensures not only successful migration and ongoing management of processes offshore but also compliance with federal and state regulations. Our strength lies in our people and how we work together to build relationships and create value for each organization.

ABOUT THE AUTHOR

Ravi Shah is an Assistant Vice President at Tēla Sourcing. Ravi comes to Tēla with deep domain expertise in the healthcare industry and understands the dynamics of developing and managing BPO relationships. Ravi started his career with SP Jain Consulting in Bombay and consulted with India's largest organizations. He has also worked with the Mitchell Madison Group (a spin-off of McKinsey & Co.). Ravi received his MBA from Michigan State University.

** Information contained in this paper is based on primary as well as secondary research. Certain sections reflect the author's judgment and in many cases are based on the author's knowledge and prior project experience. This paper also contains certain forward-looking statements that involve risk and uncertainty. Tēla Sourcing, LLC will not be liable for any decisions made based on information contained herein.*

Gartner

Industry Research

Publication Date: 28 September 2009 **ID Number: G00171267**

Healthcare Insurers Must Jump-Start Their Corporate ICD-10 Initiatives

Maureen O'Neil

Although U.S. healthcare insurers have begun their International Classification of Diseases, 10th Revision (ICD-10) awareness and planning processes in earnest, too many are focusing exclusively on the impact to their core administrative systems. ICD-10 conversion extends well beyond that, and Gartner provides four Tactical Guidelines for insurers to manage their ICD-10 programs.

Key Findings

- An increasing number of healthcare insurers recognize the business impacts of ICD-10, and that the conversion offers them strategic change, but most have failed to move beyond the planning phase.
- The multiple core administrative systems that insurers have tolerated historically will impair their flexibility in ICD-10 conversion options by requiring alternative compliance strategies that will add greater complexity.
- Many of the business processes that offer healthcare insurers opportunities for return on investment, cost reduction and quality improvement reside in processes that surround the core, such as underwriting, care management and provider network management. However, most CIOs are viewing these functions as secondary in their ICD-10 conversion efforts.

Recommendations

- Itemize your core administrative systems and the compliance strategies (remediate, replace or neutralize) that you have selected for each. Align these strategies with front-end processes, surrounding business systems and external communication outlets.
- Update (or develop) your enterprise risk management (ERM) program. ICD-10 conversion will increase organizational risk through exposure to, for example, staggered internal and external readiness to process ICD-10 codes, overpayment or higher levels of claims, an increase in real and perceived levels of fraud and abuse, customer and provider dissatisfaction, and the unavailability of skilled resources. These risk factors will require the development of countermeasures.
- Frequently communicate your system readiness for ICD-10 compliance to internal and external stakeholders via multiple channels.

WHAT YOU NEED TO KNOW

The U.S. effort to convert ICD-9 diagnostic codes to the ICD-10 standard is comprehensive and touches most aspects of healthcare processes. However, healthcare insurers will be ill-prepared if they focus exclusively on the transaction components of this conversion.

ANALYSIS

Introduction

The World Health Organization developed ICD-10 as an international standard to code diseases, signs and symptoms. It replaces the decades-old ICD-9 diagnostic code standard, identifies twice as many diagnostic codes as ICD-9, 20 times as many injuries and 50 times as many procedures. Moreover, ICD-10 allows for alphanumeric codes, and modernizes the fundamental structure for code assignment and revision made necessary by an ever-increasing number of identifiable diseases. Implementation of ICD-10 will increase coding accuracy, improve first-pass claims processing success, and improve the care management, reimbursement and rating processes.

Although ICD-10 was widely adopted outside the U.S. starting in 1994, its use will not become mandatory in the U.S. until 1 October 2013. Implementation of the U.S. Health Insurance Portability and Accountability Act (HIPAA) X12, Version 5010 standard is a prerequisite for using ICD-10, and will become mandatory on 1 January 2012.

Implementation of HIPAA 5010 is largely a technical electronic data interchange effort. However, some CIOs naively view ICD-10 conversion as a similarly simple technical matter. It is not.

Compared with the HIPAA 5010 conversion, ICD-10 fundamentally impacts business processes. In addition to the increased number of available codes and a new format, conversion to ICD-10 will require extensive business process changes among healthcare insurers, physicians, hospitals and application vendors. Although Gartner has seen an increased interest in ICD-10 since the beginning of 2009, most U.S. health insurance companies remain in a planning phase. CIOs at healthcare insurers must accelerate their efforts and begin implementing ICD-10 now.

Take These Four Steps to Facilitate ICD-10 Conversion

Gartner urges U.S. healthcare insurers to approach ICD-10 implementation with an understanding of four Tactical Guidelines:

(1) Finalize Your Core Administrative System's Compliance Strategy

Gartner has seen three strategic responses emerge for ICD-10 implementation:

- **Remediation:** This involves a line-by-line analysis of code and an upgrade of references from ICD-9 to ICD-10's code structure. Moreover, logic that may have grouped many ICD-9 codes must be amended to refer to the enhanced structure and volume of ICD-10 codes.
- **Replacement:** This involves the swapping out of core administrative systems with new vendor offerings, new version upgrades of vendor products, or replacing a system via business process outsourcing (BPO).
- **Neutralization:** This baseline of compliance involves surrounding the ICD-9 processing systems and insulating them from the need to address ICD-10 code formats or volumes.

Preapplication crosswalks will convert submitted ICD-10 diagnostic codes to ICD-9 codes.

Each of these strategies offers healthcare insurers key advantages and disadvantages, as seen in Table 1.

Table 1. Advantages and Disadvantages of ICD-10 Implementation Strategies

	Advantages	Disadvantages
Remediation	Detailed review of code and business process allows for business process improvement opportunities. Independent of vendor commitments to other clients.	Time- and staff-consuming, little net new advantages and retention of large pockets of old application code.
Replacement — New Application	Ability to achieve compliance while gaining access to new technologies, which can allow for new product definitions and business processes.	New vendors, codes and processes in a time-constrained environment.
Replacement — New Version	Familiarity with existing application while targeting specific conversion needs.	Time and resources.
Replacement — BPO	Eliminates the need to remediate code or manage business processes.	New business model with management, cultural and integration issues.
Neutralization	The least-intrusive strategy. Little change in claims inventory, business processes and/or diagnosis grouping.	Time-vault strategy. Healthcare insurer is basically compliant, but frozen in the logic and processes associated with ICD-9.

Source: Gartner (September 2009)

Having multiple core administrative systems only increases the challenge. Many vendors, or a mix of homegrown systems with vendor products, may force a multitier strategy. As seen in Table 2, it would not be unlikely for a healthcare insurer to upgrade a vendor product, migrate other lines of business (LOBs) to the new version, or outsource a low-revenue product (such as Medicare or Medicaid) while neutralizing a locally developed application due to code complexity.

Table 2. Matrix of ICD-10 Conversion Strategies

Healthcare Insurer Application LOB	Potential Conversion Strategy
Indemnity legacy system	Neutralization
Managed care homegrown system	Remediation
Managed care vendor application	Replacement — New Vendor Version
Consumer-defined health plan or value-based benefit products	Replacement — New Application
Medicare	Replacement — BPO

Source: Gartner (September 2009)

(2) Use the Healthcare Insurance/Business-IT Alignment Model to Guide Your Interapplication Use of Diagnostic Codes

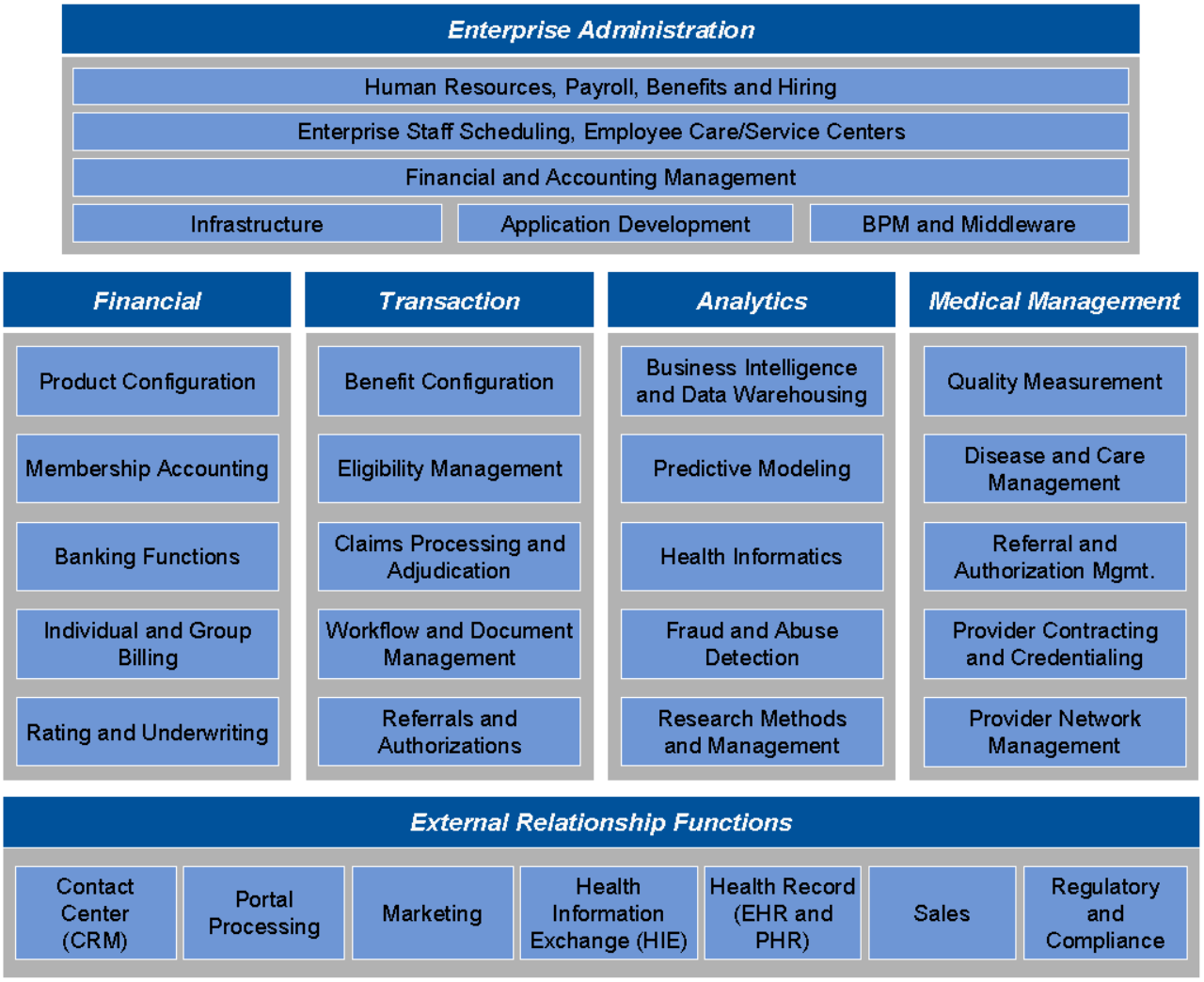
Conversion to ICD-10 affects more than the core administrative systems. Applications that support underwriting and risk management, portals, provider network management, health and wellness, and care management use diagnostic codes. Healthcare insurers must map the flow of ICD-9 codes throughout the enterprise to determine the full impact of ICD-10 conversion. Gartner proposes the use of a healthcare solution map to identify similar functions that may share diagnostic information.

The Healthcare Insurance/Business-IT Alignment Model (see Figure 1) offers insurers a guide to untangling the nested use of diagnostic codes, and identifies where challenges to ICD-10 conversion may be. The model aligns the business functions of healthcare payers into three components:

- **Finance-based functions:** Product configuration, medical banking and underwriting exemplify the functions grouped in the financial component of the solution map. These finance functions impact the entire health insurance organization, and depend on the consistent use of diagnostic codes.
- **Those that support the processing of transactions:** Transaction processing functions receive, categorize and process data against predescribed rules, and fuel the enterprise with information that enables market-differentiating services. Diagnostic codes are critical to these functions. The predominance of ICD-10 efforts and expenses will be incurred in these functions, although other commodity functions will yield little direct benefits.
- **Functions that manage the quality of care:** By aligning provider network management with disease management, case management and utilization management to control medical costs and improve the quality of care management, the new healthcare insurance solution map emphasizes the functions that healthcare insurers use to manage medical costs and improve quality. ICD-10 conversion will prompt insurers to develop new care models, better support care protocols and guidelines, and rationalize provider reimbursement models.

Diagnostic codes permeate all three of these major healthcare insurance processes (see Figure 1).

Figure 1. Healthcare Insurance/Business-IT Alignment Model



Source: Gartner (September 2009)

Other functions that will be affected by ICD-10 conversion include:

- **Analytics:** Assembly and management of data derived from all sources into a "single source of the truth" for access by all users are the key values of this alignment. This will be a common point of diagnostic code from multiple systems.
- **External enablement functions:** By combining all externally facing processes into a collective sense of service — from presales marketing through post-sales service and to Web portals — customer service can be marshaled into high-value service, regardless of the source of inquiry or stakeholder served.

(3) Update Your ERM Plans to Prepare for Several Chaotic Years

Gartner defines ERM as an integrated, consistent and strategic method to manage risk across an organization. ERM involves identifying, assessing and planning for anticipated risk events (see "Q&A: Healthcare Insurers Fine-Tune Their Risk Management Fundamentals"). The ubiquity of

diagnostic codes across a healthcare insurer's internal and external realms significantly raises the risk profile for ICD-10 conversion. Potential risk events include:

- Staggered internal readiness to process ICD-10 codes will challenge healthcare insurer applications and business processes. Having many core administrative systems, as well as a preponderance of surrounding and LOB applications, means that some core systems may be ready before others are, and business process applications will fall behind.
- External business partners (vendors, hospitals, providers and employers) will progress according to their own internal deadlines, rather than those proposed by individual healthcare insurers, thereby forcing insurers to develop dual processing systems regardless of their own ICD-10 compliance strategies.
- Business impact rather than technology readiness differentiates ICD-10 compliance from previous efforts of Y2K and HIPAA transactional compliance. Relearning the rules of, for example, benefit development, underwriting guidelines and care management will differentiate healthcare insurers that exploit ICD-10 capabilities from those that treat the task as a transactional upgrade.

Identifying, assessing and planning for likely risk events associated with ICD-10 conversion will require healthcare insurer CIOs and senior business leaders to focus on the following critical steps:

- Assess the different categories and types of risks associated with ICD-10. This means looking beyond the most common risk possibilities — HIPAA 5010 — to include areas such as care management programs, enterprise portals, provider networks and business partners.
- Analyze the risks to include current and future risks, the probability of the event occurring, and the business impact if the risk event occurs. A balance between risk tolerance, probability and selected countermeasures is essential. When comparing the anticipated risk level for an event with the risk tolerance associated with the event, the risk manager can best select the appropriate risk mitigation actions.
- Planning for overall compliance reporting is key to providing executives with information regarding the enterprise risk position for regulatory, commercial and organizational risks. The assessment, reporting and management of risks must use consistent processes that are practical and organizationally compatible, and that provide actionable information.

(4) Institute an ICD-10 Communication Plan to Keep All Constituents Aware of Your ICD-10 Readiness

Clear and consistent communication is essential during any change cycle. The demand for communication is directly proportional to the complexity of the change environment.

The time period leading up to ICD-10 implementation, the chaotic change during the year, and, likely, during the next year, will be no different. Healthcare insurers must communicate with internal and external stakeholders on ICD-10 strategies, timelines and progress against timelines, and potential risk mitigation contingencies.

Healthcare insurance CIOs may be the overall ICD-10 communicators, or they may work through an ICD-10 program manager or enterprise communication efforts. Regardless of the model used,

CIOs should take advantage of the opportunity to shine with their knowledge of end-to-end processing and the impact on the ICD-10 initiative.

The ICD-10 communication plan should aim to provide insight into the healthcare insurer's conversion initiative, including time-critical information on conversion priorities, implementation testing and training (internal and external). Messages must satisfy distinct stakeholders (vendors, providers, regulators, and internal and external business partners), but also reflect the context in which the communication is being made. Context for ICD-10 includes:

- Compliance guidelines
- The readiness of the vendor, provider and insurer
- The intention to use ICD-10 to implement current or future changes in provider network management, underwriting and risk management, and care management protocols

A CIO's communication plan's situational analysis should answer critical questions, including:

- What level of readiness has the healthcare insurer achieved?
- What is the readiness of business partners?
- What are the risk elements?

In addition to overall context, the healthcare CIO will be expected to describe the goals and decisions that will occur throughout the initiative — for example, crosswalk plans; the correspondence of conversions, replacements and customizations with business impacts; and plans for dual-coding operations, along with data conversion and reporting.

The ICD-10 communication plan should also provide the opportunity for feedback and measures. Whether via portals, social network sites, or customer, provider and business partner service processes, CIOs must always know what is being said about their companies' ICD-10 efforts.

A communication plan that is well-crafted and executed will not guarantee success with ICD-10 conversion, but it will go a long way toward building and sustaining positive relationships with vendors, regulators, and internal and external business partners during a challenging time.

Tactical Guidelines

Maximizing the return on your ICD-10 conversion program requires the following actions:

- Finalize your core administrative system's compliance strategy.
- Use the Healthcare Insurance/Business-IT Alignment Model to guide your interapplication use of diagnostic codes.
- Update your ERM plans to prepare for several chaotic years.
- Institute an ICD-10 communication plan to keep all constituents aware of your ICD-10 readiness.

This research is part of a set of related research pieces. See "ICD-10 Compliance Puts the Spotlight on U.S. Health Insurers' Core Administration Applications" for an overview.

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Gartner

Marketing and Enrollment

Products and Segments Overview • Marketplace Environment • Summary of Enrollment Trends • Segment Performance and Strategies • 2011 and Beyond

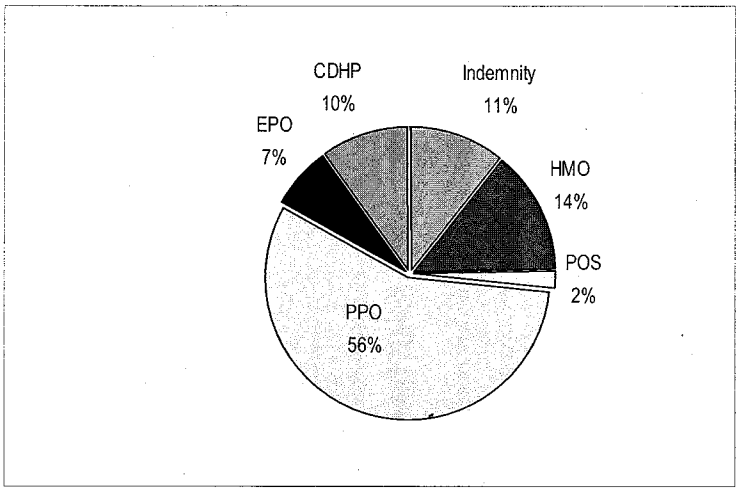
Products and Segments Overview

Products

BCBSD offers a full range of products for the commercial health care benefits marketplace. These include:

- **Preferred Provider Organization (PPO)** Members receive the highest level of coverage when they receive care from a Blue Cross Blue Shield contracted "preferred" provider in Delaware (or anywhere in the nation through the national BlueCard® program) and receive reduced benefits when they receive care from a non-preferred provider. PPO plans are BCBSD's most popular product. Today, 56% of BCBSD members are enrolled in a PPO product.
- **Exclusive Provider Organization (EPO)** Coverage is only provided when a member receives care from a Blue Cross Blue Shield contracted "preferred" provider.
- **Health Maintenance Organization (HMO)** BCBSD HMO plans are based on the Independent Practice Association (IPA) model. Members are required to select a Primary Care Physician who helps coordinate care, including referral to network specialists.
- **Point of Service (POS)** As with HMO plans, members select a Primary Care Physician to coordinate care and referrals, but POS members may self-refer to non-network providers for reduced benefits.
- **Consumer Directed Health (CDH)** CDH plans are high-deductible plans based on PPO, EPO or HMO core designs and are compatible with Flexible Spending Accounts (FSAs), Healthcare Reimbursement Arrangements (HRAs), and Health Spending Accounts (HSAs). Members access consumer tools for information on the costs of services to help make decisions on their care. CDH products first emerged in the early 2000's and have become BCBSD's fastest growing plans. Today, 10% of BCBSD members are enrolled in a CDH product.
- **Traditional Indemnity and Comprehensive Major Medical (CMM)** Under traditional plans, members are not required to follow managed care rules or use network providers. The popularity of these traditional plans has fallen considerably since the introduction of lower-cost network and managed care products.
- **Medigap and Medicare Carve-out** Products serve members who are enrolled in Medicare and provide coverage of costs not paid by Medicare.

BCBSD Product Membership Distribution – 2010



Note: Medigap members are included in distribution

BCBSD also offers a number of ancillary products to accompany BCBSD medical plans. BCBSD does not, as a matter of practice, sell ancillary products on a stand-alone basis. Our ancillary product offerings include:

- **Pharmacy Plans** Most BCBSD health benefits plans include pharmacy benefits; benefits are typically based on the three-tier (generic, formulary brand, non-formulary brand) structure. BCBSD pharmacy claims are administered through Argus Health Systems.
- **Dental Plans** BCBSD offers Indemnity, PPO and HMO dental plans. The PPO and HMO plans are provided through our arrangement with Dominion Dental Services USA.
- **Vision Plans** All BCBSD members enjoy discounts on eyewear purchases through our arrangement with Davis Vision. BCBSD also sells Davis Vision expanded vision plans that provide coverage of eyewear and vision exams. Davis Vision is a subsidiary of Highmark.

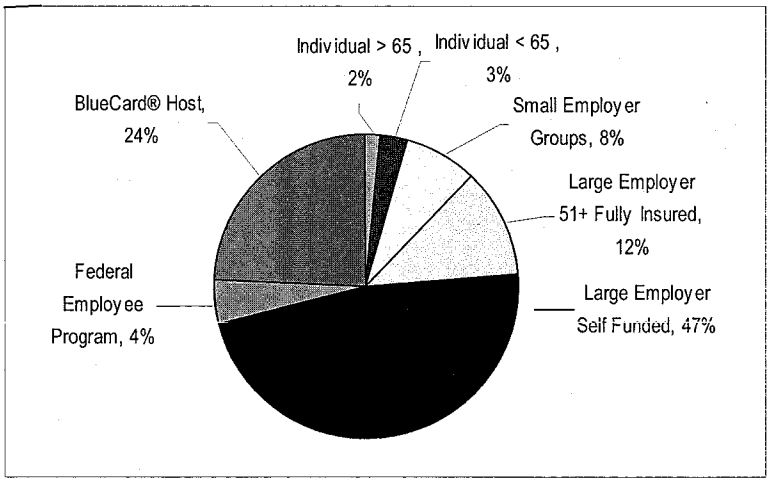
In addition, BCBSD established the Delaware Ancillary Insurance Agency (DAIA) to sell group and voluntary products such as Life, Disability, Dental and Vision to both large and small employers who purchase our health plans. DAIA has established relationships with Fort Dearborn Life, Companion Life and other insurance carriers to offer a comprehensive portfolio of employee benefits products.

BCBSD products include a number of value-added options, including basic Wellness programs (delivered through Healthways) and discounts on alternative health services, hearing screenings and hearing aids, laser eye surgery, mail-order contact lenses, eldercare management, personal trainers and nutrition counseling. Large employers can purchase customized and expanded versions of these programs.

Segments
BCBSD serves the following market segments in Delaware:

- **Individual Under 65** Individuals who do not have access to employer-sponsored coverage may purchase health care insurance from BCBSD directly.
- **Individual Over 65** Individuals who are enrolled in Medicare and do not have access to employer-sponsored coverage may purchase Medigap insurance plans from BCBSD directly.
- **Small Employers** The small employer health insurance market in Delaware includes employers with as few as one and as many as fifty eligible employees.
- **Large Employer, Fully Insured** This segment includes Delaware-based employers with more than 50 eligible employees who purchase fully insured plans.
- **Large Employer, Self Funded** BCBSD provides Administrative Services Only (ASO) or self-funded plans to many Delaware-based employers with two-hundred or more eligible employees.
- **Federal Employee Program (FEP)** The FEP program is the national Blue Cross Blue Shield offering to employees of the federal government's Federal Employee Health Benefits Program (FEHBP).
- **BlueCard ® Host** The national BlueCard program allows members to receive full health care benefits while traveling or living outside of their home Blue Plan service areas. Participating providers and the independent Blue Plans across the country are linked through an electronic network that enables members to access local networks and discounts. Delaware's "Host" segment consists of members of other Blue Plans who reside in and receive health care services in Delaware.

BCBSD – Contract Distribution by Market Segment -- 2010



Marketplace Environment

Service Area

BCBSD's licensed service area is comprised of Delaware's three counties: New Castle, Kent and Sussex. Over the next five years, it is expected that the state's population will grow by approximately 5%.

	2010 Population (est.)	*2015 Population (est.)	Percent Change	** Establishments in DE 500+ Employees
Delaware	891,495	936,348	5.0%	63

*Source: Delaware Population Consortium Annual Population Projections, October 29, 2009, Version 2009.0)
Note: 2010 Census population results will released in December
** Source: DOL DE Database

Marketplace Environment

The current economy, for both Delaware and the nation, has created challenges in the marketplace. Delaware's job market peaked in February 2008 at 439,000 jobs. Since then, Delaware's unemployment rate has risen from less than 4% in March 2008 to 8.5% as of June 2010. Significant local plant closings include General Motors and Chrysler Corporation, both of whom were BCBSD clients through the BlueCard Host program. As the economy recovers, employment levels are expected to remain flat through 2011.

Health Care Reform

The passage of the Patient Protection and Affordable Care Act (PPACA) in March, 2010, imposes sweeping changes in the health care industry. BCBSD has identified four major areas that health care reform will have strategic implications on the Delaware marketplace:

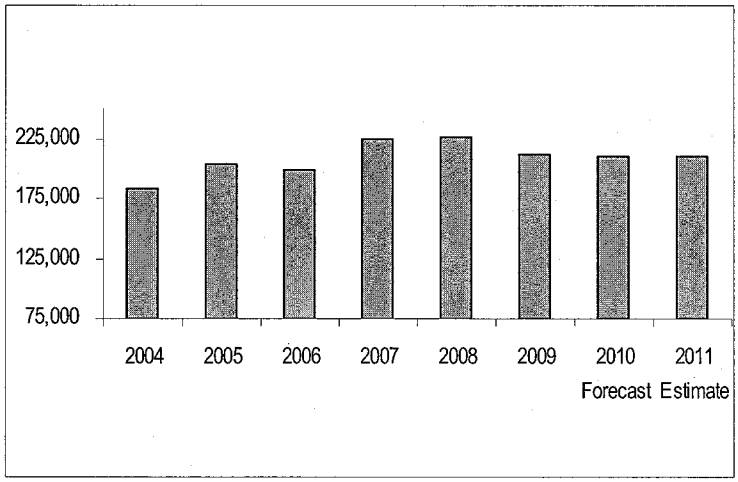
- **Retention of Existing Business** – Due to potential market disruption caused by health care reform, BCBSD recognizes the importance of retaining existing membership by expanding services, providing premium stability, and introducing innovative products to assist employers in meeting new demands in benefits.
- **Retail Market Shift** – With many new regulations on employers and the introduction of Health Benefit Exchanges in 2014, BCBSD expects a meaningful shift in enrollment from employer market segments to the individual segment.
- **Bending the Cost Curve** – Accelerating health care costs will require BCBSD to take aggressive action to control administrative and medical costs to meet marketplace demands.
- **Growth Markets** – It will be critical to add new sources of revenue. BCBSD is reviewing the potential for new growth markets that are likely emerge in response to the reformed market environment.

Summary of Enrollment Trends

From the early 2000's through 2008, BCBSD enjoyed meaningful enrollment increases and peaked at 435,230 members. Following the economic downturn at the end of 2008, enrollment declined by 8% in 2009 to 399,836. In 2010, as unemployment levels stabilized, BCBSD's enrollment has remained relatively flat, with a projected loss by the end of 2010 of just over 1% to 394,886. In 2010, BCBSD has been able to retain nearly 93% of employer group accounts. Enrollment in 2011 is expected to remain comparable to 2010 levels.

The economic decline, combined with medical inflation, also has resulted in a shift of employer groups toward lower-cost, high-deductible plan designs. High deductible CDH plans now represent 10% of BCBSD's total enrollment.

BCBSD Enrollment Contract Trends



Total BCBSD Contracts

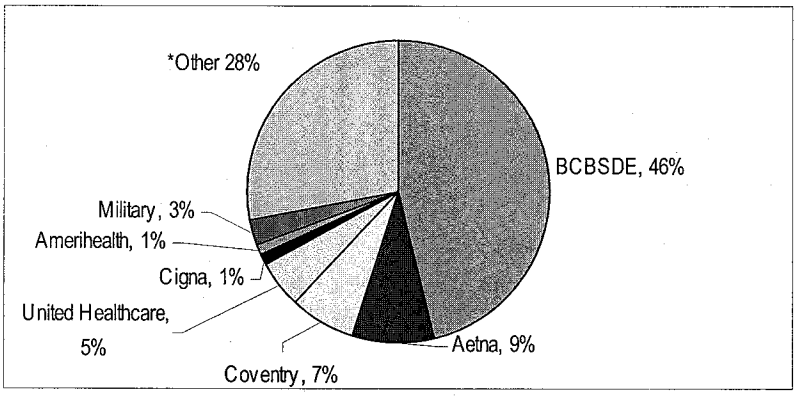
	2008 Actual	2009 Actual	2010 Forecast	2011 Estimate
Locally Managed	169,411	160,716	159,264	160,240
Other Blue Plan (BlueCard Host Contracts)	56,961	51,291	51,065	50,554
Total BCBSD Contracts	**224,159**	**212,007**	**210,329**	**210,794**

Total BCBSD Members

	2008 Actual	2009 Actual	2010 Forecast	2011 Estimate
Locally Managed	322,897	302,814	298,884	300,915
Other Blue Plan (BlueCard Host Members)	115,461	97,022	96,002	95,041
Total BCBSD Members	**435,230**	**399,836**	**394,886**	**395,956**

BCBSD remains by far the market leader in Delaware with an estimated 46% market share (as last measured December, 2009). BCBSD has been successful in maintaining its market share despite aggressive marketing efforts from its main competitors. For a detailed analysis of BCBSD's major competitors, see Appendix II.

2009 Market Share



* Includes government programs and uninsured.

Segment Performance and Strategy

Individual Under-65 Segment

Individual Under-65 Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	[redacted]				
Premium (in millions)					
Medical Loss Ratio					

[redacted]

[redacted]

Individual Over 65 / Supplemental Segment

Individual Over 65 Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	[redacted]				
Premium (in millions)					
Medical Loss Ratio					

[redacted]

Small Employer Segment

Small Employer Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	[redacted]				
Premium (in millions)					
Medical Loss Ratio					

[redacted]

[redacted]

Large Employer Fully Insured Segment (51+ Employees)

Large Employer Fully Insured Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	[redacted]				
Premium (in millions)					
Medical Loss Ratio					

[redacted]

Large Employers Self Funded Segment

Large Employer Self Funded Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	[redacted]				

[redacted]

Account Name	Contract Count
[redacted]	

Federal Employee Program (FEP) Segment

FEP Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	17,363	17,737	17,661	18,049	18,234

Under the Federal Employee Program, BCBSD participates with all BCBS plans around the country to provide for the national delivery of health care benefits and provider

network and discounts to employees of the federal government. BCBSD is compensated for the administrative services we provide under the program, including our marketing efforts to expand enrollment into the plan. BCBSD enjoys outstanding market share in the FEP program, with 99% of eligible enrollees in Delaware selecting BCBSD over our competitors.

BlueCard ® Host Segment

BlueCard Host Segment	2007 Actual	2008 Actual	2009 Actual	2010 YTD	2011 Plan
BCBSD Enrollment (members)	116,508	115,461	97,022	95,685	94,747

Enrollees in BCBS plans around the country can receive benefits and access local providers when traveling to or residing in another state through the BlueCard program. "Home" BlueCard members of BCBSD national accounts receive this benefit outside of Delaware. And, BCBSD is "Host" to BlueCard members from other plans who receive care in Delaware. Under the arrangement, plans apply modest transaction fees to compensate each other for administrative services. Over the last ten years, as BCBS national account enrollment has expanded, BCBSD's share of this business has grown substantially. The 2008 economic downturn has resulted in a nationwide decline in employment, and enrollment results in recent years reflect that reduction. Enrollment in 2011 is expected to remain stable.

2011 and Beyond

BCBSD's key drivers for success in a highly competitive marketplace include:

- **Brand Differentiation** – Continue to promote the value of "Blue," particularly in the individual and emerging growth retail market
- **Product Design** – Reevaluate benefit design in anticipation of reduced product flexibility
- **Provider Network** – Explore alternative network strategies to create cost-competitive offerings; educate customers on value and quality of the Blue provider network
- **Consumer Experience** – Develop retail capabilities; pursue national marketing and distribution partnerships with other Blue Plans
- **Operational Capabilities** – Invest in technology to streamline costs; expand functionality to further automate quoting, enrollment and account management functions

CareFirst, Inc.

Blue Cross and Blue Shield of Delaware

Need for Statutory Surplus
and
Development of Optimal Surplus Target Range

May 13, 2005

Robert H. Dobson, F.S.A.
Phyllis A. Doran, F.S.A.
James A. Dunlap, F.S.A.
Ronald G. Harris, F.S.A.

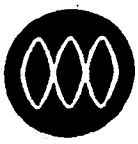
EXHIBIT
JOINT-74

CareFirst, Inc.

Blue Cross and Blue Shield of Delaware

Need for Statutory Surplus
and
Development of Optimal Surplus Target Range

A MILLIMAN GLOBAL FIRM



Milliman

Consultants and Actuaries

A MILLIMAN GLOBAL FIRM

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May 13, 2005

CONFIDENTIAL – ATTORNEY-CLIENT PRIVILEGE

Mr. John Picciotto
General Counsel
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117

Re: Enclosed Report Regarding BCBSD Statutory Surplus Needs and Optimal Target Range

Dear Mr. Picciotto:

Enclosed please find Milliman's May 13, 2005 report prepared for CareFirst, Inc., related to Blue Cross and Blue Shield of Delaware (BCBSD), and titled "Need for Statutory Surplus and Development of Optimal Surplus Target Range".

Section I of the report provides background information, as well as a discussion of the scope of our analysis. The balance of the report discusses uses and requirements of surplus for a health plan such as BCBSD, and describes the approach and findings of our analysis of the Company's optimal surplus target range.

As mentioned in Section I, we have granted permission to share the report with the Delaware Department of Insurance and others, so long as the entire report is provided. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with others.

We appreciate the opportunity to assist CareFirst, Inc. and BCBSD in this important assignment. We are available to discuss any questions you may have, or to provide additional detail regarding our analysis.

Sincerely,

Robert H. Dobson, F.S.A.
Consulting Actuary

RHD/cam/jpj

cc: Mr. G. Mark Chaney
Mr. Edward O'Neil
Ms. Jeanne Kennedy

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I. OVERVIEW

A. Background and Scope

The Company. Blue Cross and Blue Shield of Delaware (BCBSD, Inc.) is affiliated with CareFirst, Inc. (CFI), a not-for-profit company also affiliated with CareFirst of Maryland, Inc. and Group Hospitalization and Medical Service, Inc. The business of the other CFI affiliates is not reflected in this report.

Chart 1 shows the breakdown of the company's business between non-FEP insured or risk business, FEP, and ASC. For the purposes of this report, FEP refers to the Plan's participation in the Blue Cross Blue Shield Association Federal Employee Program, and ASC refers to administrative services only contracts with employers. A relatively large proportion of CFI's business is FEP, and hence we have split it out separately for each of the affiliates. While FEP is an insured program, the contract is held by the Blue Cross Blue Shield Association. Separate reserves, or surplus, are held on behalf of this program, which, at their current level, significantly reduce the underwriting risk to individual Blue Cross and Blue Shield plans such as BCBSD, Inc. ASC business, by its nature, does not present an underwriting risk, but involves other risks which are discussed later in this report.

General. Adequate surplus is central to the viability and sound operation of any insuring organization. It is needed to enable a company like BCBSD, Inc. to ensure that the promises and commitments made in offering health care protection to its customers can continue to be met. It is also needed to ensure that its promises and obligations to hospitals, physicians, and other providers can be met. Further, surplus is needed by a company like BCBSD, Inc. to develop new products, maintain and operate complementary services and coverages, build infrastructure, respond to new business opportunities, develop and maintain service capabilities, and generally operate effectively as a viable ongoing business entity over time.

Consistent with its certificate of incorporation and the Delaware insurance statute applicable to its operations, BCBSD's principal purpose is to sell health benefit plans and programs to Delaware employers and individuals. BCBSD's principal objective is to meet the needs of its customers by providing them access to the highest quality services and products at reasonable costs.

This is an important factor with regard to the platform on which the company plans and builds for the future. It means that BCBSD, Inc. must always keep itself in a position to meet the promises and commitments it has made, under whatever circumstances (anticipated or unforeseen) may arise. It also means that BCBSD, Inc. must continue over time to offer health care coverage products that customers voluntarily choose to purchase.

In order to fulfill its corporate mission, BCBSD, Inc. must be stable and strong financially. It must systematically build and maintain sufficient statutory surplus to remain viable over time, while competing in a market against strong regional entities and very large national managed care companies. These national competitors, in particular, have enormous financial and technological resources, extremely large enrollment bases over which to spread overhead costs, and the ability to diminish participation or withdraw from BCBSD, Inc.'s markets as they see fit. BCBSD, Inc. should never underestimate the difficulty of fulfilling the commitment made in the CFI corporate mission.

Financial strength for BCBSD, Inc., under these conditions, requires ever vigilant attention to the fundamental financial elements of the health insurance business. Principal among these elements are adequate rates, competitive costs (medical costs and administrative expenses), and strong statutory surplus. Inadequate performance over time with regard to any of these three elements is almost certain to lead to failure in meeting BCBSD, Inc.'s mission and commitments, and to failure to sustain itself as a viable business.

The development of an optimal surplus target range within which to strive to operate under normal circumstances is an important undertaking for a company such as BCBSD, Inc., as a matter of prudent business practice and planning. It should be updated periodically, to reflect fundamental changes in operations and the environment.

Scope of this Report. This report has been prepared by Milliman at the request of BCBSD, Inc. The purpose is to address the need for statutory surplus for BCBSD, Inc. and to quantify an optimal surplus target range within which we believe BCBSD, Inc. should strive to operate, under normal circumstances.

In order to develop an optimal surplus target range, we used actuarial projection techniques. We characterize the output of this form of analysis as "pro forma projections." They show the financial results that could be expected if actual operations were to occur exactly as stated and assumed, with no deviations. These pro forma projections are intended to serve as demonstrations of the impact of the stated assumptions within a scenario, relative to alternative assumptions and scenarios, so as to enable an understanding of the actuarial implications of the scenario assumptions. The pro forma projections are not intended to be predictions or forecasts of what the future will hold as actual circumstances emerge and contingencies arise. Actual future financial outcomes will undoubtedly vary, potentially in a material way, from any particular pro forma projection scenario.

This report has been prepared for the exclusive use of BCBSD, Inc., to help its management and Board of Directors formulate intermediate and long-term financial and business plans for the company. The material contained in it will not necessarily apply to any other situation or set of circumstances, and may not be appropriate for other than its stated purpose. To conduct our analysis, we relied on a variety of confidential and proprietary data and information provided by BCBSD, Inc. staff. We did not audit the material we received, although we did review the data for general reasonableness. However, if there are any substantial inaccuracies in the data, the results of our analysis may likewise be substantially inaccurate.

We understand that BCBSD, Inc. may wish to share this report with the Delaware Department of Insurance and others. We hereby grant permission, so long as the entire report is provided. Milliman does not intend to benefit any third party either through this analysis or by granting permission for this report to be shared with other parties.

Chart 1

BCBSD, Inc. Distribution of Business

2004 Premium and Premium Equivalents (GAAP Basis)

(millions)

	Non-FEP Insured	FEP[1]	ASC	Total
BCBSD, Inc.	$251.1	$58.6	$597.4	$907.1

[1] Includes only BCBSD, Inc.'s participation in the BCBSA Federal Employee Program. HMO and other offerings within the Federal Employees Health Benefits Program are included as non-FEP insured.

B. Approach Taken by Milliman

As indicated above, the purposes of this report are to address the need for statutory surplus for BCBSD, Inc., and to quantify an optimal surplus target range within which we believe BCBSD, Inc. should strive to operate under normal circumstances. The need for surplus is addressed specifically in Section II, and throughout the remainder of this report.

The approach to developing an optimal target surplus range for BCBSD, Inc. is documented in Sections III-VI. It begins in Section III with a discussion of minimum surplus requirements, which create a floor for our analysis and development.

Section IV presents historical underwriting results for the industry as a whole, for BCBSD, Inc., and for a comparison set of Blue Cross/Blue Shield (BCBS) Plans. This data is used to judge the reasonableness of results derived from the analysis which follows. Section V addresses specific risks and contingencies, enabling their quantification and combination through Monte Carlo simulation. The result is an actuarial approach to making provision for loss periods based on risk assessment, which are then compared to actual historical results. This approach leads to a range of potential multi-year operating loss levels, against which BCBSD, Inc.'s surplus must provide protection for the company. Section VI then describes application of the potential loss levels developed in the preceding section using pro forma financial projections, in order to determine the amount of surplus needed by BCBSD, Inc. to operate under normal circumstances as a viable company.

Section VII discusses briefly what we believe to be the key principles in managing within a recommended optimal range of surplus.

II. SURPLUS NEEDS AND USES

A. Business Environment

Continued change has been, and will continue to be, a predominant characteristic of the U.S. health care industry at large. This is driven, at least in part, by the fact that today in most areas of the country the health insurance market is increasingly dominated by aggressive and highly competitive regional and national managed care companies. In order to remain viable, a health insurer must anticipate and respond to this ever-changing competitive environment. Doing so requires substantial capital resources and surplus.

The business environment of tomorrow is certain to differ markedly from that of today. Some directional changes – such as continued advances in technology and competitive pressures from consolidation and scale of operations – can be generally anticipated. Other fundamental environmental changes simply cannot be known at this time. The continued viability of a company like BCBSD, Inc. will require that it have the foresight, savvy, and resources to both anticipate and respond effectively to such changes.

Competitor Consolidation and Scale. Perhaps the most noticeable change in the health care industry over the past decade has been the unprecedented consolidation of even sizeable insurers and managed care plans into large and jumbo-sized companies. Most commercial life insurance carriers – stock and mutual companies – have withdrawn from the health insurance market, selling their sizeable blocks of business to the few remaining managed care companies. Likewise, a large proportion of HMOs have gone through mergers or acquisitions, producing an ever smaller number of increasingly larger surviving entities which operate regionally and nationally. Significant consolidation is also occurring within the Blue Cross and Blue Shield system.

The capital resources of these new competitors tend to be enormous. Such resources enable them to invest in new, leading technologies and to aggressively build and contract with provider networks. It gives them negotiating clout, risk-spreading capacity, and funding for market

acquisition. A large scale of operations also enables them to spread overhead costs more effectively.

Role of Technology. Virtually every segment of our economy is being bombarded with technological change. Not only is every aspect of the way business operates changing, but what businesses do as a result of new technology-driven capabilities continually changes as well.

The inherent natures of medical delivery and of health care financing place a high degree of importance on communication, data gathering and processing, testing and analysis, and information feedback among these activities. Health insurers must stay near the forefront in terms of the effective integration of communication, information processing, and computing technology. This requires capital investment, which has become virtually continuous with the rapid development and obsolescence of technology.

Care Management Evolution. Care management strategies and programs come in a number of forms today, but virtually all health care coverage is "managed" in some manner. This was initiated, at least in part, by the public acceptance of and dramatic growth in HMOs during the past 10-20 years. Today, care management can be considered more appropriately in terms of the nature, form, and extent of the clinical and financial management involved in whatever health care products are found in the local market, rather than in terms of the enrollment in any particular product type.

The clinical and financial management of care has not only expanded, it has evolved. This has been driven, at least in part, by a blend of consumer and provider pressures and advances in information technology. As technology has enabled the detailed analysis of financial and member information, the industry has begun to manage and evaluate the delivery of medical services against protocols and benchmarks derived from a combination of cost and quality factors. This new direction for the industry is also being driven by factors such as the rapid introduction of new drugs and therapies, including the use of member direct marketing strategies.

Simply keeping pace with these kinds of changes, let alone playing a leadership role in the market, is a daunting challenge for every major health insurer. Core competence, corporate

capabilities, and support systems in the clinical and financial management of care must be re-established and overhauled every few years. This requires the maintenance of strong business and professional leadership, a depth and breadth of clinical management resources, and astute financial thinking. It also requires ongoing capital investment, which at times may be substantial.

Competitive Market, Small Underwriting Margins. With the exception of certain brief periods and certain atypical geographic areas, underwriting margins (i.e., the excess of premium over claims and expenses) for health insurers generally have been remarkably low over time. A notable exception historically was the early 1990s, when certain aggressive, publicly traded managed care companies achieved substantial gains for a number of consecutive years (at least in part through favorable risk selection). Even then, the primary source of sizeable profit growth for many publicly traded HMOs was through mergers and acquisitions.

The health care coverage market continues overall to be price sensitive. From time-to-time and from place-to-place, price and underwriting margin pressures ease somewhat for brief periods. However, the pervasive ongoing outlook is for strong competition, enabling only modest levels of sustainable underwriting margins. Two direct implications are that (i) a pattern of consistent gains year-after-year for any extended period is rarely achieved without loss years interspersed throughout, even for a well run insurer, and (ii) full recovery from a period of substantial and prolonged losses is very difficult without radical actions. These point to the importance of financial "staying power" – sufficient surplus or other sources of equity capital to recover from cyclical downturns and unexpected adversities.

Competing in the Market as a Not-For-Profit Company. BCBSD, Inc. is a not-for-profit health insurer offering health care products in its licensed service areas, under the name Blue Cross Blue Shield of Delaware (BCBSD) a CareFirst company. The corporate mission of BCBSD, Inc., as stated earlier, is to "...meet the needs of its customers by providing them access to the highest quality services and products at reasonable costs." To fulfill this mission, BCBSD, Inc. must compete successfully in the market against all competitors who elect to enter, whenever they choose to do so. It must not only sell its health care coverage products to willing customers, but it must do so on a basis which can be sustained indefinitely.

A significant requirement of meeting this mission and competing effectively is to maintain sufficient equity capital resources. BCBSD, Inc. faces the same insuring and business needs for equity capital as its major competitors – for-profit or not-for-profit. Since it is not owned by shareholders, it has no access to equity capital other than its surplus. This necessitates both the maintenance of a strong surplus level, and the cautious management of that surplus. Failure to do so would jeopardize the entire foundation of BCBSD, Inc. – including its future viability, and therefore its ability to reliably and sustainably provide access to affordable and quality health care.

Access to Capital. Historically, most health insurers were mutual or not-for-profit companies. The surplus held by such companies comes largely from accumulated underwriting gains and investment income. Today, most of the major national health insurers and managed care companies, as well as many regional ones, are publicly traded stock companies. This affords them long-term access to equity capital markets for risk-taking, operational development, or growth needs – in addition to their accumulated underwriting gains and investment income (i.e., in addition to their surplus).

The market value of publicly traded health insurers and managed care companies is very large relative to the surplus of such companies accumulated from operations. The excess of their market value over tangible net worth (a rough proxy for surplus) represents additional equity capital value to which the company can gain access for various purposes, if necessary. Clearly, this is a major financial advantage which these for-profit companies hold in access to equity capital.

Catastrophic Risks. Virtually all types of insuring entities in today's world face the risk of certain catastrophic events occurring. Such events, by definition, have a low probability of occurring and very severe adverse financial consequences. For health insurers such as BCBSD, Inc., potential catastrophic events range from the impact associated with terrorism, to epidemics or pandemics, to natural or other disasters, to extraordinarily high damage awards from major class action or other litigation.

Because of the low probability of particular catastrophic events occurring, and their changing prospects and nature over time, it is not unexpected that a company would not have actually experienced an occurrence of the sort of catastrophic event for which it is presently at risk. Failure of the insurer to provide protection against such risks, however, means that the company is exposed to ruin or incapacity from such an event. More importantly, it means that the company does not maintain the resources to protect its subscribers and members, its providers, and its vendors against catastrophic loss should such an event occur. Prudence regarding fundamental soundness and assuring ongoing viability dictates a meaningful level of surplus protection against such events.

B. Surplus and Risk-Taking Capital Needs

The surplus for a Plan like BCBSD, Inc. is the equity capital (excess of assets over liabilities) available to ensure the future viability of the company. Ensuring future viability recognizes (i) the possibility of adverse financial results and of unexpected events occurring, (ii) the periodic need to provide for extraordinary health care development costs or investments in support of the company's operations, and (iii) the capacity necessary to enable reasonable growth.

The overall surplus needs of a not-for-profit Blue Cross Blue Shield Plan include all of these considerations – risk capital, funding of health care development costs, and growth capital. All of BCBSD, Inc.'s risk-taking capital needs created by the varying risk characteristics of its business and all other immediate needs for equity capital must be met by the company's surplus.

To ensure the future viability of a health insurer requires recognition of all of the kinds of adverse financial results and unexpected events or circumstances that might occur. Some of these adverse results and unexpected occurrences are directly related to the types of insurance risk assumed by the company through the normal course of conducting its business. Other types of risk pertain more generally to various aspects of the operation of the company – including fluctuations in expense levels, fluctuations in interest rates and asset values, and various business risks. Finally, risk is associated with a variety of catastrophic events that might occur, and that a company like BCBSD, Inc. must be prepared to withstand.

Broadly speaking, these risks represent the adverse cyclical results and the contingencies or unexpected occurrences faced by a health insurer in the day-to-day conduct of its business. The term risk capital can be used to refer to the level of surplus needed by the company to prudently manage and absorb these risks.

Maintaining an adequate level of risk capital is necessary for a health insurer in order to ensure that provision is made for all of these risks assumed by the company. Without adequate risk-taking capital of its own, a health insurer is faced with a small number of potential alternatives.

They may include:

- permanent equity capital infusion from an external source (not generally available to a not-for-profit insurer, other than possibly as part of a merger or acquisition).

- temporary equity capital infusion from an external source, such as a surplus note (which may or may not be available or affordable, and which usually has significant strings attached, typically involving loss of some or all of the control of the Board of Directors).

- transfer of risk to another entity with adequate risk capital (which may or may not exist or be feasible), and the loss of control that might accompany such a shift.

- compensation for inadequate surplus by immediately charging extraordinarily high premium rates for the company's products (difficult, if not impossible, in a competitive and closely regulated market), to eliminate as much as possible the risk of future losses.

- compensation for inadequate surplus by immediately taking inordinately deep cost cutting actions, to mitigate as much as possible the risk of future losses.

Some of these potential alternatives may not be feasible, and none of them is likely to come without serious ramifications. Specifically, extraordinarily high premium rates or inordinately deep cost cutting actions cannot be made in a vacuum; they may have severely adverse effects such as significant enrollment losses due to uncompetitive pricing or poor customer service.

C. Use of Capital for Development and Growth

An additional need for surplus is the funding of health care development costs or operational capacity (infrastructure) investments. These might be improvements or innovations such as new product development; periodic revamping of delivery system networks, reimbursement structures, or management of utilization; or development or acquisition of new communications, information, or processing systems. Such investments must be made periodically, and the corresponding costs incurred, if the company is to be successful in the health insurance business. Often such capital expenditures do not produce hard assets that can be admitted on the company's statutory balance sheet. This means that such expenditures generally must be absorbed immediately out of surplus.

Growth and expansion is a major goal for most successful business entities operating in a competitive market. This requires the presence of market opportunity, plus the resources necessary to pursue growth from such opportunities. Growth can be achieved directly through day-to-day competition in existing markets, through entry into relatively new markets, or through long-term affiliation in existing or new market areas. Examples at this particular time include new consumer oriented product demands and opportunities, and expansion of insured products to the senior market under Medicare reform.

Developing and absorbing growth requires growth capital to fund developmental costs, to cover the initial losses resulting from the need to be price-competitive at the outset in order to become established, to absorb any losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in surplus). Obviously, a prerequisite for financially sound growth for a not-for-profit health insurer is strong surplus.

III. MINIMUM AND OPTIMAL SURPLUS REQUIREMENTS

A. Background

In the wake of various insolvencies (and near insolvencies) around the country in the not-too-distant past, attention has been directed at minimum standards for the surplus of managed care organizations generally, and of Blue Cross and Blue Shield Plans specifically. Historically, individual states had done little to effectively monitor the financial condition of such organizations and to detect organizations that were becoming troubled financially, prior to the immediate threat of insolvency. Notwithstanding any differences of opinion among parties with regard to appropriate thresholds for minimum surplus levels, the common theme of this growing industry and regulatory attention has been ensuring adequate minimum levels of surplus to protect against organizational insolvency, thereby protecting the insured members from loss.

For a number of years, the Blue Cross and Blue Shield Association (BCBSA) has required that all BCBS Plans calculate Plan-specific measures related to solvency, and that a Plan's surplus not fall below certain thresholds relative to such measures. This process has been part of the BCBSA membership requirements; and compliance has been necessary in order to maintain good standing and retain use of the trademark.

Over time, the Association's minimum requirements became formalized in the form of Capital Benchmark formulas and calculated values. With the development and adoption of Risk Based Capital (RBC) formulas and standards for managed care organizations by the National Association of Insurance Commissioners (NAIC), BCBSA likewise adopted RBC as the foundation for its own membership requirements (effective late 1999).

The RBC mechanism is now widely recognized as a standardized approach to developing minimum solvency indicators. Calculated RBC values are required for inclusion in the NAIC annual financial statements filed by health insurers; and most States (including Delaware) have adopted the NAIC's RBC-based compliance standards to help assure that health plans meet minimum requirements for solvency. The RBC methodology provides for the calculation, by

detailed formula, of a benchmark or reference value, multiples of which are used to establish standards for external monitoring and intervention.

The use of RBC as a methodology, and of the values calculated from it, obviously have significant limitations. The RBC formula is a structured and mechanical approach to trying to capture and quantify the risk characteristics for a wide range of different types of companies operating in a variety of environments, with changing circumstances over time. As a structured and mechanical formula that attempts to address complex matters, it necessarily contains elements that represent broad simplifications. Nonetheless, it serves a highly useful purpose in identifying companies whose surplus levels may be precarious, and therefore warrant careful scrutiny. Such scrutiny cannot be applied in a meaningful way, however, without a detailed examination of company conditions and circumstances by knowledgeable professionals experienced in the field. Because of these factors, the principal and most important role of calculated RBC values is to serve as a screening or flagging mechanism, to indicate potentially serious situations that may warrant undertaking more thorough and comprehensive evaluations.

The RBC formula was designed and developed for identifying companies that may be facing the prospect of impending insolvency. At such a point, all efforts (internal and external) should be directed at stabilization and financial rehabilitation, in order to prevent claims payment default or cessation of business. The RBC formula does not address needs associated with ongoing business viability and success. In developing an optimal range for a company's surplus, as opposed to a minimum threshold for solvency monitoring, surplus needs for matters not contemplated in the RBC formula must be considered and addressed.

B. Minimum Capital Thresholds

The use of Risk Based Capital (RBC) measurements is intended to provide a systematic approach to developing benchmarks for individual companies for use in monitoring minimum levels of statutory surplus needed for protection from insolvency. As indicated above, the RBC formula adopted by the NAIC for managed care organizations (including Blue Cross and Blue Shield Plans) provides an objectively calculated reference value that can be used for this purpose. Although far from perfect, it does recognize a company's size, structure, and volume of retained risk. It also incorporates elements that address underwriting or insurance risk, asset risk and various forms of business risk.

The key reference value developed by the RBC formula is termed the "Authorized Control Level" (we refer to this as RBC-ACL). Multiples of the RBC-ACL (e.g., 900% of RBC-ACL) can then be used to establish thresholds, with higher multiples producing an increased likelihood of security against insolvency.

This use of consistently calculated reference values, along with various multiples for different purposes or degrees of concern and security, provides a useful tool for State regulators and industry organizations (such as BCBSA). Key RBC threshold levels applicable to BCBSD, Inc. are described below[1]. Also indicated are the actions associated with these key RBC-based levels, along with equivalent measurements of them in terms of percentages of annual premium.

[1] All surplus and related financial items addressed in this report are on a statutory basis, unless stated otherwise.

BCBSA Minimum RBC-Based Thresholds. BCBSA maintains certain minimum financial requirements that Blue Cross and Blue Shield Plans must meet, as part of the membership standards for use of the trademark. Two key thresholds involving surplus are based on the RBC formula, and are expressed generally as follows:

BCBSA Threshold	Percent of RBC-ACL
Early Warning Monitoring Level	375%
Loss of Trademark Level	200%

Delaware Minimum RBC Requirements. Delaware has adopted statutory minimum requirements for the surplus levels of commercial health insurance companies, nonprofit hospital service corporations, and HMOs domiciled in the State. These minimum requirements are expressed in terms of a company's RBC-ACL level, and are generally consistent with the corresponding standards recommended by the NAIC and adopted by most states around the country. Upon triggering the 200% of RBC-ACL threshold, a domestic insurer must formally notify the Insurance Commissioner of the corrective actions it plans to take. Direct regulatory interventions are triggered if surplus drops to even lower percentage levels.

Implications of RBC Minimum Requirements. As indicated above, 200% of RBC-ACL is the threshold for mandatory corrective action plan notification by domestic insurers to the Insurance Commissioner. The 200% of RBC-ACL level is also the threshold at which a Blue Cross and Blue Shield Plan loses the use of the trademark. Stated in terms that may be more intuitive, 200% of RBC-ACL equates to approximately 6.3% of annual risk premium for BCBSD, Inc., or about 3¼ weeks' worth.

The loss of trademark due to inadequate financial strength would likely be a catastrophic event: if the trademark were lost the remaining organization, and more importantly its Delaware subscribers, would lose the breadth and strength of the Blues' system. Product recognition, favorable reimbursement rates out-of-area, and current levels of service would be forfeited. Certain other financial opportunities would also be lost as a result, such as the ability to offer benefits to certain large national accounts and the Federal Employees Health Benefits Program and the access fees for offering BCBSD, Inc.'s network to other BCBS Plans. Furthermore, removal of the trademark due to financial weakness would open the door to the entry of a replacement BCBS Plan.

C. Minimum Thresholds vs. Optimal Range

The BCBSA risk capital thresholds indicated above are directed at minimum levels – specifically, early warning monitoring, and withdrawal of the trademark. Where states or other jurisdictions have adopted the RBC-based standard, the application is likewise directed at minimum solvency levels. The focus of oversight and regulatory bodies on adequate minimum surplus levels is understandable and appropriate. These bodies bear responsibility for monitoring the continuing solvency of the health plans under their jurisdiction, and for taking actions before impending insolvency and closure. They had been widely criticized in the past for not maintaining adequate minimum surplus standards or sufficient monitoring of financial strength, and for not taking timely and forceful action with regard to health plans with poor performance.

The proper focus of a financially healthy non-profit Blue Cross Blue Shield Plan, however, is on achieving and maintaining an optimal ongoing surplus level. Such a level is intended to (i) ensure the continuing viability of the company, (ii) inspire warranted confidence by group customers, subscribers and providers, (iii) enable the development of competitive yet adequate premium rates for customers (rather than needing to be excessively high, because of inadequate surplus to back them), and (iv) provide funding for long-term development costs and investments. Such a focus by company management is prudent and appropriate.

An optimal ongoing operating range for a company's surplus level clearly will be higher than the minimum level used by regulators and oversight bodies as a benchmark for warning signals against insolvency and necessary intervention. Prudent company management will focus not only on an appropriate range for its ongoing and long-term needs, but also on the avoidance of approaching levels that may trigger special external scrutiny or intervention, or that may create subscriber, provider, or public concern. Such a range, therefore, must be (i) high enough to avoid having the company's surplus falling to a level where external scrutiny is initiated, and (ii) wide enough to absorb the rises and declines in relative surplus levels that occur during the normal course of business over an extended period of time.

An upper level for surplus, by contrast, would represent the point at which additional accumulation of funds would not contribute meaningfully to furthering the goal of ensuring the future viability of the company or protecting its members. By definition, exceeding such a level would not add to the well being of the company.

D. Goals for Optimal Surplus Target Range

The establishment of an optimal target range for its surplus is one of the more important financial policy issues BCBSD, Inc. must address. It has fiduciary, business management, and strategic implications.

The goals for BCBSD, Inc. in determining a target surplus range should begin, we believe, with the BCBSA thresholds. Specifically, we recommend that they be established to achieve the following goals:

- ***Early Warning Monitoring Threshold Avoidance*** – Provide a high likelihood that the overall surplus level for BCBSD, Inc. will remain above the BCBSA Early Warning Monitoring threshold level, even after a particularly adverse period of multi-year underwriting losses, thereby enabling ongoing viability;

- ***Loss of Trademark Avoidance*** – Assure with virtual certainty that surplus will remain above the BCBSA Loss of Trademark threshold level for the operation, even if a severely adverse period of multi-year underwriting losses were experienced, or if back-to-back loss cycles were to occur without adequate recovery between them, thereby avoiding failure; and

- ***Adequate Provision for Development and Growth*** – Provide equity capital to enable periodic investments in technology, product development, building or acquisition of complementary business capacity, and growth in business in force without jeopardizing the company's risk capital position.

IV. BUSINESS CYCLES

A. Underwriting Cycles in the Health Insurance Industry

Nature of the Business. A basic characteristic of health insurance is that the ultimate cost to the insurer of the services which will be used by the purchaser under the coverage being sold is not known at the time of sale. The insurer does not know the volume and scope of the benefits that will be used; and the actual cost of the benefits also varies depending on the provider that renders the service. As a result, the actual costs cannot be fully determined until some time after the coverage period has expired, when all claims have been submitted and processed. In providing coverage, a health insurer bears the financial risk in the event that actual costs exceed the expected costs reflected in the premiums being charged.

Underwriting gains and losses are a result of the differences between premium revenue and expenses. Premium rates are established by the insurer based on assumptions as to future claim cost levels (cost of care), administrative and other expenses, and investment income, with allowances for profit and/or contributions to surplus. The most important of these components is the claim cost level, which often constitutes 80%-90% of the total premium. Although estimation and uncertainty are present for all of the premium components, uncertainty as to future claim cost levels creates the most substantial risk for the insurer.

Under normal circumstances, estimates of future claim cost levels are projected from historical claims experience, with consideration as to changes in benefits, likely rates of change for factors such as price and utilization trends, changes in health care practices and technology, impact of care management initiatives, or changes in the characteristics of the covered population. Despite continuous efforts by most health insurers to contain or stabilize these rates of change, their impact cannot be predicted with certainty.

The period of time required for medical claims to be reported, processed and adjudicated is approximately two months for typical health insurance coverages. Because of the resulting delays in measuring historical claims experience and because premium rates must be determined many months in advance of their applicable rating periods, claims must often be projected for a

period of 21 to 24 months, and even then using imperfect historical claims data. Health care costs in recent years have frequently increased at annual rates of 10% to 15%, or even higher. Therefore, the uncertainty in projected aggregate claim cost levels for even a large block of mature business can be substantial over a multi-year period of time.

When variances do occur, their timely recognition is crucial. By the time financial reports have been compiled to show underwriting results for the previous year, premium income for the current year has been largely determined through twelve-month rate guarantees that are already in place. Corrective actions taken in response to these financial reports are unlikely to yield results until the subsequent year, because of the lead time needed to implement rate changes and the development time required for cost control initiatives. As a consequence of this inherent nature of health insurance operations, multi-year periods of unexpected or unplanned gains or losses commonly arise. This tends to produce cyclical underwriting results for health insurance business.

Historical Underwriting Cycles. Underwriting results of health insurers have been characterized historically by marked underwriting cycles, resulting in part from such delays in response time. Periods of industry-wide underwriting gains have been followed by periods of losses, and then again by periods of gains.

While specific patterns have varied by company and by market segment or region, marketwide results historically exhibited a consistent six-year underwriting cycle – three years of gains followed by three years of losses – throughout the twenty-five year period from the mid-1960s to the end of the 1980s. This is shown in Chart 2, which summarizes aggregate annual underwriting gain/(loss) for all Blue Cross and Blue Shield Plans. Note that these results do not reflect investment income, nor do they reflect Federal income taxes. Comparable data available for commercial insurance companies through 1993 exhibits a similar pattern.

Underwriting cycles in the industry have been driven to a significant extent by changes in claim trends, which historically have also followed a cyclical pattern. Chart 2 also shows the pattern of health care cost trends, as represented by the Health Cost Index™ maintained by Milliman. This measure of health care cost trends reflects nationwide changes in non-Medicare health costs,

exclusive of factors affecting specific carriers such as adverse selection, shifts among product types, deductible leveraging, and changes in comparative discounts; as a result, it tends to understate the trend levels that would have been experienced by a particular carrier in one market or another. Nevertheless, it is apparent that underwriting results and health care trends have been inversely correlated.

This correlation has occurred because carrier rating practices tend to reflect past claims experience projected at recent trend levels. When claim trends increase unexpectedly, underwriting losses materialize because carrier premium rate levels have not anticipated the higher trends. Once recognized, the higher trends are considered in the calculation of future premiums, which leads to higher premium rate increases by carriers, often generating underwriting gains once trends begin to decline.

The delay involved in carriers' abilities to recognize trend and other rating parameter changes and build them into future premium rates contributes to cyclical underwriting results. Another factor, highly related, is that when recent underwriting results have been favorable the marketplace often begins to reflect optimism, which translates into relatively more aggressive pricing by competitors; similarly, after a period of losses carriers generally become more pessimistic, which translates into more conservative pricing. Further, carrier development costs and/or losses associated with the introduction of new products have compounded these results.

While underwriting cycles have long been recognized by health insurers, predicting their course has never been a simple matter – particularly because the precise timing and magnitude of such cycles tend to vary by carrier, region, and market segment. Further, competitive pressures limit any individual carrier's ability to increase rates significantly faster than competitors.

As shown in Chart 2, the cyclical pattern of the Blue Cross and Blue Shield underwriting results for the system as a whole has changed somewhat in recent years. Beginning in 1989 these results exhibit an extended period of six years of moderate underwriting gains overall, followed by an extended period of moderate losses in the subsequent years, then with gains in the most recent years. The experience of many HMOs was similar during this period. The extended duration of these phases represents a departure from previous cycles.

There are a number of possible explanations for this recent change in the pattern of underwriting results. Foremost was a moderation in health cost trends during the 1990's, resulting at least in part from low inflation coupled with aggressive carrier contracting with providers and significant expansion of managed care activities. In addition, many health plans had negotiated global fee schedules, and even provider risk-taking arrangements that provided some protection to the insurer against losses by transferring risk to providers. Many of these moderating factors have since diminished or disappeared, creating considerably more uncertainty and volatility for health insurers.

Considerations for the Future. A number of specific features of the health insurance business environment have changed over the course of the past 20-25 years, but the fundamental nature of the uncertainties that exist and the characteristics of the products that give rise to cyclical results still remain.

As noted in the previous section, and shown in Chart 2, the cyclical pattern of Blue Cross and Blue Shield underwriting results for the system as a whole has changed somewhat in recent years. Within the past several years, a number of specific changes have occurred that warrant consideration and ongoing attention with regard to the BCBSD, Inc.'s need for surplus. Principal among them are:

- Reduction in managed care constraints, affecting utilization levels and trends, without incorporation of other forms of compensating controls by providers.

- Intensity of provider price and contracting pressures, due at least in part to government program cost-shifting and provider consolidations.

- Resulting high and volatile medical cost per member trends.

- Underlying market instability produced by recent but continuing high medical cost trends and increased competitive pressure on ASC fees.

- Legislative and regulatory mandates and compliance requirements, necessitating ongoing operational investments.

- Escalating technology support and information demands.

- Growing market pressure for new group and individual products, with stronger financial incentives for members.

- Ongoing reform of Medicare, with the opportunities and uncertainties created for health plans.

- Growing catastrophic risks, from litigation and terrorism.

The first four of these environmental factors are all contributors to, or consequences of, high and volatile medical cost trends. Historically, uncertainty as to trends, and periodic intervals of high trend levels, has contributed directly to downward business cycles. In addition, trends create "surplus strain" – not unlike enrollment growth – where the absolute dollar level of required surplus grows significantly simply because the dollar volume of business has grown.

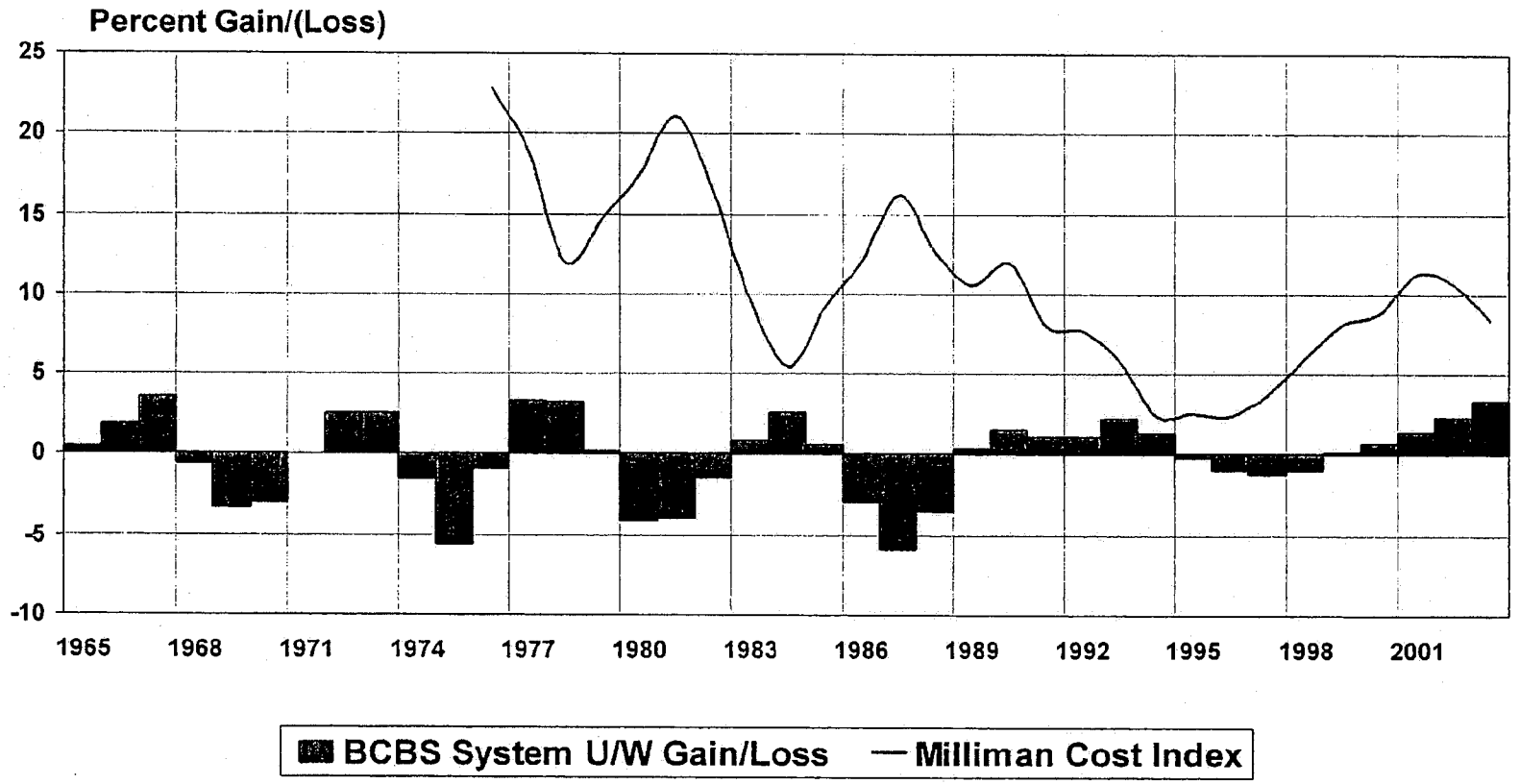
The remaining five environmental factors contribute to either significant investment needs or the risk of catastrophic loss. The pressure on capital investments for infrastructure and new products is likely to be ongoing; responses to market opportunities and pressures are essential; and the prospects for catastrophic events are heightened, in our judgment.

It is impossible to predict the form of future business cycles and whether the traditional six-year underwriting cycle will reappear at the industry-wide level, in either its previous form or some modified version. Nevertheless, the forces and factors at work serve to create cyclical financial results for a health insurer. As a result, multi-year cycles in financial results at the company level are virtually inevitable. Health insurers can take steps to minimize the impact of the adverse part of the cycles facing them, but cyclical results are heavily driven by the basic nature of health insurance and its guarantees, and by external competitive forces. Note that trend escalation and volatility, which has historically led to adverse cycles, continues. Such volatility

in trends is a reminder of the considerable uncertainties in the health insurance business, and historically has been a direct contributor to cyclical underwriting results.

Chart 2

Underwriting Cycles and Trends



B. Adverse Gain/(Loss) Cycles Experienced by BCBSD, Inc.

BCBSD, Inc. is subject to the same types of cyclical forces that drive the results for the industry overall. It is subject to uncertainty in trends, as well as to periodic cycles in the trend levels themselves. With its geographic market, and resulting concentration of business, BCBSD, Inc. is sensitive to this sort of risk. Once losses have begun and have been measured, BCBSD, Inc. then faces the same inherent delays in effecting corrections, due to the basic nature, advance notice of rates, and rate guarantees associated with health insurance. Chart 3 displays the underwriting gain/(loss) cycles experienced by BCBSD, Inc. since 1980. As can be readily seen, there were three distinct adverse cycles during this period.

The BCBSD, Inc. underwriting gain/(loss) cycles displayed in Chart 3 are shown as percentages of premium (as in Chart 2). They are shown, however, on two different bases – as percentages of total premium (insured including FEP plus ASC) and as percentages of non-FEP insured premium only. This distinction is important because the magnitudes, when expressed as percentages, differ significantly (expressed relative to total vs. non-FEP insured premium); and BCBSD, Inc.'s practice with respect to statutory reporting of premium changed from total to insured-only premium (including FEP) beginning in 1991.

A careful comparison of the historical underwriting gains and losses for BCBSD, Inc. (Chart 3) and for the industry as a whole (Chart 2) indicates that the timing of the favorable and adverse cycles was highly consistent for most of this historical period. In addition, the magnitudes of the cycles (based on the "Total Insured + ASC Premium Equivalents" loss measures for BCBSD, Inc.) were generally consistent.

As mentioned previously, the separate reserves that are held on behalf of the FEP program significantly reduce the underwriting risk to BCBSD, Inc. for this business. For this reason, unless stated otherwise, in the balance of this report we will express BCBSD, Inc. underwriting losses as a percentage of non-FEP insured premium – i.e., as a percentage of the portion of the premium that carries what can be characterized as a typical health insurance underwriting risk.

Chart 4 summarizes the cumulative underwriting losses for the three adverse business cycles experienced by BCBSD, Inc. since 1980, expressed as a percent of annual non-FEP insured premium. Underwriting gain/(loss) reflects the excess of premium over claims and expenses, prior to such items as investment income and Federal income taxes; it provides a direct measure of business performance, in terms of the adequacy of premium rates (relative to claims and administrative expenses).

Each adverse or down cycle shown in Chart 4 was a distinct multi-year period of underwriting losses: 1980-82, 1986-89, and 1997-2000. Separating these adverse underwriting loss cycles have been multi-year periods of gains, or upward business cycles. The three adverse cycles produced cumulative underwriting losses that ranged from 8% to 17% of a year's non-FEP insured premium, averaging about 12%.

Chart 3

BCBSD, Inc. Underwriting Gain/(Loss)

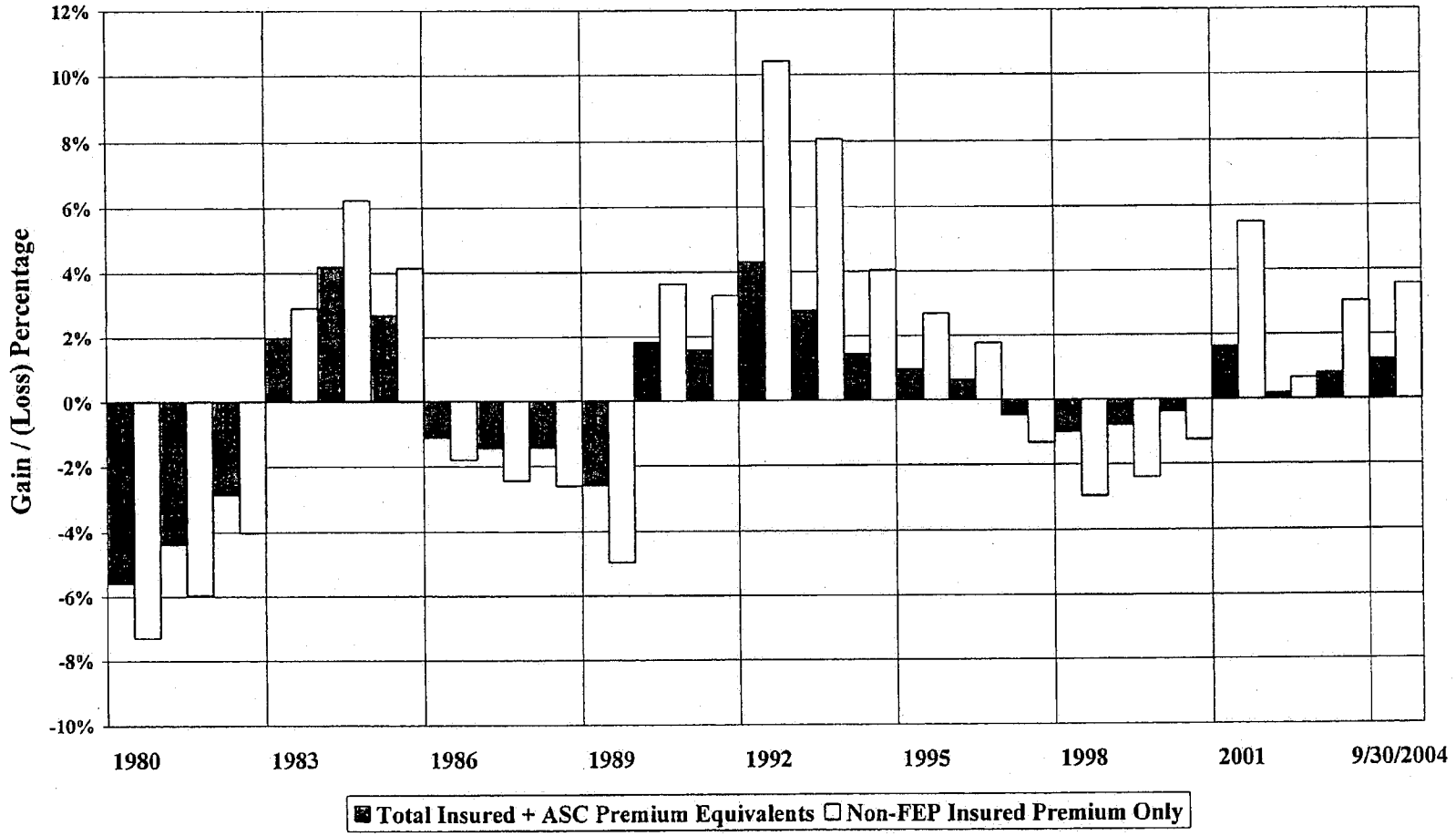


Chart 4

BCBSD, Inc. Underwriting Loss Cycles[1]

	Cumulative Underwriting Loss for Entire Cycle[2]		
	1980-82	1986-89	1997-2000
BCBSD, Inc.	(17.3)%	(11.8)%	(7.9)%

Notes:

(1) Gain/(loss) expressed as a percentage of estimated non-FEP insured annual premium. Excludes FEP and ASC premium equivalents for all years.

(2) Underwriting gain/(loss) is the excess of premium over claims and expenses, prior to investment income or income taxes. Cumulative percentages are the sum of annual loss percentages, over the loss cycle indicated.

C. Adverse Cycles for a Comparison Set of BCBS Plans

In order to take a closer look at adverse cycles experienced by individual companies within the health insurance industry, we compiled underwriting results as a percent of premium for the roughly one-half of all reporting BCBS Plans in the country that are closest in size to BCBSD, Inc., starting with 1980. The results are shown in Chart 5. Also shown on this chart are the results for BCBSD, Inc. and the overall results for the industry as a whole. Although BCBSD, Inc. has experienced its own unique circumstances, the similarities among Plans are apparent.

Note that in Chart 5, results for BCBSD, Inc. are expressed as a percentage of total insured (including FEP) plus ASC revenue, generally corresponding to the first set of data points in Chart 3. Similarly, it is our understanding that most of the Comparison Plan results are also reported on this basis, although there may be exceptions. It is important to note, in the context of this analysis, that a consequence of this form of reporting historically by most BCBS Plans is a systematically understated set of calculated loss cycle percentages. All of the rest of this analysis is expressed relative to non-FEP insured premium only.

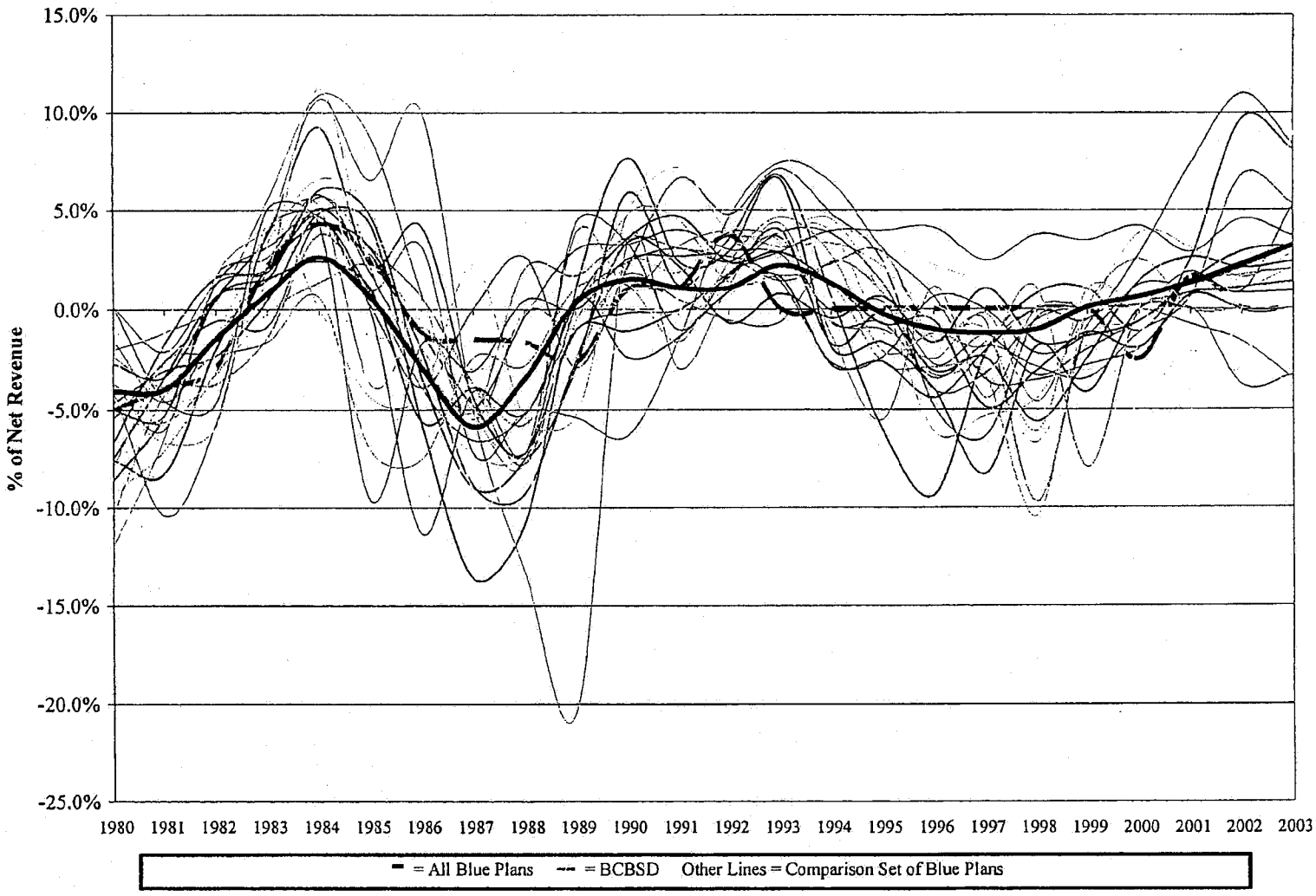
Among the 30 BCBS Plans in the Comparison Set, there were a total of 99 adverse cycles during the period 1980 – 2003. Most of these Plans had three adverse cycles during this period, the same as experienced by BCBSD, Inc. The following table summarizes the total loss percentages corresponding to the 90^{th}, 85^{th}, 80^{th} and 75^{th} percentiles of all 99 adverse cycles experienced by this set of BCBS Plans.

Adverse Cycle Results for Comparison Set of BCBS Plans	
Percentile of Adverse Cycles*	**Cumulative Underwriting Gain/(Loss) Percentage**
90th	(22)%
85th	(20)
80th	(18)
75th	(18)

* Percentile of all adverse cycles for the period 1980-2003, among the set of 99 adverse cycles for the BCBS Plans observed.

We have focused on these percentiles of the historical loss cycles for the Comparison Set of BCBS Plans in order to be able to quantify the magnitude of particularly or severely adverse cycles (discussed later in this report). We have not considered the magnitude for loss cycles beyond the 90th percentile for the Comparison Set in order to exclude those individual cycles for their respective companies across the industry that may have been truly outliers or materially anomalous for some reason.

Chart 5
Underwriting Gain/(Loss) for Selected BCBS Plans



V. RISKS AND CONTINGENCIES

By observing multi-year underwriting results for health insuring entities – BCBSD, Inc., other BCBS Plans, or the industry as a whole – one can measure the combined actual impact of the risks and contingencies, including expenditures for developmental activities, faced by such entities on their underwriting gains or losses. In the previous section of this report, we presented such results for historical periods beginning with 1980. This provides an empirical experience base for evaluating loss periods that carriers have had to withstand.

In this section of the report we take an actuarial approach to quantifying the risks and contingencies faced by BCBSD, Inc. This approach involves developing a range of possible values and associated probabilities for each of several major categories of risk and funding contingencies in BCBSD, Inc.'s operations, for which surplus requirements need to be recognized.

A. Major Risks and Contingencies

We have identified several major categories of risks and contingencies for which surplus is required. They can be summarized as follows:

Major Risk and Contingency Categories	
(1)	Rating adequacy and fluctuation
(2)	Unpaid claim liabilities and other estimates
(3)	Interest rate and portfolio asset value fluctuations
(4)	Overhead expense recovery risk
(5)	Other business risks, including ASC business
(6)	Catastrophic events, including litigation
(7)	Provision for unidentified development and growth

These categories generally follow the types of risk categories recognized in the RBC formula for managed care companies, but they further reflect components associated with ongoing viability (beyond solvency alone).

Rating Adequacy and Fluctuation. BCBSD, Inc.'s development of premium rate increases is intended to make provision for expected trends in claims cost and utilization, as well as changes in required retention components and other rating elements. Unfavorable variances for any of these factors require drawing on surplus.

BCBSD, Inc. must establish reliable base period claims experience and determine trends in claims costs to use in developing its premium rates, which involve a high degree of uncertainty for its major segments of business, and even higher for its individual group customers or other rating pools. Data accuracy and appropriateness itself is an area of ongoing uncertainty. Projecting such data into the future then requires the use of suitable trend assumptions to project the future. An underlying driver affecting trends in claims costs is changes in secular cost and utilization levels and delivery patterns. Influencing and altering the impact of such secular forces are a wide array of carrier-specific factors – provider contracting methods and network performance, management of care activities, member usage of out-of-area providers for services, the carrier's ability to model and predict trends, and shifts in the exposure characteristics of the rating pools involved (including the prospect of adverse selection). In addition, carrier size and mix of business segments affect its trends, although even sizeable rating pools are subject to random fluctuations in experience.

Similarly, variations between actual and budgeted operating expenses occur during the normal course of business. BCBSD, Inc. may be faced with an unbudgeted and yet necessary expenditure as a result of some unexpected event or an unanticipated reduction in revenue to pay for operating expenses. Other rating factors and formula elements are involved as well in setting premium rates, all of which are subject to periodic mis-estimation or imbalance.

In general, a substantial lag exists for all health insurers between a change in underlying cost trends or other factors and their recognition. For example, an inherent delay is present in the

evaluation of claims incurred during an experience period due to lags in reporting claims, as discussed previously. Even after claims have been sufficiently developed, the initial manifestations of a trend change are generally so slight as to be obscured by other phenomena, such as seasonal fluctuations. Finally, when the effects become clearly perceptible, the actuary and Plan management are faced with the question as to whether they represent a change in the underlying trend or a temporary random fluctuation. Because evidence of trend change is generally not obvious before a substantial period of time has elapsed, a trend change can deplete surplus for several years.

In order to provide as much of a factual, experience-based foundation as possible, the usual practice in setting trends for premium rates is to rely heavily on the trends observed over at least the most recent twelve-month period. Use of a twelve-month or longer period results in more gradual changes in rates than would occur if short-term fluctuations were given full credibility. These data-based approaches are essential for evaluating past and current claims cost levels and trends; however, future outcomes are almost certain to involve additional and differing influences. Regardless of how trend assumptions may be developed, the result is an understatement of premium income if trends worsen and an overstatement if trends improve.

Since premium rates for a large portion of BCBSD, Inc.'s business are guaranteed for a twelve-month period, following a significant period of advance notice of premium rates to customers, immediate implementation of trend or other changes cannot be made. Thus, provision must be made in surplus for withstanding delays in implementing trend or other rating parameter changes. In addition, any regulatory requirements for approval of rates or rating factors may entail delays in implementation, or even reductions in requested rate levels. Again, surplus is essential to withstand these adversities.

Unpaid Claim Liabilities and Other Estimates. Since a health insurer's surplus is defined as the excess of assets over liabilities, any misstatement or risk of fluctuation in either of them has a corresponding impact on reported surplus. The potential for misstatement applies, in particular, to those actuarial or other items contained in the company's statutory insurance blank which require estimation.

The single most significant of BCBSD, Inc.'s actuarial items, in terms of the degree of estimation required, is its unpaid claim liabilities. To the extent that actual claim runoff differs from the liability estimate for unpaid claims, surplus will be correspondingly overstated or understated. Surplus is the insurer's means of providing protection against this eventuality.

Other actuarial items contained in BCBSD, Inc.'s balance sheet also require estimates, and therefore entail uncertainty. These include unpaid claims adjustment expense liability and other items.

Interest Rate and Portfolio Asset Value Fluctuations. Admitted assets related to non-affiliated companies and carried by BCBSD, Inc. on its statutory balance sheets are reported on one of two bases. Nearly all fixed income securities are carried at adjusted book value, since virtually all are of high or highest quality. The remaining fixed income securities and all equity holdings in non-affiliated companies are carried at market value.

The asset portfolio of BCBSD, Inc. is dominated by investment in interest-bearing instruments of various durations, spread among government, government agencies, mortgages and both public and private corporate placements. Overall, 87% of the investment portfolio was invested in interest bearing instruments at the end of 2003. The remainder was invested in equities.

Since long-term assets-to-liability matching is not a significant investment management issue for a company with mostly short-term obligations like BCBSD, Inc., the primary matter of concern regarding surplus is fluctuation in market values of the asset portfolio. Beyond the possibility of default or impairment, the primary risk of an adverse fluctuation in interest-bearing securities is an unexpected rise in interest rates generally in the market along with the prospect of having to liquidate assets at that time. For equities, risk is present with regard to market conditions generally, and the performance of individual securities and instruments specifically.

Overhead Expense Recovery Risk. A contingency for which surplus provision needs to be made is an unanticipated fluctuation in the level of administrative expense recoveries. These

recoveries are made, under normal circumstances, through the administrative expense component of premium rates for insured business, fees paid by ASC groups, and fees or revenue otherwise generated from other business activities. An adverse fluctuation may occur, for example, because a large group terminates unexpectedly, with a resulting decrease in retention revenue or ASC fees. A corresponding decrease in expenses would not occur immediately, and expense ratios would therefore increase.

Other Business Risks, including ASC Business. As with any business operation, BCBSD, Inc. faces a host of business risks during the normal course of business. Most of these can be absorbed within the scale of BCBSD, Inc.'s overall operations.

A particular category of risk, which is perhaps unique to a health insurer such as BCBSD, Inc., is risk associated with ASC business. Unlike some self-funded business administered by a third party administrator for an employer using employer funds, BCBSD, Inc.'s ASC business entails a variety of risks for the insurer. These include default in reimbursement by an employer group, refusal to reimburse certain claims, defense of disputed claims, audit or litigation related to payment policies and practices, contractual disputes regarding discounts, etc. Such risks are not insignificant.

BCBSD, Inc. has a substantial volume of ASC business, primarily involving larger employer groups. For 2004, the volume of self-funded business equated to almost two times the volume of insured business written by BCBSD, Inc.

Catastrophic Events, including Litigation. As discussed earlier in this report, BCBSD, Inc. faces the risk of catastrophic events occurring. Such events include extraordinary medical costs due to terrorism, epidemics or pandemics, and natural or public health disasters. They also include other events with a potentially extraordinary adverse financial impact – such as major fire or other business interruption disaster, or excessive damage awards from major class action or other litigation.

A prudent insurer must provide protection against such risks, so that the company is not exposed to ruin or incapacity from such an event. This is necessary to remain a viable company. It is also necessary to protect the ability of BCBSD, Inc.'s members, providers, and vendors to safely rely on the company for the financial security that they believe they have contracted for or purchased. Prudence dictates that surplus for BCBSD, Inc. be sufficient to withstand the risk created by such threats, to the maximum extent possible.

Provision for Unidentified Development and Growth. To maintain competitiveness and ongoing viability, as discussed previously, BCBSD, INC. must periodically make substantial investments in developmental activities and the acquisition of operational capabilities. These include such far ranging items as new product development, rebuilding of delivery networks, enhancement of care management capabilities, acquisition of new communications or information technology capacities, and adaptation of existing and integration of new administrative processes. Often these capital expenditures do not produce admitted assets, which means that they generally must be absorbed directly and immediately out of surplus.

Likewise, developing and absorbing growth requires equity capital to fund developmental costs, to cover the initial losses resulting from the need to be price-competitive at the outset in order to become established, to absorb any initial losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in surplus). Obviously, a prerequisite for financially sound growth is strong surplus.

B. Monte Carlo Simulation of Losses

Associated with each of the risk and contingency categories identified above is a range of possible impacts on BCBSD, Inc.'s operating results. We use the term "operating results" here as opposed to "underwriting results", since investment results are included in some parts of the analysis. Under this actuarial approach to quantifying the potential multi-year loss against which the company's surplus needs to provide protection, we have developed what we believe is a reasonable range of possible values for each risk and contingency category. Possible outcomes for each risk and contingency category are divided into a discrete number of representative outcome values, to each of which we have assigned a probability or likelihood.

These values and probabilities are based on analysis of historical data, our observation of similar results in connection with our work at various Blue Cross and Blue Shield Plans, interpretation of that data in light of the current and anticipated future operating environment of the Plan, and professional judgment. For those categories of risk involving fluctuations (e.g., rating parameters, unpaid claims liabilities, and interest rates and portfolio asset values), the range includes representative outcomes in which operating results would produce gains, as well as those in which overall cumulative losses would occur. Assignment of probabilities to be associated with each of these outcomes is based on the same considerations used in developing the ranges of values and representative outcomes.

Several of the risks and contingencies faced by BCBSD, Inc. are interrelated. We recognized this in our treatment of the probabilities by considering certain risks or contingencies to be independent, while considering others to be dependent. The primary independent risk category was fluctuation in rating parameter adequacy. Risks from unpaid claims liability fluctuation and unidentified development and growth were each considered to be fully or partially dependent on the rating fluctuation contingency.

The values and probability distributions for each risk and contingency category were combined using a computerized Monte Carlo simulation technique to produce a composite probability distribution. This composite distribution shows the resulting probability that cumulative

operating losses in total will not exceed given percentages of annual claims and expenses. From each such distribution, a range of multi-year loss cycle amounts can be determined, reflecting the combined risks which have been evaluated and a high probability or likelihood (e.g., greater than 95%) that such a loss level will not be exceeded, even under significant or severe unforeseen adverse circumstances.

We carried out Monte Carlo simulations of loss cycle magnitudes based on the values and probability distributions described above, including incorporation of a higher and lower range in the assumptions with respect to the impact of fluctuation in rating parameter adequacy. The results of these simulations are summarized in Chart 6. It shows in graph form the magnitude of cumulative loss cycles, expressed as percentages of non-FEP insured claims and expenses, at various simulated percentiles of loss cycles. It also displays the range of cumulative loss cycle amounts produced for high confidence levels, as summarized below:

Percentile of Simulated Operating Loss Cycles[1]	**Cumulative Loss for Adverse Cycle[2]**
98^{th}	24% - 27%
95^{th}	20% - 23%
90^{th}	17% - 20%

1 See text below regarding the inclusion of interest rate and asset value risks in addition to risks affecting only underwriting results.

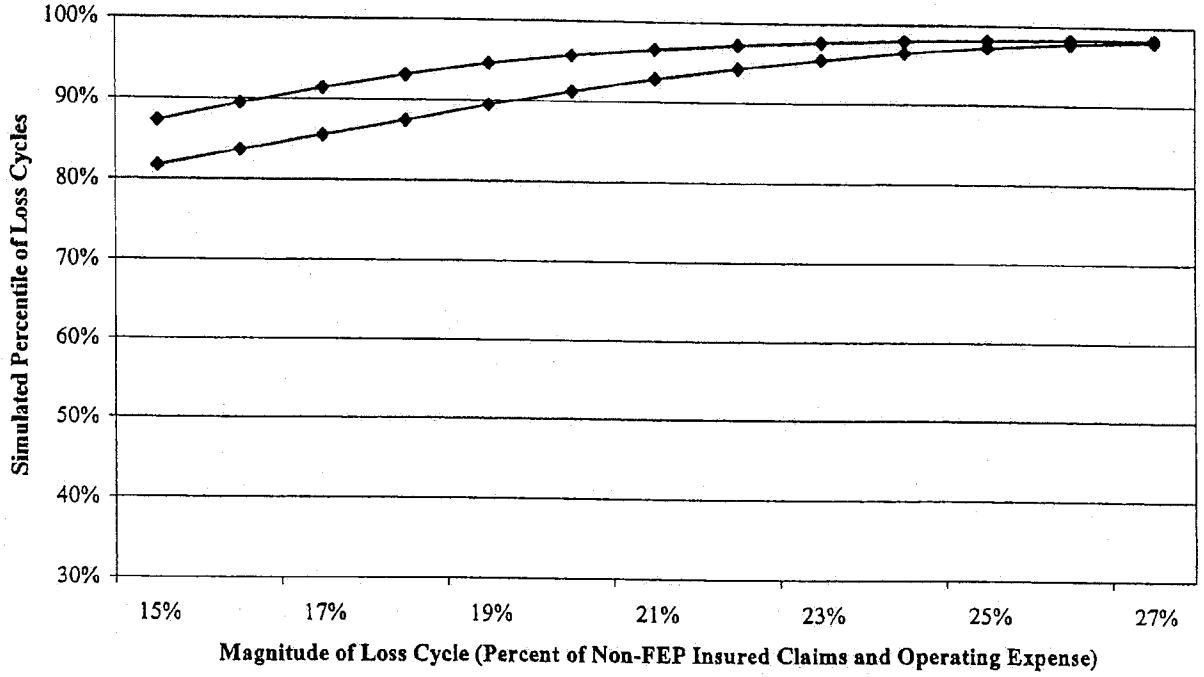
2 As percentage of non-FEP insured claims and expenses.

These simulated results include the impact of risks due to changes in interest rates and portfolio asset values, which are not reflected in the historical underwriting results reported by BCBSD, Inc. and the Comparison Set of BCBS Plans. The comparable range of losses excluding the interest rate and portfolio asset value risks is 13% to 21%.

We have directed our attention to the 90th through the 98th percentiles of simulated loss cycles in order to identify the magnitude of particularly or severely adverse outcomes (discussed in Section VI of this report). Since the risks and contingencies reflected in the simulations reflect a forward-looking assessment of the BCBSD, Inc. operation itself, we have selected a relatively high range of percentiles to satisfy these conditions. We have not considered the magnitudes for loss cycles simulated for BCBSD, Inc. beyond the 98th percentile, because of the remote probabilities for such an occurrence.

Chart 6

Monte Carlo Simulation of Loss Cycles*



Simulated Percentile of Loss Cycles	Cumulative Loss for Adverse Cycle
98th	24% - 27%
95th	20% - 23%
90th	17% - 20%

* Results shown for both the lower and higher range in assumptions, as described in text.

VI. DEVELOPMENT OF TARGET RANGE FOR SURPLUS

A. Provision for Loss Cycles

The goals for an optimal operating range for BCBSD, Inc.'s surplus, as discussed in Section III.D, entail surplus remaining above certain minimum thresholds regardless of the operating results that BCBSD, Inc. experiences. In particular, we recommend that these goals be established to meet the following criteria:

- ***Early Warning Monitoring Threshold Avoidance*** – Provide a high likelihood that the overall surplus level for BCBSD, Inc. will remain above the BCBSA Early Warning Monitoring threshold level.

- ***Loss of Trademark Avoidance*** – Assure with virtual certainty that surplus will remain above the BCBSA Loss of Trademark threshold level for the operation.

The target surplus range should reflect the need to achieve these goals while also recognizing the possibility of a particularly adverse multi-year period of operating losses. In establishing the potential magnitude of such a loss cycle, we are not predicting it to occur, nor are we suggesting in any way that BCBSD, Inc. should accept the inevitability of such an adverse cycle occurring during the near term. Instead, we are attempting to establish a magnitude of adversity against which the company should protect itself, its members, and its providers and vendors.

In approaching this analysis, we have used a Monte Carlo simulation approach to quantify an appropriate magnitude for the loss cycles to be considered for purposes of making provision in surplus. In using this approach, we quantified the distributions of amounts of potential loss due to major risk and contingency categories, and then combined such amounts based on provision for their respective likelihoods.

We then compared these resulting loss cycles to the multi-year loss cycles that have been experienced by the BCBSD, Inc. operation, and to the multi-year adverse cycles that occurred during the past two decades within the industry for generally similar BCBS Plans, as presented in preceding sections of this report. The results of our comparison can be summarized as follows:

Source/Basis	Total Cycle Loss
Simulation of Risks and Contingencies	17 - 27%[1]
BCBSD, Inc. Experience	8 - 17%[2]
Comparison Set of BCBS Plans	18 - 22%[3]

1 Cumulative losses, expressed as a percentage of annual non-FEP insured claims and expenses.
2 Cumulative underwriting losses, as a percentage of annual non-FEP insured premium.
3 Cumulative underwriting losses as reported by BCBSA.

Provision for Early Warning Monitoring Threshold. One of the three surplus goals identified earlier in this section of our report is to provide a high likelihood that the overall surplus level for BCBSD, Inc. will remain above the BCBSA Early Warning Monitoring threshold, even after a particularly adverse period of multi-year operating losses. In order to meet this goal of avoiding the Early Warning Monitoring threshold, the surplus target must be high enough so that (i) a particularly adverse loss cycle can be absorbed, without (ii) the surplus level dropping below the Early Warning Monitoring threshold (375% of RBC-ACL).

To represent a particularly adverse loss cycle based on the simulation of risks and contingencies for BCBSD, Inc., we have assumed a multi-year operating loss period creating a cumulative loss falling in the range of 17-23% of annual non-FEP insured claims and administrative expenses. Provision to withstand a loss cycle falling in this range would have included 95% of the simulation loss periods, 94% of the loss cycles experienced by the Comparison Set of BCBS Plans, and would have covered all three of the adverse cycles experienced by BCBSD, Inc. over the past 25 years. Using these criteria to establish a target surplus level means that BCBSD, Inc.

must be able to absorb a 17-23% cumulative loss over a 3 to 4 year period without surplus dropping below 375% of RBC-ACL.

Provision for Loss of Trademark Threshold. Similar conditions apply to meeting the goal of avoiding the Loss of Trademark threshold. The surplus target must be high enough so that (i) a severely adverse loss cycle can be absorbed, without (ii) the surplus level dropping below the Loss of Trademark threshold (200% of RBC-ACL).

To represent a severely adverse loss cycle, we have assumed multi-year cumulative operating losses falling in the range of 24-27% of annual non-FEP insured claims and administrative expenses. Provision to withstand a loss cycle falling in this range would have included 98% of the simulation loss periods, and substantially all of the historical loss periods experienced by BCBSD, Inc. and the Comparison Set of BCBS Plans. This is consistent with the Loss of Trademark goal of assuring with virtual certainty that failure does not occur as a result of breaching this threshold.

These adverse cycle loss results form the foundation for our pro forma projection model development of BCBSD, Inc. target surplus levels. To develop such targets, provision for a multi-year loss cycle of the magnitudes indicated in the chart above is combined with minimum floor levels for BCBSD, Inc.'s surplus, based on the BCBSA thresholds, and with investment earnings and other pro forma financial items needed to evaluate changes in surplus.

B. Pro Forma Modeling of Loss Cycle Impact

To establish the BCBSD, Inc. surplus operating range that would meet the goals established, we projected on a pro forma basis the level of BCBSD, Inc. surplus balances emerging year-by-year under the adverse loss cycle ranges identified above[2]. In each loss cycle scenario, we selected an initial potential surplus target level, and then tested by projecting the impact of the specific operating loss scenario to determine whether the resulting surplus balances projected over time remained above the threshold within the goal.

Viability Testing Against Early Warning Monitoring Threshold. The upper portion of Chart 7 shows the range of RBC ratios needed at the onset of the indicated operating loss cycles for the company's RBC ratio to remain above the BCBSA Early Warning Monitoring threshold of 375% of RBC-ACL. Results are shown under both 12.5% and 15% assumptions as to annual growth in BCBSD, Inc. aggregate premium (premium rates and volume of inforce business combined). These growth rate assumptions are intended to reflect modest to moderate sustainable growth rates in enrollment, plus mid-range premium rate increases (high single digit to moderate double digit medical cost trends).

These pro forma results indicate that a starting or target surplus level of 950-1200% of RBC-ACL for BCBSD, Inc. is needed in order for the company to remain viable while withstanding a particularly adverse operating loss cycle. Under the pro forma projections, BCBSD, Inc. could withstand such a loss period and remain above the BCBSA Early Warning Monitoring threshold.

Failure Testing Against Loss of Trademark Threshold. The lower portion of Chart 7 contains the corresponding range of RBC ratios needed at the onset of the indicated operating loss cycles to remain above the BCBSA Loss of Trademark threshold of 200% of RBC-ACL. Alternate annual premium growth rates of 12.5% to 15% are reflected.

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[2] Other key projection assumptions include 4.3% average annual investment yield, other income levels generally consistent with BCBSD, Inc.'s long-term expectations, 200% RBC-ACL equating to approximately 6.3% of insured claims and expenses for the operation, the expected impact of a pending acquisition on average expense levels, and the elimination of BCBSD, Inc.'s deferred tax asset with an adverse loss period.

These pro forma results indicate that a starting or target surplus level of 950-1100% of RBC-ACL is needed by BCBSD, Inc. in order for the company to avoid the loss of trademark as a result of a severely adverse loss cycle. Under the pro forma projections, BCBSD, Inc. could withstand such a loss period and remain above the BCBSA Loss of Trademark threshold.

Surplus Target Range for BCBSD, Inc. Based on this analysis, we have concluded that a reasonable target for BCBSD, Inc.'s surplus is 950-1200% of RBC-ACL under normal operating circumstances. This range encompasses the values developed from the pro forma projections and shown in Chart 7.

Chart 7

RBC Ratio Needed to Remain Above Minimum Surplus Floor Levels

Simulated Results under Range of Operating Loss Cycles

Operating Loss Cycle	Early Warning Monitoring Floor (375% of RBC-ACL)	
	12.5% Premium Growth*	15% Premium Growth*
17%	950% - 1000%	1000% - 1050%
23%	1150%	1200%

Operating Loss Cycle	Loss of Trademark Floor (200% of RBC-ACL)	
	12.5% Premium Growth*	15% Premium Growth*
24%	950% - 1000%	1000% - 1050%
27%	1000% - 1100%	1100%

* Aggregate growth in premium revenue, including changes in both premium rates and enrollment.

VII. SURPLUS TARGET RANGE AND MANAGEMENT PROCESS

A. Basic Goal for Surplus Management within Target Range

As we indicated earlier, the establishment of a target range for its surplus is one of the more important financial policy issues that a company like BCBSD, Inc. must address. The same applies to the development, implementation, and periodic updating of business plans to reach and maintain a surplus position within an optimal target surplus range.

Based on the analysis contained in the previous sections of this report, we conclude that an appropriate target for BCBSD, Inc.'s surplus falls in the range of 950-1200% of RBC-ACL. A reasonable goal for BCBSD, Inc. with regard to achieving this, we believe, is to establish rates overall with a premium margin (surplus contribution factor, along with other financial elements) sufficient to place the company well within the target surplus range, and then maintain this level. This 950-1200% of RBC-ACL range should be wide enough to allow for a reasonable degree of fluctuation in operating results year-to-year, under normal operating circumstances, over a multi-year horizon.

By positioning the Plan's surplus well within the range, the company can then take measured steps in the management of day-by-day financial operations. As the actual level of surplus fluctuates within this range, BCBSD, Inc. should generally take steps to (i) gradually increase the RBC ratio level as surplus nears the lower end of the target range, and (ii) slow the rate of surplus growth as it nears the upper end. Sustaining favorable operating results for an extended period of time has been rare within the industry, as has been discussed. By focusing on actions to strengthen surplus as it nears the lower end of the target range, and before it drops below the target range, BCBSD, Inc. can compensate for the fact that the lower end of the target range may not provide the degree of security that a viable company might wish to have. Likewise, by taking actions to ease surplus growth as it nears the upper end of the target range, BCBSD, Inc. can reduce the likelihood of accumulating surplus amounts that do not further the well-being of the company, without jeopardizing its security.

B. Actions When Surplus is Above Target Range

As indicated above, the basic goal for surplus management by BCBSD, Inc. under normal circumstances should be to continually attempt to maintain its level well within the target range established. Periodically, the continued appropriateness of the target range itself should be reconsidered, but revised only as fundamental changes in the environment or BCBSD, Inc.'s circumstances and experience clearly warrant.

Needs Outside the Norm. On a regular basis, near-term circumstances that may not be "normal" on an ongoing basis should be closely monitored. From time-to-time, such circumstances may warrant a surplus level above the target range. Such circumstances might involve major upcoming development activities with significant expected costs (e.g., new systems), growth opportunities involving heightened uncertainty and/or probable surplus strain (i.e., downward movement in RBC ratios, due to increased business in force), attractive acquisition candidates requiring equity capital and many other possibilities. These are the sorts of specific circumstances that may require additional surplus, but vary over time as the market and business environment change.

Stable Operating Results and Surplus. For a large insurance company upon whom many depend for their health insurance coverage and the personal security it provides, financial strength and stability are essential. Financial strength has been addressed at length in this report. It is needed, in particular, to provide protection against the risks and uncertainties associated with medical costs and all of the other business matters affecting the insurer. A critical challenge for BCBSD, Inc.'s management team is to manage these risks and, in particular, the premium revenue generated to pay for claims and expenses and to maintain surplus.

Management of premium revenue has its own set of financial and market or customer challenges. Among these are to stabilize year-to-year changes in premium rates to the extent possible, at levels which are sustainable. This is important for BCBSD, Inc.'s customers, who must pay them, and for BCBSD, Inc.'s own financial planning and management. This is a key reason why gradual steps to build or ease its surplus are important, since such steps directly affect the

company's premium rates. Taking other than gradual steps affecting surplus also increases uncertainty for the company, as opposed to steps which ease surplus levels up or down slowly and permit course corrections as ongoing experience emerges.

C. Conclusions

We believe that targeting BCBSD, Inc.'s overall surplus level in the range of 950 – 1200% of RBC-ACL is reasonable and appropriate under normal operating circumstances, to ensure financial viability for the company and to provide security in the health coverage provided to its approximately 350,000 members.

CONFIDENTIAL

Report to the

Regarding BCBSD, Inc.

Sandler O'Neill & Partners, L.P.

NOVEMBER 2003

EXHIBIT
JOINT-75

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Exhibits

A. Draft Administrative Services and Business Affiliation Agreement dated October 20, 2003

B. October 20, 2003 Draft Amended Bylaws of BCBSD

C. October 20, 2003 Draft Certificate of Amendment and Restatement of The Certificate of Incorporation of BCBSD

D. Statement of Investment Policy

E. Management Biographies

I. INTRODUCTION

A. OVERVIEW OF THE ASSIGNMENT

A. Overview of the Assignment

The Department of Insurance of the State of Delaware (the "Delaware Department") is evaluating the proposed modification of the Business Affiliation Agreement (the "Proposed Agreement") entered into by CareFirst, Inc. ("CareFirst") and BCBSD, Inc. ("BCBSD" or the "Company") on December 23, 1998 (the "1998 Agreement"). In that connection, Sandler O'Neill & Partners, L.P. ("Sandler O'Neill") has been retained to assist the Delaware Department in evaluating BCBSD, from a financial point of view, as a consequence of the Proposed Agreement. Sandler O'Neill has conducted activities that included, but were not limited to, a review of BCBSD's current business and financial characteristics, including a review of the Company's 5-year historical financial performance and 2003 budget forecast, and discussions with BCBSD management regarding the business, financial condition and results of operations of BCBSD, including their assessment of executive resources, claims management, underwriting, information systems and technology, investments and competitive position.

On March 22, 2000, CareFirst became the sole member of BCBSD pursuant to the 1998 Agreement. The Proposed Agreement based on a draft dated October 20, 2003, supersedes the 1998 Agreement, except for the continuation of certain previously agreed to employee benefits to the employees of both parties and will be come effective on December 31, 2003. Reflecting certain provisions in the Proposed Agreement, BCBSD's Bylaws and Certificate of Incorporation were also amended. Among the most relevant provisions of the Proposed Agreement for purposes of Sandler O'Neill's report are the following:

Continuation of Intercompany Service Activities

The Proposed Agreement reaffirms both CareFirst and BCBSD's intentions to continue the existing provision of services between the two parties in order to preserve the operation and financial benefits of the affiliation. There is also a commitment, according to BCBSD management, to continue actual cost as a basis for determining charges for products and services provided. (See page 24 for Flow of Funds Relating to Intercompany Payments)

Transfer of Blue Cross Blue Shield Marks

The Proposed Agreement provides for BCBSD to obtain the Blue Cross Blue Shield service marks in Delaware. It is Sandler O'Neill's understanding based on representations by BCBSD senior management that the Blue Cross Blue Shield Association ("BCBSA") has agreed, subject to ratification by its Board, to approve the licensing of said service marks to BCBSD and that CareFirst has agreed to relinquish the Delaware marks.

Future Corporate Governance of BCBSD

The amended and restated Bylaws of BCBSD provides for the transfer of majority membership in BCBSD, and thereby control over BCBSD, to the BCBSD Board of Directors. CareFirst shall be entitled to have one individual, who shall not be an employee or officer of CareFirst, elected by CareFirst to serve on BCBSD Board of Directors. While the Chief Executive Officer of BCBSD (currently the Chief Executive Officer of CareFirst) will continue in that capacity, his death, resignation, or removal by the BCBSD Board of Directors will not automatically confer that his successor will be a CareFirst executive.

Future Corporate Conduct of BCBSD

The amended Certificate of Incorporation of BCBSD continues to state its corporate purpose as developing, marketing and underwriting all types of health insurance and other employee benefits programs and related health care activities. Management has indicated its intention to continue to commit its efforts in support of these health insurance goals.

B. INFORMATION REVIEWED AND INTERVIEWS CONDUCTED

B. Information Reviewed and Interviews Conducted

In performing our review and regarding this report and any testimony, Sandler O'Neill has relied upon the accuracy and completeness of all of the financial and other information that was available from public sources, provided by BCBSD and CareFirst, and has assumed such accuracy and completeness for purposes of this report and any testimony. We have further relied on the representations of management of BCBSD that they are not aware of any facts or circumstances that would make any of such information inaccurate or misleading. We have not been asked to independently verify, and have not undertaken an independent verification of, any of such information and we do not assume any responsibility or liability for the accuracy or completeness thereof. In particular, we have not been asked to, and have not, made an independent evaluation or appraisal of the assets or the liabilities (contingent or otherwise) relating to BCBSD, nor have we been furnished with any such evaluations or appraisals other than those specifically referenced herein. We have not evaluated the financial condition of CareFirst. We are investment bankers and not actuaries and, accordingly, our services did not include any actuarial determinations or evaluations. Nor did we attempt to evaluate actuarial assumptions, and have assumed that such assumptions are consistent with the standards established by the American Actuarial Society for health insurers and are otherwise reasonable. We are not attorneys and, accordingly, do not opine on the interpretation or legal consequence of the Proposed Agreement and other corporate documents. We have assumed that all reinsurance and other contracts to which BCBSD is a party will be performed in accordance with their terms. We also have assumed the October 20, 2003 draft Administrative Services and Business Affiliation Agreement will not be changed in the final agreement in the significant areas addressed by Sandler O'Neill.

Information reviewed included, but was not limited to:

- Annual statement of BCBSD for the year ended December 31, 2002
- Management report dated August 31, 2003, including 2003 budget on a total company and a segment basis
- Statutory-basis financial statement and other financial information for BCBSD for the years ended December 31, 2002, 2001, 2000, 1999, and 1998 with report of independent auditors
- Consolidated financial statements (GAAP) for BCBSD for the years ended December 31, 2002, 2001, 2000, 1999, and 1998 with report of independent auditors
- Report of examination of the BCBSD by the State of Delaware Department of Insurance as of December 31, 1999

- BCBSD payments to CareFirst for 2002 and projected for 2003
- October 20, 2003 draft Administrative Services And Business Affiliation Agreement (Refer to Exhibit A)
- October 2003 draft amended bylaws of BCBSD (Refer to Exhibit B)
- October 2003 draft Certificate of Amendment and Restatement of the Certificate of Incorporation of BCBSD (Refer to Exhibit C)
- Marketing materials: Small Group Program Options
- List of BCBSD's 20 largest insured groups based on projected 2003 revenue
- BCBSD's investment portfolio summary (Refer to Exhibit D)
- Statement of investment policy, adopted by BCBSD on July 31, 2002
- Biographies of senior BCBSD management (Refer to Exhibit E)

Interviews with senior management of BCBSD included, but were not limited to, the following individuals:

- Christine L. Alrich, Vice President, Corporate Marketing
- Iris Carr, Director, Underwriting
- Philip A. Carter, Corporate Controller
- Timothy J. Constantine, President
- George H. English, Jr., Vice President, Operations
- William E. Kirk, III, Vice President, General Counsel & Corporate Secretary
- Eileen Masterson-Carr, Director, Provider Relations & Contracting
- Sally A. Retzko, Director, Systems Planning & Development
- R. Foster Seaton, Manager, Actuarial Support
- Deborah M. Sweeney, Director, Quality Improvement

Also interviewed Mark Chaney, Executive Vice President and Chief Financial Officer, CareFirst.

C. BCBSD'S RATIONALE FOR AN AFFILIATION

C. BCBSD's Rationale for an Affiliation

BCBSD began operations in 1935 and was licensed to use exclusively the Blue Cross Blue Shield marks by the BCBSA for the state of Delaware. Beginning in the late 1980's, BCBSD experienced more intense competition from larger, financially stronger health insurers that had the ability to incur operating losses in order to secure market share to the detriment of BCBSD. Additionally, unbranded (because of BCBSA rules on territory exclusivity) Blue Cross Blue Shield entities and regional health insurers were entering the Delaware market. The Company struggled to achieve membership growth and was concerned that its share of a very small market was at risk and could not be protected in a sustained price war.

Any significant shrinkage of BCBSD's market share would jeopardize the Company's ability to maintain a competitive administrative cost ratio which, in turn, would result in operating losses or force BCBSD to increase rates, furthering its competitive disadvantage.

Other issues impacting BCBSD were (a) its ability to service national and regional accounts whose employee base "spilled" over to adjoining states; (b) providing access to specialized out-of-area (surgical) hospital facilities such as those existing in Philadelphia and Baltimore; and (c) offering coverage to Federal employees.

It was assumed that affiliating with a larger health plan also would deter predatory pricing by competition. BCBSD management also believed that the ability to share marketing, product development and technology initiatives would offer significant cost savings.

In 2000 BCBSD formally affiliated with CareFirst. In 2003 concerns relating to regulatory and legislative developments in Maryland and the possible impact on BCBSD caused the Company, CareFirst and the Delaware Department to have discussions regarding modifications of the existing Business Affiliation Agreement.

As will be discussed in Section IV of this report, based on Sandler O'Neill's review and analysis of the information and data set forth in this report, and on conversations with BCBSD management, Sandler O'Neill believes that the existing affiliation has been advantageous to BCBSD's operating capability and results.

II. BRIEF OVERVIEW OF THE HEALTH INSURANCE INDUSTRY

II. Brief Overview of the Health Insurance Industry

Historically, U.S. health insurers had narrow, local presence reflected in, for example, the 130 Blue Cross Blue Shield ("Blue") plans with as many as three Blues (with clearly defined territories) covering a single state. In the 1930's and 1940's, medical cost inflation was modest and most health insurance plans provided indemnity coverage. Virtually all life insurers and multi-line insurers had group and individual health insurance operations.

Inflationary trends escalated and competition emerged in the 1970's which caused most of the diversified insurers and life insurers to abandon health insurance to specialists. Continued medical cost inflation created a cost push backlash by employers, and beginning in the 1980's, a distinction was drawn between more traditional health insurers such as the Blues and managed care organizations.

Managed care organizations utilized the health maintenance organization ("HMO") model which attempted aggressively to cut costs. These cost cutting initiatives focused on reducing reimbursement for services and shifting some costs and risks to providers and patients through capitation arrangements. The other cost containment focus was on reducing consumer utilization. Primary care physicians acting as gatekeepers sought to limit access to repetitive or higher cost specialty procedures. Due to these initiatives, the Blues gradually began to lose their preeminent position to HMOs.

Recently, the Blues have rebounded as they have launched a broader array of product offerings including HMO plans and, more recently, consumer oriented plans such as preferred provider organizations ("PPO") and point-of-service ("POS") plans which offer greater choice among providers. According to a recent study by Conning Research & Consulting, Inc. (a well recognized insurance consultant), some of the increase in Blue enrollment may be due to the success of the Blue Card program, a national enrollment program that links independent Blue plans into a single electronic network for claim reimbursement. [1]

A number of critical issues still face the health insurance industry including low operating income per employee, a great deal of paper flow without, necessarily, a beneficial result, intense price competition, complaints by consumers on the quality of service provided and relatively ineffective medical management. Additionally, national multi-site employers are increasingly demanding consistent, seamless services for all

[1] Blue Cross Blue Shield Plans: Roaring Back?, 2003.

their locations requiring essentially similar networks and hospital affiliations in more than one or two states.

The industry response to some of the foregoing issues has been to expand geographically, primarily via acquisitions or affiliations. Both managed care and Blues insurers have embarked on this strategy to gain economies of scale in administrative and information systems, better serve national or multi-state employers, diversify risks in single markets and to counter similar growth through consolidation initiatives by other health insurers. Some of the Blues have also converted to for-profit status to facilitate their acquisition agenda and to ease access to capital markets. More recently, the announced combination of Anthem Inc. ("Anthem") and WellPoint Health Networks, Inc. and UnitedHealth Group ("UnitedHealth") and Mid-Atlantic Medical Services Inc. reflecting combined enrolled members of 26.1 million and 19.0 million, respectively, result in the creation of the two largest health insurance groups. The mass scale encompassed by these two mega mergers may further enable these health groups to drive their administrative expense ratios below other smaller competitors. Comments by executives of both organizations post their merger announcements also suggest that their new business focus will be on large and national employer groups.

Such concentration of capital, human and operation resources increase concerns by some industry observers on the future of smaller health insurers. As reported in an article in the Wall Street Journal[2] "Investments in automation needed to spur improvement in quality of care, consumer service and efficiency require enormous capital outlays that only very large organizations can afford."

The recent developments in the health insurance industry confirm that smaller companies such as BCBSD will benefit from a properly structured affiliation with a strong regional or national health insurance group.

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[2] Wall Street Journal dated October 28, 2003, *Managed-Care Mergers: No Quick Cure-All for Industry.*

III. BCBSD

A. OVERVIEW OF BCBSD

A. Overview of BCBSD

BCBSD is a non-stockholder-owned not-for-profit health insurer which operates exclusively in Delaware although it provides coverages to insureds who require care in other jurisdictions.

The Company's mission as reflected in its articles of incorporation statement of purpose is to develop, market and underwrite all types of health insurance and other employee benefits programs at reasonable costs; to promote policies and programs which foster effective health care cost containment; to act as underwriter and administrator for governmental health care programs; and to provide all types of health services and other related services and products.

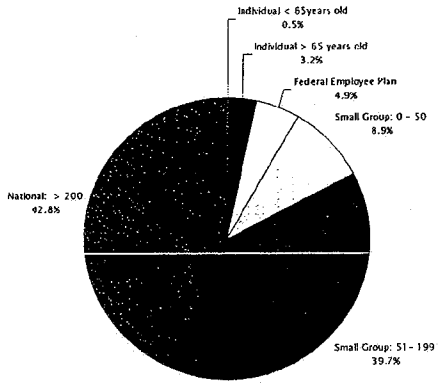
BCBSD has a comprehensive product portfolio ranging from administrative services only ("ASO") for large employer groups (more than 200 lives) to an array of offerings for smaller groups and individuals, including traditional indemnity coverages, HMO, POS, individual practitioner ("IPA"), PPO, exclusive provider organizations ("EPO") and two different plans for Medicare supplement coverages.

BCBSD has a number of the larger employers in the state as clients, almost universally on an ASO basis, with its 20 largest groups accounting for 59% of total revenues (on a premium equivalent basis). BCBSD's share of the Delaware market has increased to 35% with the closest competitors being Coventry (23%), Amerihealth (6%) and Aetna (5%).

Management ascribes the growth in its market share to synergies from their affiliation with CareFirst, the exit of a competitor in the Federal Employee Plan ("FEP") market, with a significant share of that business being assumed by BCBSD, and to growth in both national accounts (ASO) and smaller (risk-bearing) groups (i.e., 200 lives or less).

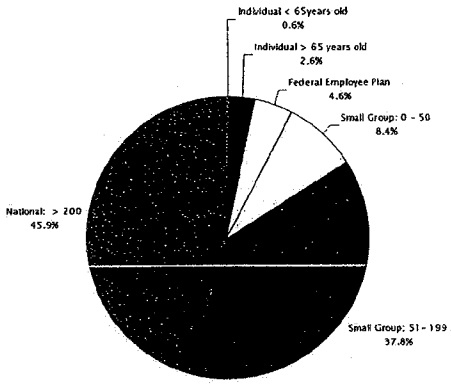
In 2002, 43% of BCBSD's customers were national accounts (200 or more employees) and 40% were groups of 51-199 employees. The Company has planned a 15% increase in its penetration of national accounts in 2003.

2002 Total Enrollment by Number of Contracts



Total Enrollment: 164,272 contracts

2003 Plan Total Enrollment by Number of Contracts



Total Enrollment: 175,117 contracts

Source: Company management

The breadth of BCBSD's provider networks are estimated to embrace 87% - 90% of the total provider market. The breakdown by type of provider is:

Provider Type	Managed Care	Traditional / Indemnity
Primary care physicians	832	852
Specialists	1,247	1,285
Institutional provider	27	27
Behavior health provider	332	491
Behavior health institutional provider	16	16
Allied health	203	203
Other	35	35

Source: Management presentation

In 2002, BCBSD was ranked number 1 out of 62 Blue Cross Blue Shield plans ("Blues") throughout the nation for "Member Experience" which measures the difference between BCBSD and competitors on overall member satisfaction and loyalty. The Company was also recognized for "Host / Par Plan Services" for providing the best service to "Out-of-Area" members. In a Utilization Management satisfaction survey conducted by BCBSD in September 2003, primary care physicians gave BCBSD a higher score than the other major insurers in Delaware. Management has cited very high performance standards / achievements as one of the contributing factors to its growth in membership and market share. BCBSD calculates and monitors a variety of operating criteria to assess its ongoing performance. Among these on a current basis are:

- 98% of all claims are paid within 30 days
- 99% of all claims are processed error free

Access and Availability of Primary Care Physicians

	Standard	Compliance Rate
Emergency care	Same day	100%
Urgent care	Same day	100%
Non-urgent - sick	Within 4 days	100%
Routine	Within 90 days	99.2%
After hours access	-	100%

Source: Management presentation

Selected Service Measurements*

	SCORE (0 to 100 Scale)	
Category	BCBSD	All Competitors
Overall satisfaction	67	47
Ease of doing business with insurer	63	48
Claims process overall	65	47
Timeliness of claims payments	71	49
Accuracy of claims payments	68	53

Source: Management presentation

* Results obtained from Provider Benchmark Study conducted by CareFirst Market Research in July 2003

Network Adequacy

BCBSD Standard	Compliance Rate

1 Acute care hospital in 20 mile radius	98.8%
2 Primary care physicians within 10 mile radius	>99%
1 Specialist within 10 mile radius	87.7% - 100%
1 Behavioral health practitioner within 10 - 20 miles	95% - 100%

Source: Management presentation

B. REVIEW OF BCBSD'S OPERATING AND FINANCIAL PERFORMANCE

B. Review of BCBSD's Operating and Financial Performance

We primarily utilized GAAP financial data throughout this report because it facilitates comparing BCBSD against selected health insurers and because statutory financial statements do not reflect accrual accounting. We have added back brokers' commissions to the "Gross Revenues" line (such sales costs are typically deducted from revenues) to better determine the medical loss ratio and administrative costs ratio).

In the GAAP financial statements, revenues are grossed up to a "premium equivalent basis" for the ASO business. The latter process involves adding to premiums a notional amount to equate the administrative services only non-risk bearing accounts to a risk-bearing format. This provides a more accurate depiction of the administrative cost ratio but inflates the medical loss ratio. The benefit of the ASO business is to spread overhead and certain staff costs over a larger revenue base.

Operating performance has registered significant improvement in 2001, 2002 and projected 2003 due to appropriate medical inflation trend assumptions in pricing models, high rates of premium growth, aided by inflation, new ASO and risk accounts and the benefits of a lower administrative cost ratio due to the aforementioned growth factors. A satisfactory underwriting ratio for a health insurer would be in a range of 1% - 2%. BCBSD has achieved that level of performance in recent years as small underwriting losses in 1999 and 2000 improved to underwriting margins of 2.1% and 1.7% in 2001 and 2002, respectively, with an underwriting margin of 1.3% projected in 2003.

Investment income has been essentially flat during the past 5 years shown below as fixed income yields have declined more recently and the growth in capital (Total Reserves) has only grown at a 4% compound annual rate. Total Reserves accounted for 81.4% of long- and short-term investments at year end 2002.

Selected GAAP Financial Information

(Dollars in thousands)

	Years Ending December 31,					6 mths ended	CAGR[1] /	
	1998	1999	2000	2001	2002	6/30/03	Avg*	
Income statement data								
Gross revenues	$408,967	$402,971	$456,748	$578,133	$704,291	$410,783	15%	
Cost of care	343,783	348,397	400,368	501,102	623,371	363,232	16%	
Total operating expenses [2]	419,394	406,039	470,274	565,900	692,931	401,716	13%	
Investment income (net)	10,560	7,793	8,230	9,134	9,102	4,068	-4%	
Pre-tax income from operations	133	4,725	(5,296)	21,367	14,171	13,135	221%	
Net income (continuing operations only)	339	3,668	(4,060)	16,941	11,108	10,508	139%	
Operating performance								
Medical loss ratio	84.1%	86.5%	87.7%	86.7%	88.5%	88.4%	86.7%	*
Administrative expense ratio [3]	17.5%	14.3%	12.8%	11.2%	9.8%	9.4%	13.1%	*
Combined ratio	101.5%	100.8%	100.4%	97.9%	98.3%	97.8%	99.8%	*
Underwriting margin	-1.5%	-0.8%	-0.4%	2.1%	1.7%	2.2%	0.2%	*
Balance sheet data								
Total assets	$216,910	$198,267	$222,625	$250,068	$284,332	$314,152	7%	
Medical claims payable	53,040	51,000	58,640	70,555	89,550	99,620	14%	
Total reserves	88,964	86,144	82,559	98,418	103,579	116,207	4%	

[1] Compound annual growth rate from 1998 - 2002.

[2] Operating expenses include broker fees.

[3] Administrative expense ratio excludes one-time charges.

Source: Income statement and balance sheet data are from the Company's audited financial statements in accordance with auditing standards generally accepted in the United States. Gross revenue numbers are from the Company.

In contrast to GAAP accounting, revenues in Statutory accounting only reflect actual risk premiums collected and the accounting is on a modified cash basis versus accrual.

Revenues have accelerated in more recent years and the sharp improvement in the administrative cost ratio has enabled the Company to support a higher medical loss ratio. The combined effect has been to enhance underwriting profitability. A substantial portion of the losses in the "Total other income" line reflects operating losses in the ASO line. During the past 5-year period, RBC ratios have been maintained at superior levels compared to guidelines promulgated by the BCBSA.

Selected Statutory Financial Information

(Dollars in thousands)

	Years Ending December 31,					CAGR[1] /	
	1998	1999	2000	2001	2002	Avg*	
Income statement data							
Total revenues	$157,732	$159,280	$171,319	$205,470	$234,354	10%	
Total medical and hospital expenses	124,262	123,004	132,526	163,595	194,960	12%	
Total administrative expenses	35,351	32,769	33,727	22,311	30,678	-3%	
Net underwriting gain (loss)	(1,900)	3,480	5,066	19,563	8,716	NM	
Net investment gain (loss)	8,853	9,587	7,506	8,582	2,147	-30%	
Total other income	(3,918)	(7,410)	(18,317)	(13,365)	(7,940)	NM	
Net income (loss)	3,034	5,657	(5,745)	14,780	2,923	-1%	
Operating performance							
Medical loss ratio	78.8%	77.2%	77.4%	79.6%	83.2%	79.2%	*
Administrative expense ratio	22.4%	20.6%	19.7%	10.9%	13.1%	17.3%	*
Combined ratio	101.2%	97.8%	97.0%	90.5%	96.3%	96.6%	*
Balance sheet data							
Total admitted assets	$184,367	$184,951	$197,183	$193,036	$195,587	1%	
Total liabilities	101,207	95,830	117,444	99,410	101,194	0%	
Total capital and surplus	83,159	89,121	79,739	93,626	94,393	3%	
Risk-based capital analysis							
Total adjusted capital	$83,304	$89,121	$79,739	$93,626	$94,393	3%	
Authorized control level risk-based capital	9,489	4,536	5,631	8,466	7,567	-6%	
Risk-based capital ratio	878%	1965%	1416%	1106%	1247%	1322%	*

[1] Compound annual growth rate from 1998 - 2002.

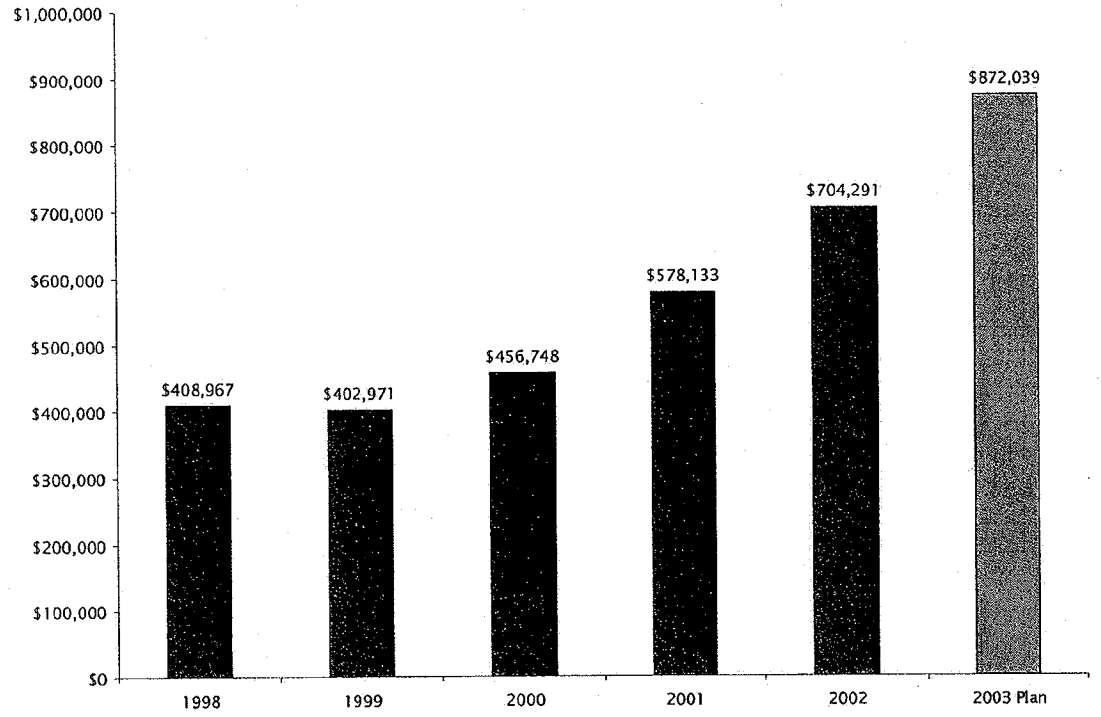
Source: Company Management and Company's 2002 Annual Statement as filed with the Insurance Department.

GAAP Gross Revenues

BCBSD has experienced significant gross revenue gains, with a compound annual growth rate of 15% since 1998. Gross revenues have grown from $409 million in 1998 to $704 million in 2002. Management expects revenues to increase 24% in 2003, to $872 million. Premium growth in each of the past three years through year-end 2003 of 27%, 22% and 24%, respectively, have been well in excess of medical loss cost inflationary trends. BCBSD utilized medical inflation factors in those years which approximate 12% - 15% and

the balance of growth in premiums was the result of additional employer group clients in both smaller group risk accounts and ASO groups.

GAAP Gross Revenues: 1998 - 2002 Actual; 2003 Plan
(Dollars in Thousands)



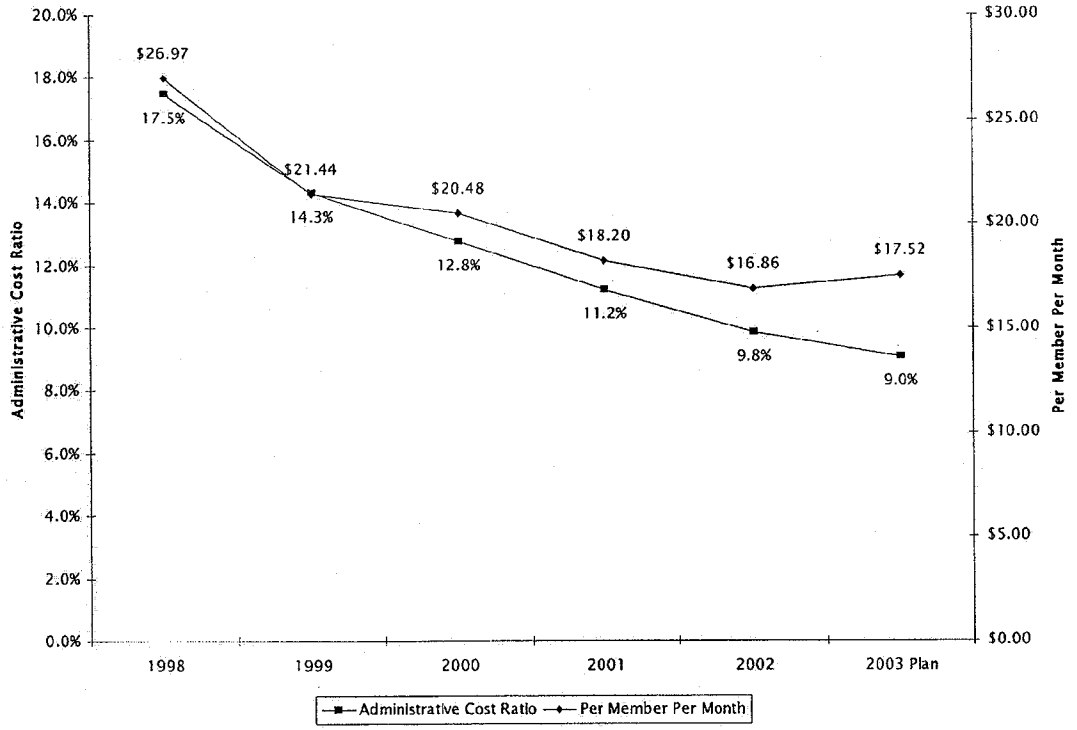
Note: Gross revenue includes premium equivalents for non-risk business
Source: Company management and 2003 budget.

GAAP Administrative Costs (including Broker Fees)

BCBSD's administrative cost ratio has decreased since 1998. Management has reported that the primary causes for this decrease are BCBSD's ability to spread costs over a larger revenue base and strong growth in the FEP and national account ASO business.

On a Per Member Per Month basis, administration costs declined 37% from 1998 to 2002. Management has reported that the increase in 2003 Plan is primarily due to higher real estate lease costs for new facilities, and costs associated with "catch up" hiring in service areas.

Administrative Cost Ratio and Administrative Costs Per Member Per Month: 1998 - 2002 Actual; 2003 Plan



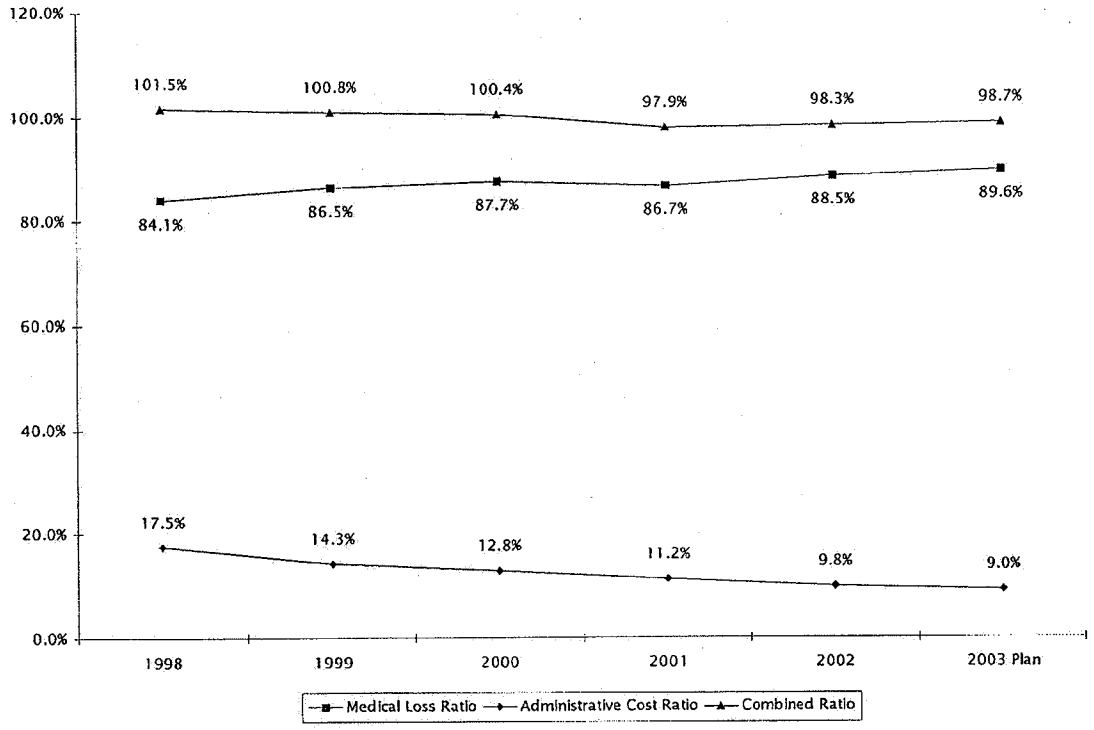
Source: Derived administrative cost ratios from the Company's audited financial statements and obtained Administrative Costs Per Member Per Month from the Company management.

GAAP Combined Ratio

The underwriting performance of health insurers tends to vary widely, impacted by the amount of ASO business and ancillary business. Therefore, the most appropriate measure of underwriting performance is the combined ratio (see page 18 for a comparison of operating statistics among selected health insurers).

Management reports that the worst financial year for BCBSD in the past decade was in 1998, when the Company had a combined ratio of 101.5%. Medical cost and administrative cost ratios were 84.1% and 17.5% respectively. The significant decline in 1999 over 1998 in the administrative cost ratio reflects the termination of the Company's international health line. Since 1998, the Company has achieved an average combined ratio of 99.8%. Management indicates that enhanced operating efficiencies through the CareFirst affiliation, a strong growth in revenues, increased ASO accounts and general account growth have all aided the fairly dramatic improvement in the administrative cost ratio.

Administrative Cost Ratio, Medical Loss Ratio and Combined Ratio: 1998 - 2002 Actual; 2003 Plan



Source: Derived from the Company's audited financial statements and 2003 budget.

Comparison of Operating Statistics

In terms of underwriting profitability for the past 5 years, the Company has, on average, outperformed the selected publicly traded national companies and Blues listed below. BCBSD's 5-year average combined ratio was 99.8%. This ratio is slightly higher than that of the selected regional and niche companies. The Company's 5-year revenue growth has somewhat lagged the publicly-traded Blues, at 14%, compared to the mean and median of 22% and 26%, respectively.

Institution		2002 Administ. Cost Ratio	2002 Medical Loss Ratio	2002 Combined Ratio	5 Yr. Avg Combined Ratio	5-Year Prem. CAGR	5-Year EBITDA CAGR
BCBSD		**9.8%**	**88.5%**	**98.3%**	**99.8%**	**14.6%**	**221%**
National Companies							
UnitedHealth Group (1)	UNH	17.7%	83.0%	100.7%	102.6%	9.0%	103.3%
Aetna, Inc. (2)	AET	24.0%	82.8%	106.8%	106.4%	6.5%	-12.4%
CIGNA (3)	CI	33.2%	91.0%	124.2%	115.9%	4.7%	NM
	Mean	**25.0%**	**85.6%**	**110.6%**	**108.3%**	**6.7%**	**45.4%**
	Median	**24.0%**	**83.0%**	**106.8%**	**106.4%**	**6.5%**	**45.4%**
Blues							
WellPoint (4)	WLP	16.7%	81.9%	98.6%	99.6%	28.5%	29.8%
Anthem (3)	ATH	19.3%	82.4%	101.7%	106.0%	26.0%	29.6%
WellChoice (3)	WC	16.9%	85.3%	102.2%	104.2%	10.9%	82.8%
	Mean	**17.6%**	**83.2%**	**100.8%**	**103.2%**	**21.8%**	**47.4%**
	Median	**16.9%**	**82.4%**	**101.7%**	**104.2%**	**26.0%**	**29.8%**
Regional							
Health Net (3)	HNT	10.5%	83.4%	93.9%	96.3%	3.6%	NM
Oxford Health Plans (3)	OHP	11.8%	79.3%	91.2%	95.7%	1.3%	NM
Humana Inc. (3)	HUM	15.6%	83.6%	99.2%	99.1%	3.3%	-2.0%
PacifiCare Health Systems (3)	PHS	12.4%	87.1%	99.5%	98.1%	3.7%	-10.1%
	Mean	**12.6%**	**83.4%**	**95.9%**	**97.3%**	**3.0%**	**-6.1%**
	Median	**12.1%**	**83.5%**	**96.5%**	**97.2%**	**3.4%**	**-6.1%**
Niche							
Coventry Health Care (3)	CVH	12.2%	83.3%	95.5%	98.5%	14.6%	158.0%
Mid Atlantic Medical Services (3	MME	10.8%	84.2%	95.0%	98.1%	19.1%	64.4%
	Mean	**11.5%**	**83.8%**	**95.3%**	**98.3%**	**16.8%**	**111.2%**
	Median	**11.5%**	**83.8%**	**95.3%**	**98.3%**	**16.8%**	**111.2%**

NM - Not Meaningful; NA - Not Available

Source: Information for selected health insurers obtained and / or derived from Form 10K; information for BCBSD obtained and derived from Company's financials.

(1) Administrative cost ratios are based on consolidated numbers; medical loss ratios are only for healthcare segment.

(2) All ratios are based on the healthcare segment.

(3) Administrative cost ratios and medical loss ratios are based on consolidated numbers.

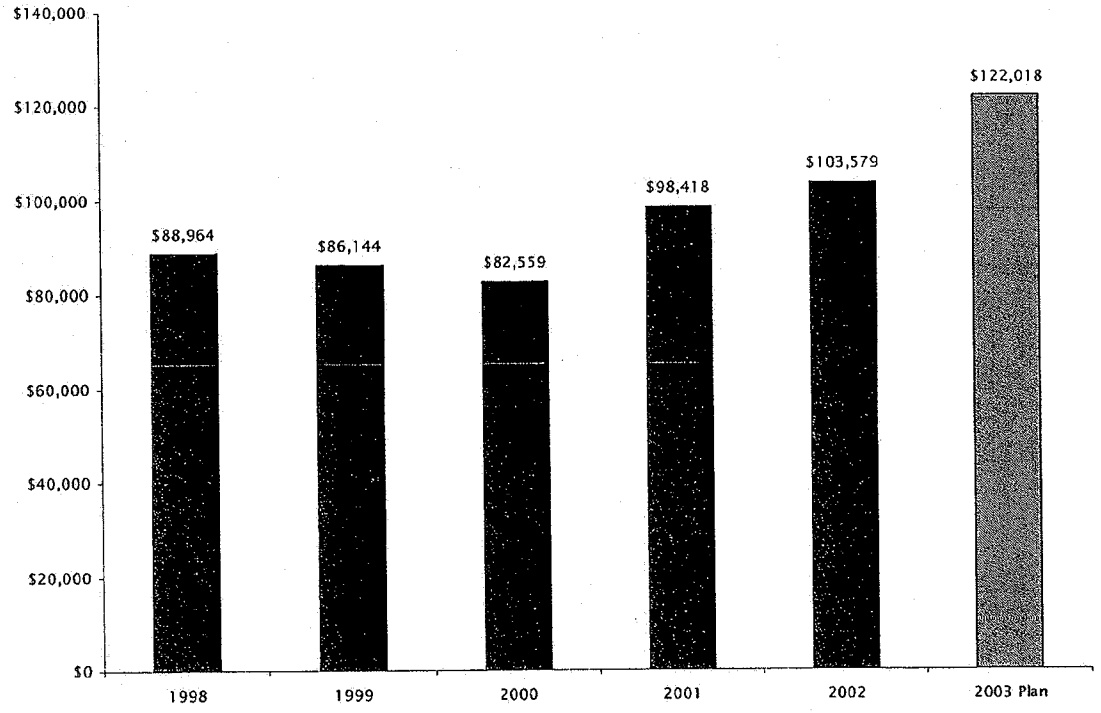
(4) Administrative cost ratios, and 1998 and 1999 medical loss ratios are based on consolidated numbers. Administrative cost ratios include other revenue

Capital Strength

Total Reserves (GAAP equity) have grown at a compound annual rate of 4% between 1998 and 2002. BCBSD management expects $122 million or a 18% increase in Total Reserves for 2003 from 2002 levels. The Company has maintained a conservative capital base as reflected in a risk-based capital ("RBC") ratio of 1,278% as of June 30, 2003.

GAAP Total Reserves: 1998 - 2002 Actual; 2003 Plan

(Dollars in Thousands)



Source: Company's audited financial statements and 2003 budget.

Risk-Based Capital Ratio

The RBC ratio reflects a formula calculation of actual capital adjusted for, among other factors, the type and performance of (a) medical claims costs, (b) investments and (c) administrative costs. The factors of claims and investments and the absolute level of capital impact the RBC ratio the most. For example, traditional indemnity claims are rated as high risk and ASO as very low risk. Investments with a National Association of Insurance Commissioners ("NAIC") rating of 1 are rated as low risk and NAIC 3 or more are rated high risk. The RBC ratio is also influenced by the degree of change in the aforementioned factors. As an example, a 1% deterioration in BCBSD's medical claims

costs could reduce the RBC ratio by 100 percentage points, while a 2% deterioration could reduce the RBC ratio by 300 percentage points.

According to BCBSD management, the BCBSA's minimum RBC ratio for Blues is approximately 400%, with a more preferred ratio for a smaller Blue of approximately 800%.

At June 30, 2003, BCBSD's RBC ratio was 1,278%.

Sensitivity Analysis

Three important determinants to operating performance are the medical loss ratio, the administrative cost ratio, and investment income. For 2003, management projects the medical loss ratio to be 89.6% and the administrative cost ratio to be 9.0%. The current yield on the fixed income portfolio is 5%. The most significant RBC ratio factors are medical loss costs and the type (risk versus non-risk), quality and character of the investment portfolio and total reserves (capital). We have indicated in the following page the impact on June 30, 2003 RBC ratio based on the following scenarios which are considered to be significant changes from the current operating results:

A. a 50 basis point reduction in the investment return
B. a 1% increase in the medical loss ratio
C. a 1% increase in the administrative cost ratio
D. a combined ratio of 101.5% (the worst year in the past 10 years)

In addition, we have assumed a prolonged deterioration in the underwriting performance over a 3 year period (2004 - 2006) resulting in a 100.2% combined ratio, which is 1.5% higher than the 2003 plan combined ratio. During this same 3 year period, we assume premiums grow 7.5%, well below the actual growth in recent years.

Results of the Sensitivity Analysis

Scenario

A. a 50 basis point reduction in the investment return
   Result: No impact on the RBC ratio.

B. a 1% increase in the medical loss ratio
   Result: The RBC ratio decreases 29 percentage points to 1,249%.

C. a 1% increase in the administrative cost ratio
   Result: Essentially no impact on the RBC ratio

D. a combined ratio of 101.5% (the worst year in the past 10 years)

Result: The RBC ratio decreases 99 percentage points to 1,179%.

E. Prolonged deterioration in the underwriting performance over a 3 year period (2004 - 2006) resulting in a 100.2% combined ratio, while premiums are assumed to grow at 7.5% over this period.
Result: The RBC ratio decreases 217 percentage points to 1,061% in 2004. In 2005, the resulting RBC ratio is 996% and in 2006, 934%.

Medical Claims Payable Reserve Adequacy

Management believes that it has been conservative in its medical claims reserving. The Company's year end reserves are typically checked against the Independent Auditor's and are often at the higher end of the Independent Auditor's range.

In recent years, BCBSD has had favorable reserve development due to conservative medical inflation trend assumptions which were built into the Company's rating models.

Capital Expenditures

The Company typically budgets approximately $3 million per year for capital expenditures, reflecting minor technology enhancements, furniture, personal computers, etc., in line with depreciation.

Profile of Investment Portfolio

At December 31, 2002, substantially all fixed income securities held in BCBSD's portfolio had a NAIC designation of "1" and were managed on a total return basis. BCBSD's fixed income portfolio has a maturity of less than 6 years. The Company's equity portfolio consisted of a large capitalization equity portfolio and an actively managed small capitalization equity portfolio. (Refer to Exhibit D - Statement of Investment Policy).

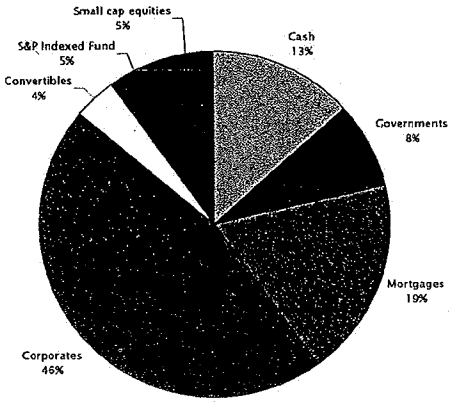
The investment funds are managed externally with Wilmington Trust and Wellington Asset Management managing the core fixed income portfolio. Investment managers for the equity and convertible investments are The Vanguard Institutional Fund, S&P Index Fund, Calamos Investment Management - Convertible Securities and Denver Investment Advisors - Small Capitalization Value.

At mid-year 2003, the equity component of the portfolio was 9.9% of the investment portfolio. A 15% decline in the equity portfolio, or a $2.1 million reduction, would reduce the capital (Total Reserves) by 1.8%.

Asset Class	Target Allocation	Minimum	Maximum
Short-term fund	5%	2%	20%
Fixed income portfolio			
Core bonds	80%	70%	85%
Convertible bonds	5%	0%	5%
Total fixed income	85%	70%	90%
Equity portfolio			
Domestic large cap equity	5%	0%	8%
Domestic small cap equity	5%	0%	7%
Total equity	10%	0%	15%

Source: BCBSD's Investment Portfolio Summary

Portfolio Breakdown at June 30, 2003



Total: $180.9 million

Source: BCBSD's Investment Portfolio Summary and Company management

Systems Technology

BCBSD has a mature information technology system that has, over time, been heavily customized. Following the affiliation with CareFirst, BCBSD undertook a project to determine the feasibility of integrating the Company's technology system with CareFirst's. While this project is still underway, BCBSD management believes that the BCBSD system is able to operate autonomously, and that while some portion of the CareFirst systems are superior, some are not. Management has represented that none of the Blues or, for that matter, other health insurers have a "state-of-the-art" system which is clearly superior. Sandler O'Neill has not attempted to assess the present or future capabilities of BCBSD's information technology.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Compliance

HIPAA has mandated a series of transactional, interface and administration changes required for all health insurance providers over a scheduled basis over the next several years.

As part of the second stage (Transaction & Code Sets Implementation) of HIPAA, BCBSD has developed an interface with CareFirst's system.

The following are HIPAA implementation dates and BCBSD's status:

	Implementation Date	BCBSD Status
Privacy	April 14, 2003	Completed
Transactions & Code Sets	October 16, 2003	In Process
Security	April 20, 2005	In process

Source: Company management

C. FLOW OF FUNDS RELATING TO INTERCOMPANY PAYMENTS

C. Flow of Funds Relating to Intercompany Payments

CareFirst provides certain services and makes payments for some charges incurred by BCBSD. The services are represented by management to be on an actual cost basis. Additionally, to date, the Company has not been charged for staff costs relating to compliance and internal audit. Projected 2003 payments to CareFirst by BCBSD are:

Amount	Description
$910,000	Allocated portion of senior management costs for integrated functions.
$200,000	BCBSD marketing related costs.
$4,750,000	Final 2002 and estimated 2003 income tax payments.
$1,100,000	Allocated property/casualty insurance premiums (multi-peril, computer crime, fiduciary liability, etc.).
$1,250,000	Employee benefit costs for long-term disability and miscellaneous health benefits.
$260,000	BCBSA dues
$280,000	Reimbursement of costs relating to Federal employee insured program subcontracted to CareFirst.
$500,000	Final payment relating to WellPoint merger costs.
$1,200,000	Reversal of pension benefit cost of BCBSD paid by CareFirst. Pension costs of BCBSD are administered and paid by BCBSD.

Source: Company management

IV. OBSERVATIONS

IV. Observations

Based upon Sandler O'Neill's review and analysis of the foregoing information and data, and conversations with BCBSD management, Sandler O'Neill believes that BCBSD benefits from a number of factors which favorably influence the financial condition of BCBSD as an essentially independent provider of health insurance services. These factors include, but are not limited to:

- Good current operating performance reflected in a relatively stable medical loss ratio over the past 3 years and a reduced administrative cost ratio;
- Management extant at BCBSD is experienced and has remained generally intact and can effectively continue to direct the affairs of BCBSD (see Exhibit E, "Management Biographies");
- Enhanced share of the market (35%), a 3 percentage point gain over the past 3 years, has strengthened BCBSD's position among larger employer accounts which, while not providing meaningful profits, absorb significant overhead / fixed costs. Gains also have been achieved in the smaller groups (under 200 lives);
- Smaller group accounts in Delaware can be experience / risk rated as opposed to other state jurisdictions which mandate a "community rating" approach, often resulting in more volatile results or adverse selection;
- A very strong capital position, as reflected in an RBC ratio of 1,278% as of June 30, 2003, provides excellent support for current operations and is sufficient to absorb any foreseeable conceivable adverse trends in the next 3 - 5 years in key drivers to operating performance: medical loss costs, administrative costs and investment returns;
- BCBSD is not an insurer of last resort;
- High service ratings in all important categories versus benchmark standards or competitors;
- BCBSD has a comprehensive product portfolio with a strong PPO program, the most desired plan currently demanded by employer groups;
- BCBSD has an extensive provider network in all categories;
- Claims reserves have been adequate, indicating a level of conservatism; and

- Investment portfolio with a high quality (A or better) orientation in the fixed income segment and a moderate (10% of the portfolio) exposure to equities, with a 50/50 mix between large capitalization companies and a more aggressive small capitalization focus.

Notwithstanding the foregoing, there are certain risks which pertain to BCBSD. These risks include, but are not limited to, the following:

- BCBSD operates in a small state with only an 800,000 population base;

- The 20 largest out of 2,500 Delaware accounts represent 59% of 2003 estimated revenues (on a premium equivalent basis). The offset is that these groups are virtually all ASO accounts with limited profit potential because of intense price competition among large employer accounts. Spokesmen for the Anthem and UnitedHealth merger transactions have announced the likely targeting of large, national accounts which is a clear threat to BCBSD's significant stake in that segment of the market;

- Limited access to external capital, which could prove a detriment if, for example, substantial expenditures for technology were required;

- Exposure to a dramatic change in health care reimbursement which, by its nature, might require a substantially different technology support system. This is not a risk unique to BCBSD but, because of its size, the costs of implementation could be relatively expensive. There is nothing currently on the horizon suggesting a dramatic change in the delivery of healthcare reimbursement;

- Inherent risks in the health insurance industry
  - highly cyclical
  - historically very small operating margins exposed to less predictable changes in utilization, inflation cost surges
  - many large competitors with greater resources can engage in predatory pricing
  - potential conflicts with provider networks;

- Exposure to regulatory or legislative changes; and

- Critical need to maintain Blue Cross Blue Shield Marks.

On balance, the financial strength and local market position of BCBSD is very good. However, the significant consolidation in the health insurance sector and the likely

targeting of large, national accounts puts any smaller insurer in jeopardy of losing market share and suffering the operating consequences of functioning in a stand-alone position.

CareFirst Affiliation

- The rationale for BCBSD's affiliation with CareFirst, as described by BCBSD management, was responsive to the trends in health insurance industry and the risks that those trends created for a smaller company such as BCBSD. BCBSD management expected that the affiliation would help BCBSD maintain and increase its market share, including by enhancing its ability to service national and regional accounts, and also result in savings in operating costs through shared marketing and other services, with a resulting improvement in BCBSD's administrative cost ratio.

- Since the CareFirst affiliation in 2000, BCBSD has continued to experience favorable trends both with respect to its market share and with respect to its operating costs, resulting in a material improvement in its administrative cost ratio. In BCBSD's management's opinion, the continuation of these favorable trends since 2000 reflect in part benefits derived from the affiliation, including increased penetration of larger accounts and material cost sharing benefits in marketing products and in certain administrative expense areas.

- It is reasonable to infer that BCBSD's favorable trends since the affiliation in part do reflect benefits derived from the affiliation, although the short history of the affiliation and the limitations in the data available do not permit a quantification of those benefits or a judgment as to their relative importance. The affiliation with CareFirst has been advantageous to BCBSD's operating capability.

- Since the affiliation with CareFirst, trends in the health insurance industry, including the significant mergers announced only within the last two weeks, have strengthened the need and rationale for an affiliation by BCBSD with a regional or national health insurer.

V. CONCLUSION

D. Conclusion

The Proposed Agreement draft dated October 20, 2003, by its terms, reaffirms both CareFirst's and BCBSD's intentions to continue the existing provision of services between the two companies in order to preserve the operation and financial benefits of the affiliation. The Proposed Agreement also provides BCBSD with the flexibility to alter its relationship with CareFirst in the future, including even to disaffiliate under certain circumstances.

Based upon Sandler O'Neill's review and analysis of the information and data referenced in this Report, and reflecting the key provisions in the Proposed Agreement that the existing intercompany services will continue, the transfer of the Blue Cross Blue Shield service marks to BCBSD and the transfer of membership and voting power to the BCBSD Board of Directors, Sandler O'Neill believes, as the date hereof, and subject to the limitations and qualifications set forth herein, that:

- The Proposed Agreement will not have a material adverse effect on the financial condition of BCBSD.

- An affiliation with CareFirst or another substantial regional or national health insurer will continue to be important to BCBSD's operating and financial condition.

EXHIBIT A: DRAFT ADMINISTRATIVE SERVICES AND BUSINESS AFFILIATION AGREEMENT DATED OCTOBER 20, 2003

ADMINISTRATIVE SERVICES

AND

BUSINESS AFFILIATION AGREEMENT

OCTOBER ___, 2003

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ADMINISTRATIVE SERVICES AND BUSINESS AFFILIATION AGREEMENT

This ADMINISTRATIVE SERVICES AND BUSINESS AFFILIATION AGREEMENT (the "Agreement"), effective midnight, December 31, 2003, is made and entered into by and among BCBSD, Inc., ("BCBSD") a Delaware non-stock corporation, CareFirst, Inc., ("CareFirst") a Maryland non-stock corporation, and as to Sections 2.1 and 2.3 only, CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. (BCBSD and CareFirst are hereinafter together referred to as the "Companies" or the "Parties" and, separately, as "Company" or "Party").

RECITALS

WHEREAS, on March 22, 2000, CareFirst became the sole member of BCBSD pursuant to the Business Affiliation Agreement entered into between the Companies and the other parties named therein on December 23, 1998 (the "1998 Agreement"); and

WHEREAS, the affiliation created by the 1998 Agreement (the "Affiliation") between the Companies has proven successful and beneficial for both Companies; and

WHEREAS, regulatory and legislative developments in Maryland during 2003 have given rise to concerns within BCBSD that CareFirst may now be operating in a regulatory and statutory environment that could adversely impact CareFirst and its affiliates and subsidiaries; and

WHEREAS, as a result of these developments, the Insurance Commissioner of the State of Delaware (the "Delaware Commissioner") issued a Rule to Show Cause on May 22, 2003 (the "Rule to Show Cause") as to why the Affiliation should not be dissolved, and has scheduled a hearing for November 4, 2003 to review the issues raised by the Rule to Show Cause; and

WHEREAS, since May 22, 2003, the Companies and representatives of the Delaware Commissioner have actively discussed possible modifications to the Affiliation that would resolve the issues and areas of concern raised by the Delaware Commissioner and BCBSD; and

WHEREAS, the Insurance Commissioner of the State of Maryland (the "Maryland Commissioner"), by a memorandum dated September 11, 2003, has provided legislative and regulatory interpretations which help alleviate certain of the issues raised by the Delaware Commissioner and the Board of Directors of BCBSD; and

WHEREAS, the Board of Directors of BCBSD has indicated that it requires certain modifications to the terms of the Affiliation, including transfer of majority membership in BCBSD to the Board of Directors of BCBSD, in order to continue the beneficial aspects of the Affiliation; and

WHEREAS, the Boards of Directors of CareFirst and BCBSD are willing to approve the proposed changes to the Affiliation in order to preserve the operational and financial benefits of the Affiliation to the maximum extent possible.

NOW THEREFORE, in consideration of the mutual agreements and covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, but subject to satisfaction of the regulatory and other conditions set forth herein, the parties hereto agree as follows:

ARTICLE I

CLOSING

Section 1.1 Time and Date of Closing.

Subject to the terms and conditions of this Agreement, the closing under this Agreement (the "Closing") shall take place in the BCBSD Boardroom, One Brandywine Gateway, Wilmington, Delaware, 19801, commencing at 10:00 am on December 30, 2003 or, if earlier, on the third business day following satisfaction or waiver of all conditions of the Parties to consummate the transactions contemplated by the Agreement and after receipt of all required regulatory and other third party approvals for the transactions contemplated by this Agreement, or such other date and place as may be agreed upon in writing by the Companies.

Section 1.2 Closing Deliveries.

a. By CareFirst. At Closing, CareFirst shall deliver to BCBSD each of the following:

1. evidence of the filing in the office of the Maryland State Department of Assessments and Taxation of an amendment to or restatement of the Charter of CareFirst substantially in the form of Appendix "A" hereto;

2. a copy of the CareFirst Charter certified by the Maryland State Department of Assessments and Taxation;

3. a copy of the By-laws of CareFirst, as amended substantially in the form of Appendix "B" hereto, certified by the Secretary of CareFirst;

4. copies of resolutions of the Board of Directors of CareFirst, certified by the Secretary of CareFirst, authorizing the execution, delivery and performance of this Agreement and the consummation of all transactions contemplated thereby; and

5. an opinion of Piper Rudnick LLP substantially in the form of Appendix "C" hereto.

b. By BCBSD. At Closing, BCBSD shall deliver to CareFirst each of the following:

1. evidence of the filing, in the office of the Delaware Secretary of State, of an amendment to or restatement of the Certificate of Incorporation of BCBSD, amending or restating that Certificate substantially in the form of Appendix "D" hereto;

2. a copy of the BCBSD Certificate of Incorporation certified by the Office of the Secretary of State of Delaware;

3. a copy of the By-laws of BCBSD, as amended substantially in the form of Appendix "E" hereto, certified by the Secretary of BCBSD;

4. copies of resolutions of the Board of Directors of BCBSD, certified by the Secretary of BCBSD, authorizing the execution, delivery and performance of this Agreement and all transactions contemplated thereby;

5. an executed copy of BCBSD's license agreement with the Blue Cross and Blue Shield Association permitting BCBSD to use the Blue Cross and Blue Shield service marks in the State of Delaware; and

6. an opinion of Parkowski, Guerke & Swayze, P.A., substantially in the form of Appendix "F" hereto.

ARTICLE II

PRESERVATION OF BUSINESS AFFILIATION

Section 2.1 Termination of 1998 Agreement.

Effective upon Closing, the 1998 Agreement is terminated and superseded in its entirety by this Agreement. After the date of the Closing, the Parties shall provide employee benefits to the employees of the Parties in accordance with the provisions of the 1998 Agreement, as revised and set forth in Appendix "G" hereof.

Section 2.2 Integration of Company Operations.

To the extent not inconsistent with this Agreement or incompatible, for legal, accounting or business reasons (including, without limitation the availability of the Blue Cross and Blue Shield service marks), with the structure of the Companies following Closing, the Companies shall use commercially reasonable efforts to maintain products and services offered by the Companies as of the date of Closing. The Companies shall further use commercially reasonable efforts to maintain the level of integration of such products and services, and the operational and

administrative functions performed by or on behalf of either or both Companies, or their affiliates and subsidiaries, in each case as such were in existence and effect as of the date of Closing. Notwithstanding the foregoing, the Parties may modify or terminate any of the operational or administrative functions rendered in connection with this Agreement if required by an order of the Maryland Insurance Administration, the Delaware Department of Insurance, or any other appropriate state regulatory body or if the provision of such operational or administrative function would violate applicable law. Nothing in this Agreement shall require the Parties to upgrade or expand infrastructure, facilities or systems, or to hire additional employees, for the purpose of providing any product or service or operational or administrative function.

Section 2.3 Withdrawal of BCBSD from Amended and Restated Intercompany Agreement.

a. With the consent of the Parties hereto, BCBSD hereby withdraws from the Amended and Restated Intercompany Agreement (the "Amended and Restated Intercompany Agreement") entered into by and among BCBSD, CareFirst, CareFirst of Maryland, Inc., and Group Hospitalization and Medical Services, Inc. on March 22, 2000, and BCBSD shall have no rights or obligations thereunder except as provided in subsection b. hereof. Notwithstanding the foregoing, Section V of the Amended and Restated Intercompany Agreement , entitled "Cost Allocations" (as amended and attached hereto as Appendix "H") shall remain effective as to the Companies for so long as this Agreement is in force with respect to all services provided, and costs allocated therefor, as of the date of Closing.

b. Subject to necessary regulatory approvals (to the extent not previously obtained), each Party shall determine all amounts due and owing to the other Parties under the Amended and Restated Intercompany Agreement up to, and through the date of Closing, and shall pay such amounts within ninety (90) days following Closing.

Section 2.4 Transfer of Sole Membership to CareFirst.

a. The BCBSD Board of Directors shall, not less than annually, take up and deliberate the merits of transferring sole membership of BCBSD back to CareFirst and restoring the terms and conditions of the 1998 Agreement.

b. Subject to all necessary Blue Cross Blue Shield Association and regulatory approvals, in the event the BCBSD Board of Directors resolves to transfer sole membership to CareFirst pursuant to subparagraph a. of this Section, the Companies shall, within 90 days' notice of such resolution provided to CareFirst, terminate this Agreement and, concurrently therewith, enter into an agreement or such agreements as will embody all of the substantive terms and conditions of the 1998 Agreement and related transactions, to the extent that such terms and conditions are either not made impossible by the occurrence of intervening events or the passage of time, or excused or amended by mutual consent of the Companies.

ARTICLE III

GOVERNANCE OF THE COMPANIES

Section 3.1 BCBSD Members; CareFirst Board Representative.

a. By operation of the BCBSD and CareFirst Board approvals, and the due execution and filing thereafter, of amended and restated corporate charters to be filed with the appropriate Maryland and Delaware state agencies and delivered at Closing (forms of which are attached as appendices hereto), the Members of BCBSD shall be comprised of CareFirst and each of the persons elected from time to time to the BCBSD Board of Directors except for the Director elected by CareFirst in accordance with subparagraph b. hereof; *provided however,* that CareFirst shall remain a member of BCBSD only for so long as this Agreement is in force. Each Member shall have one vote on all matters to be decided by the Members. Notwithstanding the foregoing, CareFirst shall not have the right to be a Member of BCBSD following termination of this Agreement.

b. The amended and restated BCBSD Bylaws (a form of which is attached as an appendix hereto) shall provide that, during the term of this Agreement, CareFirst, as a Member of BCBSD, shall be entitled to have one individual, who shall not be an employee or officer of CareFirst, elected by CareFirst to serve as a Director on the BCBSD Board of Directors, but such individual shall not serve as a Member of BCBSD. Such individual shall meet the qualifications required of a BCBSD Director under BCBSD's By-laws and Delaware law, and shall only be removed from the BCBSD Board of Directors for cause. CareFirst shall have the exclusive right to designate an individual to fill the resulting vacancy created by the death, resignation or removal of the individual elected by CareFirst to serve on the BCBSD Board of Directors.

Section 3.2 CareFirst Board of Directors.

a. The amended and restated corporate charters, to be filed with the appropriate Maryland and Delaware state agencies and delivered at Closing (forms of which are attached as appendices hereto), shall cause the following changes with respect to the Class III Directors serving on the CareFirst Board immediately prior to Closing:

1. the Class III Directors serving on the CareFirst Board shall remain three (3) in number; and

2. following Closing, the Class III Directors shall not retain the extraordinary voting rights granted them under the CareFirst corporate charter and bylaws in effect immediately prior to Closing; provided, however, that the Class III Directors shall retain the exclusive right to select and remove the Class III Directors.

b. Unless terminated in connection with a transfer of membership to CareFirst pursuant to Section 2.4 hereof, upon termination of this Agreement the Class III Directors shall cease to serve as members of the CareFirst Board of Directors, and the CareFirst Charter shall be amended to remove any reference thereto.

Section 3.3 BCBSD Chief Executive Officer.

a. The Chief Executive Officer of BCBSD immediately prior to Closing shall continue to serve as Chief Executive Officer of BCBSD following Closing, except in the case of his death, resignation, or removal by the BCBSD Board of Directors in accordance with BCBSD Bylaws in effect at such time. Successor BCBSD Chief Executive Officers shall be elected by the BCBSD Board in accordance with the BCBSD Bylaws in effect at the time of such election and such successor may or may not be the Chief Executive Officer of CareFirst, in the sole discretion of the BCBSD Board. Nothing herein shall be construed as giving rise to any actual or implied contract for employment between BCBSD and the Chief Executive Officer of BCBSD.

ARTICLE IV

REPORTING

Section 4.1 Reporting Requirements – Quarterly.

a. The following information shall be reported by CareFirst to BCBSD and to the Delaware Commissioner immediately following the filing of CareFirst of Maryland, Inc., and Group Hospitalization and Medical Services, Inc., statutory quarterly financial statements. This information should be broken down by insurance or managed care Controlled Affiliates of CareFirst and, to the extent applicable, on a group-wide basis as well. "Controlled Affiliates" shall include any entity that directly or indirectly through one or more intermediaries, controls (i.e., possesses, directly or indirectly, the power to direct or cause the direction of the management and policies of a person whether through ownership of voting securities, by contract, through membership or otherwise), is controlled by, or is under common control with, the specified person. The format of these reports should show results for each item for the quarter in question (or year in the case of year-end figures), as well as the prior three consecutive quarters, with respect to CareFirst and its insurance and managed care Controlled Affiliates.

1. RBC calculations (SAP basis).
2. Administrative Expense ratios (GAAP basis).
3. Medical loss ratios (GAAP basis).
4. Balance sheets (GAAP basis).
5. Statements of Operations (income statements) (GAAP basis).
6. Statements of cash flows (GAAP basis).
7. Membership/contract summary.
8. Membership satisfaction survey results.

9. Z-Score calculation for CareFirst for the current and prior two years.
10. To the extent not already provided, all NAIC quarterly and annual statutory financial statements for all CareFirst insurance and managed care Controlled Affiliates should also be provided to BCBSD and the Delaware Commissioner.

Section 4.2 Reporting Requirements – Immediate.

Any occurrence of the following after October 1, 2003, should be reported to BCBSD and to the Delaware Commissioner within 2 business days after the occurrence thereof becomes known to CareFirst:

a. The initiation of any investigation by the Maryland Attorney General or by the Maryland Commissioner, not already called for by either the Maryland Legislation or Commissioner Redmer's July 8, 2003 Report, of any alleged unsafe or unsound practice on the part of CareFirst or any of its officers or Directors.

b. The issuance of any findings by the Maryland Attorney General or by the Maryland Commissioner with respect to any alleged unsafe or unsound practice on the part of CareFirst or any of its officers or Directors.

c. Any communication from the Maryland Commissioner or the Maryland Insurance Administration threatening or jeopardizing CareFirst's premium tax exemption.

d. Any communication from the Maryland Commissioner or the Maryland Insurance Administration questioning, threatening or jeopardizing the renewal of CareFirst's certificate of authority.

e. Any communication, except routine correspondence, with or from the Blue Cross Blue Shield Association (including, without limitation, its counsel, representatives and other agents) addressing the continued availability of the Blue Cross Blue Shield service mark to CareFirst or any of its affiliates.

f. Any communication with or from the Blue Cross Blue Shield Association (including, without limitation, its counsel, representatives and other agents) respecting an alleged inadequacy in the financial condition of CareFirst or any affiliate thereof.

g. Any written report issued by the Joint Oversight Committee and received by CareFirst.

h. Any communication of confidential information with respect to BCBSD made by a non-voting member of the CareFirst Board to any person or entity, other than to other CareFirst Board Members, CareFirst management, attorneys for CareFirst or such non-voting member, outside auditors of CareFirst and other persons authorized by BCBSD or the CareFirst Board, including all of the Class III Directors, to receive such confidential information.

i. The resignation or removal of any CareFirst Board member or member of senior management.

j. The selection by the nominating committee or the CareFirst Board of any person for appointment or election to the CareFirst Board. (NAIC biographical information for such person must be submitted within five days of this occurrence.)

k. Any new Maryland law or regulation or any amendment of, or change to, any existing Maryland law or regulation directly affecting insurance companies that could adversely impact the financial condition, management, structure or operations of CareFirst or any affiliate thereof.

l. Any communication from the Maryland Commissioner or the Maryland Insurance Administration respecting the financial impairment or insolvency of CareFirst or any Controlled Affiliate thereof.

m. Any subpoena or formal request for information from CareFirst or any of its officers or Directors in their capacities as officers or Directors, from any state or federal investigatory authority, unless the reporting of any such subpoena or formal request for information is prohibited by law or a specific court order.

Section 4.3 Corrective Actions Based Upon Reporting Requirements.

The occurrence of any of the following events shall trigger the corresponding actions on the part of CareFirst:

a. For any CareFirst insurance company or managed care Controlled Affiliate with annual revenue in excess of $100 million: risk based capital falling below 200% of authorized control level RBC.

1. Within 30 days following the report indicating the foregoing, CareFirst must:

a) explain to the satisfaction of BCBSD and the Delaware Commissioner the reasons for the RBC level; or, if required,

b) present a plan for corrective action, satisfactory to BCBSD and the Delaware Commissioner, as if the company had fallen below Company Action Level RBC.

b. For CareFirst on a group-wide basis, and for any CareFirst insurance company or managed care Controlled Affiliate with annual revenue in excess of $100 million: negative underwriting margin.

1. Within 30 days following the report indicating the foregoing, CareFirst must:

a) explain to the satisfaction of BCBSD and the Delaware Commissioner the reasons for the underwriting loss; or, if required,

b) present a plan for corrective action satisfactory to BCBSD and the Delaware Commissioner.

c. Reduction in CareFirst's membership/contracts exceeding 10% on a rolling annual basis calculated quarterly.

1. Within 30 days following the report indicating the foregoing, CareFirst must:

a) explain to the satisfaction of BCBSD and the Delaware Commissioner the reasons for the loss in membership; or, if required,

b) present a plan for corrective action satisfactory to BCBSD and the Delaware Commissioner.

d. Increases in CareFirst's membership/contracts exceeding 20% on a rolling annual basis calculated quarterly (the purpose of this reporting requirement is to assure BCBSD and the Delaware Commissioner that CareFirst has adequate capital to support any unexpected growth in annual net premium).

1. Within 30 days following the report indicating the foregoing, CareFirst must:

a) explain to the satisfaction of BCBSD and the Delaware Commissioner the reasons for the increase in membership; or, if required,

b) present a plan for corrective action satisfactory to BCBSD and the Delaware Commissioner.

e. Any failure to satisfy any of the aforementioned reporting requirements within the specified timeframe.

1. Within 10 business days of any failure to satisfy any quarterly reporting requirement or within 10 business days of the discovery of the failure to satisfy any immediate reporting requirement CareFirst must:

a) explain to the satisfaction of BCBSD and the Delaware Commissioner the reason for such failure to report; and

b) correct such failure to report.

Section 4.4 BCBSD Reporting Requirements – Quarterly.

The following information shall be reported by BCBSD to CareFirst, which may thereafter provide such information to the Maryland Insurance Administration, immediately following the filing of BCBSD statutory quarterly financial statements. This information should be broken down by insurance or managed care Controlled Affiliates of BCBSD and, to the extent applicable, on a group-wide basis as well. The format of these reports should show results for each item for the quarter in question (or year in the case of year-end figures), as well as the prior three consecutive quarters, with respect to BCBSD and its insurance and managed care Controlled Affiliates.

1. RBC calculations (SAP basis).
2. Administrative Expense ratios (GAAP basis).
3. Medical loss ratios (GAAP basis).
4. Balance sheets (GAAP basis).
5. Statements of Operations (income statements) (GAAP basis).
6. Statements of cash flows (GAAP basis).
7. Membership/contract summary.
8. Membership satisfaction survey results.
9. Z-Score calculation for BCBSD for the current and prior two years.
10. To the extent not already provided, all NAIC quarterly and annual statutory financial statements for all BCBSD insurance and managed care Controlled Affiliates.

Section 4.5 BCBSD Reporting Requirements – Immediate.

a. In the event BCBSD receives any communication from the Delaware Commissioner respecting the financial impairment or insolvency of BCBSD or any Controlled Affiliate thereof, such occurrence shall be reported to CareFirst, which may thereafter provide such information to the Maryland Insurance Administration, within two (2) business days after the occurrence thereof becomes known to BCBSD.

b. Within two (2) business days after BCBSD becomes aware of the occurrence of any event that provides CareFirst the right to terminate this Agreement upon notice to BCBSD in accordance with Section 7.4.b. hereof, such occurrence shall be reported to CareFirst.

ARTICLE V

COVENANTS

Section 5.1 Company Operations.

The Parties hereby covenant and agree that, prior to Closing, they will operate and conduct their businesses only in the ordinary course in accordance with prior practices, shall

maintain all assets in their present state of repair (ordinary wear and tear excepted), and shall use best efforts to keep available the services of its employees and preserve the goodwill of its business and relationships with the customers, licensors, suppliers, distributors and brokers with whom it has business relations.

Section 5.2 Consents, Waivers, Authorizations, etc.

Each Party will use its best efforts to obtain all consents, waivers, authorizations, orders and approvals of and make all filings and registrations with, any governmental commission, board or other regulatory body or any third party, required for, or in connection with, the performance by them of the Agreement and the consummation by them of the transactions contemplated hereby. Each Party will cooperate fully with the other Party in assisting it to obtain such consents, authorizations, orders and approvals. The Parties will not take any action which could reasonably be anticipated to have the effect of delaying, impairing or impeding the receipt of any required approvals, regulatory or otherwise. By way of example and not in limitation of the foregoing, CareFirst shall secure the necessary approvals of its Board of Directors in connection with the amendment and restatement of the BCBSD Certificate of Incorporation and Bylaws.

Section 5.3 Public Announcements.

Prior to Closing, each Party shall not, and shall cause its Controlled Affiliates not to, issue or cause the publication of any press release or any other announcement with respect to the transactions contemplated by the Agreement without the prior written consent of the other Party, except where such release or announcement is required by applicable law, in which case each Party will permit review by the other of any such press release or announcement prior to its release or filing and shall deliver simultaneously a final copy of such release or announcement to the other upon its release or filing.

ARTICLE VI

CONDITIONS

Section 6.1. Conditions to Each Party's Obligations.

The respective obligations of each Party under the Agreement shall be subject to the fulfillment at or prior to Closing of the following conditions:

a. Consent of State Regulators. All consents of the Delaware Commissioner, the Maryland Insurance Administration, the Superintendent of Insurance of the District of Columbia and any other appropriate state regulatory bodies that are required to consummate the transactions contemplated hereby shall have been obtained pursuant to orders which by their respective terms do not impose any materially burdensome

condition on any of the Parties hereto or their affiliates (as determined by such Party), and such orders shall be in full force and effect.

b. Approval of the Blue Cross and Blue Shield Association. Any required approval of the Blue Cross and Blue Shield Association shall have been obtained.

Section 6.2. Conditions to CareFirst's Obligations.

CareFirst's obligations under the Agreement shall be subject to the fulfillment at or prior to Closing of the following conditions:

a. Closing Deliveries. BCBSD and CareFirst shall have delivered the documents required by Section 1.2.b. hereof.

b. Blue Cross and Blue Shield Association License. CareFirst shall have obtained a modified license from Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield service marks in Maryland and the District of Columbia.

Section 6.3. Conditions to BCBSD's Obligations.

BCBSD's obligations under the Agreement shall be subject to the fulfillment at or prior to Closing of the following conditions:

a. Closing Deliveries. BCBSD and CareFirst shall have delivered the documents required by Section 1.2.a. hereof.

b. Blue Cross and Blue Shield Association License. BCBSD shall have obtained a license from Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield service marks in Delaware.

ARTICLE VII

TERM AND TERMINATION

Section 7.1 Term.

This agreement shall terminate as of December 31, 2005, and shall automatically renew thereafter for successive one year terms unless any Party hereto gives notice to the other Parties, six (6) months in advance of the end of a term, of its intention that this Agreement not be renewed at the conclusion of such term.

Section 7.2 Termination Upon Mutual Consent.

This Agreement may be terminated at any time by mutual written consent of the Companies duly authorized by their respective Boards of Directors.

Section 7.3 Termination Upon Breach – Cure.

a. In the event of a breach of this Agreement (including but not limited to any material degradation in services provided pursuant to Section 2.2 hereof), or any condition imposed upon the Companies by the Delaware Commissioner in her Order, Docket No. 99-09, dated March 20, 2000, or in any supplemental Order entered by the Delaware Commissioner in Docket No. 99-09 or any subsequent docket, in any material respect, by either party, the non-breaching party may provide notice of such breach and deliver therewith a notice thereof and of the non-breaching party's intention to terminate the Agreement (the "Termination Notice").

b. Except with respect to the Triggering Events set forth in Section 7.4 hereof, upon receipt of a Termination Notice, the breaching party shall have forty-five (45) days within which to cure said breach to the reasonable satisfaction of the non-breaching party.

Section 7.4 Special Events Triggering Termination.

a. Upon the occurrence of any one of the following events, BCBSD may, in its sole discretion, terminate the Agreement with fourteen (14) days notice to CareFirst (except for Section 7.4.a.2, which shall require ninety (90) days notice).

1. Failure of CareFirst (1) to submit or satisfy any plan for corrective action for which there is no explanation that is satisfactory to BCBSD or the Delaware Commissioner or (2) to correct any failure to satisfy any reporting requirement described above which failure is determined by the Delaware Commissioner to be intentional or grossly negligent on the part of CareFirst.

2. Unanimous vote of the BCBSD Board of Directors (excluding the vote of the Director elected by CareFirst pursuant to Section 3.1.b hereof) to accept a merger or acquisition offer, an alternative business affiliation, or to convert to a for-profit basis; *provided, however*, that this provision shall not become effective for a period of six (6) months from date of Closing.

3. Any final action by the Maryland Commissioner or the Maryland Attorney General finding that CareFirst or any of its executive officers or Directors engaged in an "unsafe or unsound" practice. "Final action" shall be deemed to be a failure of CareFirst management to follow an issued warning letter and the imposition of a final sanction for such failure.

4. The adoption by the State of Maryland or any of its agencies or authorities, after October 1, 2003, of any statute, rule, regulation or similar statement of policy purporting to impose requirements or restrictions of any sort on BCBSD or BCBSD insurance or managed care Controlled Affiliates not holding certificates of authority in Maryland.

5. Unanimous vote of the BCBSD Board of Directors (excluding the vote of the Director elected by CareFirst pursuant to Section 3.1.b hereof) after December 31, 2004 and before July 1, 2005, determining in good faith that any one or more of the twelve new Class II Directors fail to meet the standards set forth in Section 5003(d)(1) of the Delaware Insurance Code or any other standards for such office set forth in the Delaware Insurance Code.

6. The determination by the Maryland Insurance Administration or Maryland Attorney General or any court of competent jurisdiction that BCBSD is required to adhere to the mission requirements of Section 14-102 of the Maryland Insurance Code by virtue of Section 14-102(f) thereof, as enacted pursuant to the Maryland Legislation, and such determination becomes final and enforceable.

7. The determination by the Maryland Insurance Administration or Maryland Attorney General or any court of competent jurisdiction that the provisions of Section 14-115(d)(11)(1) of the Maryland Insurance Code, as enacted pursuant to the Maryland Legislation, will be enforced against BCBSD with regard to Delaware matters and that determination becomes final and enforceable.

8. Any written notice issued by the Blue Cross and Blue Shield Association to CareFirst terminating, suspending, materially impairing or limiting CareFirst's right to use the Blue Cross and Blue Shield service marks (excluding any curtailment resulting from any disaffiliation regarding CareFirst and any of its subsidiaries) unless, within 30 days thereof, such termination, suspension, material impairment or limitation is either stayed, or rights in the service marks are restored in their entirety, with no termination, suspension, material impairment or limitation of BCBSD's right to use the service marks in Delaware.

9. Suspension of or failure to renew CareFirst's Certificate of Authority.

10. Modifications relating to CareFirst's Board that reduce Delaware's proportionate representation thereon or in any way dilute or negatively affect the voting power of the CareFirst Class III Directors, except as contemplated by this Agreement.

11. A determination by the Maryland Commissioner that CareFirst is in a financially impaired condition under applicable Maryland law.

b. Upon the occurrence of any one of the following events, CareFirst may, in its sole discretion, terminate the Agreement with fourteen (14) days' notice to BCBSD (except for Section 7.4.b.2, which shall require ninety (90) days notice).

1. Failure of BCBSD to satisfy any reporting requirement described above which failure is determined by CareFirst to be intentional or grossly negligent on the part of BCBSD.

2. Unanimous vote of the BCBSD Board of Directors (excluding the vote of the Director elected by CareFirst pursuant to Section 3.1.b hereof) to accept a merger or acquisition offer or to convert to a for-profit basis; *provided, however*, that this provision shall not become effective for a period of six (6) months from date of Closing.

3. Any final action by a court of competent jurisdiction, the Delaware Commissioner, or the Delaware Attorney General finding that BCBSD or any of its executive officers or Directors engaged in a material violation of any provision of Title 18 of the Delaware Code or any regulation implementing such Title. "Final action" shall be deemed to be a final administrative ruling or court order not subject to further appeal or a failure of BCBSD management to follow an order of the Delaware Commissioner and the imposition of a final sanction for such failure no longer subject to appeal.

4. Any written notice issued by the Blue Cross and Blue Shield Association to BCBSD terminating, suspending, materially impairing or limiting BCBSD's right to use the Blue Cross and Blue Shield service marks unless, within 30 days thereof, such termination, suspension, material impairment or limitation is either stayed, or rights in the service marks are restored in their entirety, with no termination, suspension, material impairment or limitation of CareFirst's right to use the service marks in Maryland, the District of Columbia or northern Virginia.

5. Suspension of or failure to renew BCBSD's authority to continue to conduct its business in Delaware.

6. A determination by the Delaware Commissioner that BCBSD is in a financially impaired condition under applicable Delaware law.

Section 7.5 Obligations of the Parties Upon Termination.

a. Following termination of this Agreement for any reason, the Parties shall use best efforts, and cooperate fully and in good faith, to ensure that the termination of this Agreement and the suspension of services provided hereunder shall be effectuated with minimal disruption to the Parties, their employees and their subscribers. During the transition period in which termination of the services provided under this Agreement is

ongoing, cost allocations made by either Party pursuant to Section 2.3.a hereof shall continue to the extent services continue to be provided by the other Party.

b. Following the final termination of all services provided under this Agreement, each Party shall calculate all amounts due and owing to the other Party under this Agreement, as such have accrued since the date of Closing and remain unpaid, and shall remit a final invoice for such amounts within thirty (30) days following the final termination of services. Subject to necessary regulatory approvals, sixty (60) days following receipt of such invoice, the Parties shall make final payment of all undisputed amounts thereof.

c. Upon termination of this Agreement, CareFirst agrees to resign as Member of BCBSD and to cause the resignation of the individual it has elected to the BCBSD Board of Directors pursuant to Section 3.1 hereof, and BCBSD agrees to cause the resignation of the Class III Directors serving pursuant to Section 3.2 hereof.

ARTICLE VIII

MISCELLANEOUS

Section 8.1 Expenses.

All costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transactions contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Without limiting the foregoing, BCBSD shall pay all costs and expenses related to obtaining and holding a separate license for its use of Blue Cross and Blue Shield service marks in Delaware.

Section 8.2 Assignment; Parties in Interest.

This Agreement and all of the provisions hereof shall be binding upon and inure to the benefit of, and be enforceable by, the Companies and their respective successors and permitted assigns, but neither this Agreement nor any of the rights, interests or obligations herein shall be assigned by any Party hereto without the prior written consent of the other Parties.

Section 8.3 Further Assurances.

The Companies agree that, from and after the Closing, upon the reasonable request of any other Party hereto and without further consideration, such Party will execute and deliver to such other Parties such documents and further assurances and will take such other actions (without cost to such Party) as such other Party may reasonably request in order to carry out the purpose and intention of this Agreement.

Section 8.4 Entire Agreement.

This Agreement, and the other writings referred to herein or delivered pursuant hereto which form a part hereof, contain the entire understanding of the Parties with respect to the subject matter hereof. This Agreement supersedes all prior agreements between the Parties (including the 1998 Agreement) with respect to its subject matter.

Section 8.5 Notices.

All notices, claims, certificates, requests, demands and other communications hereunder will be in writing and will be deemed to have been duly given when personally delivered, on the date of receipt indicated on the return receipt if delivered or mailed (registered or certified mail, postage prepaid, return receipt requested) or sent via overnight or express delivery (with proof of delivery) as follows:

a. If to BCBSD:

Blue Cross Blue Shield of Delaware, Inc.
One Brandywine Gateway
3rd Floor
Wilmington, DE 19801
Facsimile: (302) 412-3461
Attention: Timothy J. Constantine
President

with copies (which shall not constitute notice) to:

Blue Cross Blue Shield of Delaware, Inc.
One Brandywine Gateway
3rd Floor
Wilmington, DE 19801
Facsimile: (302) 412-3461
Attention: William E. Kirk, III, Esq.
Vice President, General Counsel and Secretary

Parkowski, Guerke and Swayze, P.A.
800 King Street
Suite 203
Wilmington, DE 19801
Facsimile: (302) 654-3033
Attention: David S. Swayze, Esq.

b. If to CareFirst:

CareFirst, Inc.
10455 Mill Run Circle
Owing Mills, Maryland 21117

Facsimile: (410) 998-5732
Attention: William L. Jews
President and Chief Executive Officer

with copies (which shall not constitute notice to:

CareFirst, Inc.
10455 Mill Run Circle
Owing Mills, Maryland 21117
Facsimile: (410) 998-7810
Attention: John A. Picciotto, Esq.
Executive Vice President and General Counsel

Piper Rudnick, LLP
6225 Smith Avenue
Baltimore, MD 21209-3600
Facsimile: (410) 580-3001
Attention: George A. Nilson, Esq.

or to such other address as the Person to whom notice is to be given may have previously furnished to the other in writing in the manner set forth above.

Section 8.6 Governing Law.

This Agreement shall be governed by, and construed and enforced in accordance with, the laws of the State of Maryland without regard to its provisions concerning conflicts or choice of law, except to the extent that the Delaware General Corporation Law or Delaware Insurance Code impose specific obligations upon BCBSD or any of its trustees, officers, employees or agents, or relate to the governance or regulation of BCBSD, in which case this agreement shall be construed in accordance with Delaware law.

Section 8.7 Counterparts.

This Agreement may be executed and delivered in one or more counterparts, and by the different Parties hereto in separate counterparts, each of which when executed and delivered shall be deemed to be an original but all of which when taken together shall constitute one and the same Agreement.

Section 8.8 Enforcement.

With respect to any action or proceeding commenced by CareFirst seeking to enforce any provision of this Agreement or based upon any right arising out of this Agreement, BCBSD (a) consents to the personal jurisdiction of any Federal court located in the State of Maryland or any Maryland state court, (b) agrees that it will not attempt to deny or defeat such personal jurisdiction or venue by motion or other request for leave from any such court and (c) agrees that

it will not bring any subsequent action relating to this Agreement in any court other than a Federal or state court sitting in the State of Maryland. With respect to any action or proceeding commenced by BCBSD seeking to enforce any provision of this Agreement or based upon any right arising out of this Agreement, CareFirst (a) consents to the personal jurisdiction of any Federal court located in the State of Delaware or any Delaware state court, (b) agrees that it will not attempt to deny or defeat such personal jurisdiction or venue by motion or other request for leave from any such court and (c) agrees that it will not bring any subsequent action relating to this Agreement in any court other than a Federal or state court sitting in the State of Delaware.

Section 8.9 Arbitration.

[*To be amended to bring into compliance with BCBSA MMDR*]

Section 8.10 BCBSD as Independent Licensee of the Blue Cross Blue Shield Association.

To the extent not previously relinquished, CareFirst herein relinquishes its license to use the Blue Cross and Blue Shield service marks in the State of Delaware, and shall use best efforts to support BCBSD's application for Regular Membership and for Primary Licensure to use the Blue Cross and Blue Shield service marks for the State of Delaware Service Area.

Section 8.11 Confidentiality.

a. Except as set forth in subparagraph b. hereof, each Party agrees to maintain (and to cause its affiliates to maintain) the confidentiality of proprietary non-public information (the "Information") provided by any other Party, as categories of such Information are designated as "confidential" by the Party providing such Information, and such Information shall only be used by the Parties in connection with the purposes of this Agreement. If, pursuant to a court or other legal order, a Party is requested or required (by oral questions, interrogatories, requests for Information or documents, subpoena, civil investigative demand or similar process) to disclose any such Information supplied to such Party, or its affiliates or representatives, it is agreed that such Party will provide the other Party with prompt written notice of such request or requirement so that the other Party may seek an appropriate protective order and/or waive compliance with the provisions of this Agreement; but it is understood that the Parties will be obligated to and may comply with any legal requirement for the disclosure of the Information.

b. This Section 8.11 shall not preclude any Party from sharing Information with attorneys, accountants, auditors, actuaries, investment bankers and consultants as are, from time to time, retained by, or on behalf of such Party; so long as any such third party agrees in writing to abide by the provisions of this Section 8.11. The provisions of this Section 8.11 shall not preclude a Party from sharing Information with state insurance regulators in connection with inquiries, examinations or investigations initiated by such state insurance regulators.

c. Each Party recognizes and acknowledges the competitive value and confidential nature of the Information provided to the other Party and the irreparable damage that could result if Information contained therein is disclosed to any third party. Accordingly, and in view of the nature of such Information, each Party agrees that any unauthorized disclosure of such Information or other violation, or threatened violation, of this Section 8.11 would cause irreparable damage to the other Party, and that, therefore, each Party shall be entitled to an injunction prohibiting the other Party or its affiliates or representatives from any such disclosure, attempted disclosure, violation, or threatened violation of this Section 8.11. Such remedy shall not be deemed to be the exclusive remedy for a breach by a Party or its affiliates or representatives of this Section 6.11 but shall be in addition to all other remedies available at law or equity.

d. The Parties' respective obligations under this Section 8.11 shall continue after the termination of this Agreement.

Section 8.12 Limitation of Liability.

The Parties' aggregate liability under this Agreement for damages for all claims in the aggregate in a calendar year arising out of their performance or non-performance under this Agreement or otherwise, whether in contract, tort or otherwise, shall be limited to acts of willful

misconduct or gross negligence, and shall be limited to an amount not to exceed the amount due or payable to the Parties under this Agreement for such calendar year. The limitations herein represent the Parties' agreement for allocation of risk hereunder and apply to all causes of action or claims in the aggregate, including: breach of contract; breach of warranty; negligence, strict liability, misrepresentations, claims for failure to exercise due care in performance of the services hereunder, and other torts; and any statutory claims or cause of action based on the violation of any statute, whether asserted by a governmental entity or private person. In no event shall the Parties be liable for incidental or consequential damages, including loss of profits.

Section 8.13 Taxes.

a. In addition to any amounts payable to CareFirst, within thirty (30) days after receipt of an invoice for Impositions from CareFirst, BCBSD shall reimburse CareFirst for any sales, use, transfer, privilege, stamp, documentary, value added, excise, commercial rent tax (if applicable) or other similar taxes, charges or assessments of any nature not otherwise included in the payments to be made hereunder that CareFirst is required to pay on account of the provision of the services hereunder (excepting any taxes based on the net income of CareFirst), that are levied or imposed by reason of the transactions contemplated by this Agreement or with respect to payments made by BCBSD for such services pursuant to this Agreement ("Impositions"). If BCBSD claims an exemption from any Imposition, or makes a claim that such Imposition is not applicable, then BCBSD shall furnish CareFirst with proper evidence of such exemption, along with appropriate documentation necessary to obtain such exemption, or appropriate documentation regarding the inapplicability of such Imposition, and CareFirst will use reasonable efforts to obtain an exemption, refund or determination as requested by BCBSD at BCBSD's expense. BCBSD will cooperate with CareFirst in such efforts. Notwithstanding any claim by BCBSD of or for an exemption, refund or inapplicability, if CareFirst is finally held liable for an Imposition, BCBSD shall promptly reimburse CareFirst for such amount plus any interest or penalties assessed thereon or additions thereto.

b. All payments to CareFirst pursuant to this Agreement shall be made free and clear of and without deduction for any taxes; provided, that if BCBSD is required to deduct any taxes from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable hereunder) CareFirst shall receive an amount equal to the sum it would have received had no such deductions been made, (ii) BCBSD shall make such deductions and (iii) BCBSD shall pay the full amount deducted to the relevant governmental authority in accordance with applicable law.

c. Notwithstanding anything herein to the contrary, this Section 8.13 shall have no force and effect until such time as CareFirst has provided information to BCBSD sufficient, in the judgment of BCBSD, to allow BCBSD to evaluate its potential liability for reimbursement of Impositions under this Section 8.13, and BCBSD has thereafter agreed in writing to accept such liability.

Section 8.14 Force Majeure.

The Parties shall not be liable for any interruption of a service, any delay in providing any service or any other failure to perform under this Agreement when such interruption, delay or failure results, directly or indirectly, from any cause or circumstance beyond the Parties' reasonable control, including strikes, lock-outs, acts or orders of any government (or agency or instrumentality thereof), riot, war, insurrection, terrorism or other hostilities, acts of a public enemy, embargo, fuel or energy shortage, power outages or interruptions, fire, flood, earthquake or other acts of God, accidents, telecommunication failures, malfunctions of equipment or software programs, sabotage or computer viruses. In any such event, the Parties' obligations hereunder shall be postponed for such time as its performance is suspended or delayed on account thereof. Each Party shall promptly notify the other Party either orally or in writing, upon learning of the occurrence of any such force majeure event. Upon the cessation of the force majeure event, the Party affected will use commercially reasonable efforts to resume its performance hereunder with the least possible delay. Nothing in this Section 8.14 shall be construed as limiting the right of a Party to terminate this Agreement in accordance with the terms hereof.

IN WITNESS WHEREOF, this Agreement has been duly executed and delivered by the duly authorized officers of the Parties hereto as of the date first above written.

CAREFIRST, INC.

By: _____
Name: William L. Jews
Title: President and Chief Executive Officer

CAREFIRST OF MARYLAND, INC.
(for purposes of Section 2.1 and 2.3 only)

By: _____
Name: William L. Jews
Title: President and Chief Executive Officer

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
(for purposes of Section 2.1 and 2.3 only)

By: _____
Name: William L. Jews
Title: President and Chief Executive Officer

BCBSD, INC.

By: _____
Name: Timothy J. Constantine
Title: President

EXHIBIT B: OCTOBER 20, 2003 DRAFT AMENDED BYLAWS OF BCBSD

AMENDED BYLAWS
OF
BCBSD, INC.

ARTICLE I

NAME

SECTION 1.1 NAME. The name of the Corporation shall be BCBSD, Inc.

ARTICLE II

PURPOSES

SECTION 2.1. PURPOSES. The purposes of the Corporation shall be: (a) to develop, market and underwrite all types of health insurance and other employee benefit programs at reasonable cost; (b) to promote policies and programs which foster effective health care cost containment; (c) to act as underwriter or administrator for the administration of governmental health care programs; (d) to provide all types of health services; (e) to assist individuals in defraying the costs of all types of health services; (f) to do all things in any way related to or connected with these purposes; and (g) to engage in any lawful act for which corporations may be organized under the General Corporation Law of the State of Delaware.

ARTICLE III

ORGANIZATION

SECTION 3.1. ORGANIZATION. The Corporation shall be a membership corporation, operated as a private not-for-profit corporation, and shall not have the authority to issue capital stock.

ARTICLE IV

MEMBERS OF THE CORPORATION

SECTION 4.1. MEMBERS OF THE CORPORATION. The Members of the Corporation shall be comprised of two classes, the Class A Members being the Class A Directors of the Corporation, and the Class B Member being CareFirst, Inc., a Maryland non-stock corporation. Whether a Class A Member or a Class B Member, each Member shall have one vote on all matters to be decided by the Members, except for votes concerning the election or removal of Directors as provided in Articles FIFTH and TWELFTH of the Corporation's Certificate of Incorporation.

MEETINGS

SECTION 4.2. MEETINGS. The Annual meeting of the Members of the Corporation shall be held at the principal office of the Corporation on the fourth Wednesday of March in each year, unless a different time or place is fixed by the Board of Directors and stated in the notice of the meeting. The purpose of the Annual Meeting shall be to elect the Board of Directors of the Corporation and such other purposes as may be specified in the notice of the meeting. Special meetings of the Members shall be held at such time and place as may be designated in the notice of the meeting and may be called at any time by the Chairman of the Board, the Vice Chairman, the Chief Executive Officer or the President. Members may participate in meetings by means of remote communication, if such participation is authorized by the Board of Directors.

ADJOURNMENT

SECTION 4.3. ADJOURNMENT. Any meeting of the Members, annual or special, may adjourn from time to time to reconvene at the same or some other place, and notice need not be given of any such adjourned meeting if the time and place thereof are announced at the meeting at which the adjournment is taken. At the adjourned meeting, the Corporation may transact any business that might have been transacted as the original meeting. If the adjournment is for more than thirty (30) days, notice of the adjourned meeting shall be given to each Member.

NOTICE

SECTION 4.4. NOTICE. Written notice of the annual and special meetings of Members of the Corporation shall state the date, time and place where the meeting is to be held and the purpose of said meeting. The notice shall be delivered by hand, or mailed, to each Member of the Corporation not less than ten (10) days before the meeting. If mailed, such notice shall be mailed to the address provided to the Secretary of the Corporation by the Member.

QUORUM

SECTION 4.5. QUORUM. At all annual and special meetings of the Members of the Corporation there shall be present in person or by proxy at least a majority of the Members, then in office, in order to constitute a quorum for the transaction of business, but less than a quorum may adjourn such meeting from time to time without notice until a quorum is present.

PROXIES

SECTION 4.6. PROXIES. At any meeting of the Members of the Corporation, each Member may vote by proxy executed in writing and filed with the Secretary of the Corporation, but no such proxy shall be valid after eleven (11) months from the date of the execution unless otherwise provided in the proxy.

ORGANIZATION

SECTION 4.7. ORGANIZATION. Meetings of the Members shall be presided over by the Chairman of the Board, or in his absence, by the Vice-Chairman of the Board, or in his absence, by the Chief Executive Officer, or in his absence the President, or in his absence, any Vice President, or in the absence of the foregoing persons, by a chairman chosen at the meeting. The Secretary of the Corporation shall act as secretary of the meeting, but in his absence, the chairman of the meeting may appoint any person to act as secretary of the meeting.

ACTION BY CONSENT

SECTION 4.8. ACTION BY CONSENT. Unless otherwise restricted by the Corporation's certificate of incorporation, any action required or permitted to be taken at any annual or special meeting of the Members may be taken without a meeting, without prior notice and without a vote, if a consent or consents in writing, setting forth the actions so taken, shall be signed by the minimum number of Members necessary to authorize the taking of such action at a meeting and shall be delivered to the Corporation. Prompt notice of the taking of the corporate action without a meeting by less than unanimous written consent shall be given to those Members who have not consented in writing.

ARTICLE V

BOARD OF DIRECTORS

SECTION 5.1. BOARD OF DIRECTORS. The business and affairs of the Corporation shall be managed under the direction of the Board of Directors. The Board of Directors shall consist of two classes, the Class A Directors being such individuals who, from time to time, shall be elected by the Class A Members of the Corporation, and the Class B Director, who shall be one individual elected by the Class B Member but who may not be an officer or employee of the Class B member, its affiliates or subsidiaries. The Members of the Corporation shall have the sole authority to determine, from time to time by resolution, the exact number of Directors, but in no event shall the number of Directors be less than eight (8).

ELECTION AND TERM OF OFFICE

SECTION 5.2. ELECTION, RESIGNATION AND TERM OF OFFICE. The Board of Directors of the Corporation shall be elected at the Annual Meeting of the Members of the Corporation. The Class A Directors shall be elected by a majority vote of the Class A Members entitled to vote in such election, and the sole Class B Director shall be elected by the Class B Member. Each director so elected shall hold office for a term of one year or until his successor is elected and qualified. Any director may resign at any time upon written notice to the Corporation.

VACANCIES

SECTION 5.3. VACANCIES. Any vacancy in the seat of a Class A Director occurring during the year may be filled for the unexpired term by a majority vote of the remaining Class A Directors, although less than quorum, at any meeting of the Board of Directors. A vacancy in the seat of the Class B Director may be filled for the unexpired term by election of the Class B Member. A Class A Director who is elected to fill a vacancy shall become a Class A Member upon such election.

POWERS AND DUTIES

SECTION 5.4. POWERS AND DUTIES. The Board of Directors shall have the power to adopt such rules and regulations as it may deem proper for the general management of the business and affairs of the Corporation, including the power to appoint or terminate the existence of such ad hoc committees as from time to time it shall deem advisable. It shall have the power to elect the Chief Executive Officer, all other officers of the Corporation and to define the scope of their authority as an Officer.

MEETINGS OF THE BOARD OF DIRECTORS

SECTION 5.5. MEETINGS OF THE BOARD OF DIRECTORS. The Board of Directors shall hold regular quarterly meetings during each year at such time and place as may be from time to time established by the Chairman of the Board with the consent of the Board of Directors. Any business may be transacted at any regular meeting provided seven (7) days notice of the meeting is given, as called for in Section 5.6 below. Special meetings of the Board of Directors may be called at any time by the Chairman of the Board or upon the written request of three (3) members of the Board of Directors or by the Vice Chairman, the Chief Executive Officer or the President. Members of the Board of Directors may participate in meetings by teleconference or other communications equipment by means of which all participants can hear each other.

NOTICE OF MEETINGS

SECTION 5.6. NOTICE OF MEETINGS. Notice of the time and place of each regular meeting and of the time, place and purposes of each special meeting of the Board of Directors shall be delivered by hand, or mailed, to each Director not less than seven (7) calendar days before the date of the meeting. Any Director may waive any required notice pursuant to the provisions of the General Corporation Law of the State of Delaware. If mailed, such notices shall be mailed to the address provided to the Secretary of the Corporation by the Director.

QUORUM

SECTION 5.7. QUORUM. At all meetings of the Board of Directors a quorum shall consist of a majority of the Directors then in office and qualified to act.

ANNUAL MEETING OF DIRECTORS

SECTION 5.8. ANNUAL MEETING OF DIRECTORS. Immediately following the annual meeting of the Members of the Corporation and at the place where such meeting is held, there shall be a meeting of Directors for the purpose of electing a Chairman and a Vice Chairman, to consider and vote upon the Chairman's appointments of Directors to the Board's standing committees and to transact such other business as may properly come before the meeting. If a quorum is not present, the presiding officer may designate the time and place of the supplemental meeting, giving at least five (5) calendar days written notice of such meeting to each duly elected Director.

CHAIRMAN OF THE BOARD

SECTION 5.9. CHAIRMAN OF THE BOARD. The Chairman of the Board shall be elected by the Board of Directors from among its number for a one year term and shall serve until a successor is elected to the office. The Chairman shall be subject to removal, with or without cause, by majority vote of the Directors then in office. The Chairman shall preside at all meetings of the Members of the Corporation and of the Board of Directors. He shall assure through the Chief Executive Officer that all actions of the Board are carried out, shall be a member of all committees and shall have such other powers and duties as may from time to time be assigned by the Board of Directors or imposed by these Bylaws.

VICE CHAIRMAN OF THE BOARD

SECTION 5.10. VICE CHAIRMAN OF THE BOARD. The Vice Chairman of the Board shall be elected by the Board of Directors from among its number for a one year term and shall serve until a successor is elected to the office.

The Vice Chairman shall be subject to removal, with or without cause, by majority vote of the Directors then in office. The Vice Chairman shall, in the absence or disability of the Chairman, have the powers and duties of the Chairman of the Board; and shall have such other powers and duties as the Board of Directors may from time to time determine.

COMMITTEES OF THE BOARD

SECTION 5.11. COMMITTEES OF THE BOARD. The Board of Directors shall have four standing committees, the Audit Committee, the Nominating Committee, the Personnel Committee, and the Health Care Cost and Quality Committee, and may have such other ad hoc committees designated by resolution passed by a majority of the Board of Directors. Each ad hoc committee shall have the number of members and powers specified in the resolution of the Board of Directors creating such committee. The Chairman shall, with the approval of the Board of Directors, appoint the Directors to serve on each committee and the Chairman thereof. Directors shall serve on such committees until their successors are elected. Vacancies on such committees shall be filled by the Chairman of the Board and shall be reported, at the next special or regular meeting, for the Board's approval. All committees of the Board shall have such powers in addition to those established by these Bylaws as may be fixed by resolution of the

Board of Directors, and the Board of Directors shall have the power to refer to a committee any matter which is either within or outside of the committee's assigned responsibilities and may require the committee to render a report of action taken within a specified reasonable length of time.

AUDIT COMMITTEE

SECTION 5.12. AUDIT COMMITTEE. The Committee shall have the power and the duty to recommend for Board selection the independent auditors of the Corporation, to review the results of audits conducted by the independent auditors and the Corporation's internal auditors, and to deal with matters affecting the auditing of the Corporation.

NOMINATING COMMITTEE

SECTION 5.13. NOMINATING COMMITTEE. The Nominating Committee shall consist of the Directors of the Corporation other than the Chief Executive Officer, if the Chief Executive Officer is a Director. The Nominating Committee shall meet at least annually to determine its recommendations for Directors and for the Chairman and Vice Chairman of the Board of Directors.

PERSONNEL COMMITTEE

SECTION 5.14. PERSONNEL COMMITTEE. The Personnel Committee shall annually review the Corporation's policies in regard to compensation, employee benefits and affirmative action and shall have the power to approve any changes in these policies which it deems appropriate.

HEALTH CARE COST AND QUALITY COMMITTEE

SECTION 5.15. HEALTH CARE COST AND QUALITY COMMITTEE. The Health Care Cost and Quality Committee shall have general oversight over the Corporation's policies that affect the cost and quality of health care services available to the company's enrolled members in Delaware.

The Committee shall regularly receive and act on reports regarding the cost and use of health care services; the management of health care cost and utilization; the quality of services available to enrolled members and various methods of improving said quality when and where appropriate; the quality of services provided by the corporation to its members; the credentialing of participating health care providers; and general policies with respect to provider and customer contracts.

The Committee shall have the authority to approve, repeal or change the corporation's policies that relate to these matters, which it deems appropriate.

GENERAL COMMITTEE MATTERS

SECTION 5.16. COMMITTEE COMPOSITION, RESPONSIBILITY AND PROCEDURES.

(a) **Responsibility**. Each Committee shall be responsible for establishing general Corporate policy within the duties assigned to it by these Bylaws and as may be assigned to it by the Board of Directors. Further, each committee shall report its actions to the Board of Directors.

(b) **Fiscal Authority**. All committee actions are subject to the fiscal authority of the Board of Directors.

(c) **Membership**. Each committee shall consist of at least three (3) members. The Audit Committee, the Nominating Committee and the Personnel Committee shall consist exclusively of Directors who are not officers or employees of the Corporation or of CareFirst, Inc, its affiliates or subsidiaries.

(d) **Quorum**. At each meeting of any committee, the presence of one-third, but not less than two (2) of its members then in office, shall be necessary and sufficient to constitute a quorum for the transaction of business.

(e) **Meetings**. Each committee other than the Nominating Committee shall hold at least two (2) regular meetings each year at a time and place set by the Committee Chairman. Additional meetings may be held at the call of the Committee Chairman, the Chairman of the Board, the Chief Executive Officer or the President.

NOTICE, RECORDS, AND DUTIES

SECTION 5.17. NOTICE, RECORDS, AND DUTIES. Each member of a Board Committee shall receive at least seven (7) calendar days' written notice of the time and place of each meeting. The Secretary or an Assistant Secretary of the Corporation shall keep a record of the proceedings of each committee meeting and shall present such record of the proceedings to each committee member.

REMOVAL OF DIRECTORS

SECTION 5.18. REMOVAL OF DIRECTORS. Any or all of the Class A Directors may be removed, with or without cause at any time, by a vote of a majority of the Class A Members of the Corporation then in office. The Class B Director may be removed, for cause at any time, by a vote of a majority of the Class A Members then in office, and may be removed, with or without cause at any time, by the Class B Member.

DIRECTORS' COMPENSATION

SECTION 5.19. DIRECTORS' COMPENSATION. Directors may receive compensation for their services as Directors in such amount and under such conditions as may be determined by a majority vote of the Board of Directors from time to time. Directors may also be reimbursed for their reasonable expenses for attendance at Board, committee and other business meetings.

ACTION BY CONSENT

SECTION 5.20. ACTION BY CONSENT. Unless otherwise restricted by the certificate of incorporation, any action required or permitted to be taken at any annual or special meeting of the Board of Directors may be taken without a meeting, without prior notice and without a vote, if a consent or consents in writing, setting forth the actions so taken, shall be signed by all the Directors then in office and filed with the minutes of the proceedings of the Board of Directors.

ARTICLE VI

OFFICERS

SECTION 6.1. OFFICERS. The Corporation shall have as its Officers a Chief Executive Officer, a President, a Secretary, and a Treasurer. The Corporation may also have one or more Executive Vice Presidents, Senior Vice Presidents, Vice Presidents, Assistant Vice Presidents, Assistant Treasurers, and Assistant Secretaries. The same person may hold one or more such offices.

Each Officer shall be a full-time employee of the Corporation, except the Chief Executive Officer, who may but need not be so employed. Each officer, unless discharged, removed or retired, shall continue to hold office after the expiration of his appointed or elected term until a successor is elected and qualified. If upon election or appointment no term is specified for any Officer, he shall serve until replaced, discharged, removed or retired. The Chief Executive Officer and the President shall be subject to removal, with or without cause, by majority vote of the Board of Directors then in office. All other Officers shall be subject to removal with or without cause by the Chief Executive Officer, who shall report such action to the Board of Directors at the next scheduled meeting.

The powers granted in these Bylaws to any Officer of the Corporation shall be in addition to and not in limitation of any authority granted by vote of the Board of Directors.

CHIEF EXECUTIVE OFFICER

SECTION 6.2. CHIEF EXECUTIVE OFFICER. The Chief Executive Officer shall be elected by the Board of Directors, which may in its discretion elect the Chief Executive Officer for a term or terms not exceeding five (5) years for each term. The Chief Executive Officer may but need not be a Director. The Chief Executive Officer shall be responsible to the Board of Directors for the management, administration, supervision and control of the business and affairs of the Corporation. He shall act in the capacity of administrator of the Corporation, shall execute the votes of the Board of Directors, and Committees of the Board which were passed in the exercise of the authority vested in such Committees by these Bylaws and shall establish necessary business and administrative policies. In the absence of both the Chairman and the Vice Chairman of the Board, he shall call and preside at meetings of the Members of the Corporation and the Board of Directors. He shall also have such powers and duties as from time to time may be assigned by the Board of Directors.

PRESIDENT

SECTION 6.3. PRESIDENT. The President shall be elected by the Board of Directors, which may in its discretion elect the President for a term or terms not exceeding five (5) years for each term. The President shall be responsible to the Chief Executive Officer for the direct management, administration, supervision and control of the business and affairs of the Corporation. In the absence of the Chairman, the Vice Chairman, and the Chief Executive Officer, he shall call and preside at meetings of the Members of the Corporation, the Board of Directors and its Board committees. He shall also have such powers and duties as from time to time may be assigned by the Chief Executive Officer or the Board of Directors.

EXECUTIVE VICE PRESIDENTS, SENIOR VICE PRESIDENTS AND VICE PRESIDENTS

SECTION 6.4. EXECUTIVE VICE PRESIDENTS, SENIOR VICE PRESIDENTS AND VICE PRESIDENTS. There shall be such Executive Vice Presidents, Senior Vice Presidents and Vice Presidents as from time to time may be elected by the Board of Directors upon the recommendations of the Chief Executive Officer, each to hold office and have such authority and perform such duties as are provided in the resolution electing them or as may be from time to time assigned by the Chief Executive Officer or the Board of Directors.

TREASURER

SECTION 6.5. TREASURER. The Treasurer shall be elected by the Board of Directors upon the recommendation of the Chief Executive Officer. He shall have general supervision over the care and custody of the funds and investments of the Corporation, depositing them in such bank or banks as the Board of Directors shall from time to time designate. He shall keep, or cause to be kept, full and accurate accounts of all receipts and disbursements of the Corporation and when required, shall render, or cause to be rendered, financial statements of the Corporation.

SECRETARY

SECTION 6.6. SECRETARY. The Secretary shall be elected by the Board of Directors upon recommendation of the Chief Executive Officer and shall record or cause to be recorded and shall have custody of the minutes of all meetings of the Members of the Corporation, the Board of Directors and its committees, shall have custody of the Corporate seal and shall affix the same to such instruments the execution of which has been duly authorized and in general shall perform all duties incident to the Office of Secretary and those from time to time assigned by the Board of Directors or the Chief Executive Officer.

OTHER OFFICERS

SECTION 6.7. OTHER OFFICERS. Upon recommendation of the Chief Executive Officer, the Board of Directors from time to time may appoint other Officers including one or more Assistant Vice Presidents, one or more Assistant Secretaries and one or more Assistant Treasurers to hold office for such period, have such authority and perform such duties as are

provided in these Bylaws, as may be provided in the resolutions appointing them, or as may be prescribed by the Chief Executive Officer of the Corporation. The Board of Directors may delegate to the Chief Executive Officer the power to appoint any such subordinate Officers and to prescribe their respective terms of office, authorities and duties.

ARTICLE VII

GENERAL MATTERS

SECTION 7.1. DISCLOSURE OF OTHER INTERESTS. The Corporation shall require disclosure from its Directors, Officers, Corporate Members and key employees upon election, appointment or hire and on an annual basis to determine any interests of such persons and their families which relate to the business of the Corporation. It shall be the duty of such persons to make a full and complete disclosure of any personal or family interest in the business of the Corporation as may from time to time be defined by resolution adopted by the Board of Directors.

REPORTING

SECTION 7.2. REPORTING. The Secretary of the Corporation shall report at least annually to the Board of Directors the interests of the Directors, Officers, Members and key employees which may create the potential for a conflict with the interests of the Corporation. The Secretary shall immediately report to the Chief Executive Officer and the Chairman of the Board any such interests which appear to be in conflict with the best interests of the Corporation which shall be discovered between these annual reports.

VOTING

SECTION 7.3. VOTING. No Director shall vote on any issue in which the Director or a member of the Director's immediate family has a significant interest. Such a Director may participate in the discussion of any such issue but only if he prefaces such discussion with full identification of his interest. If such preface is not made, the Secretary shall immediately call such to the attention of the meeting's presiding officer. Unless specified to the contrary in these Bylaws, the Certificate of Incorporation, or applicable statutes, all actions may be carried by a majority vote of those present and voting.

CONTRACTS AND PAYMENTS

SECTION 7.4. CONTRACTS AND PAYMENTS. The Corporation may enter into contracts of any kind, within the general purpose of the Corporation, provided however that the contract be signed in the name and on behalf of the Corporation by one of its Officers or by a person designated in writing by the Chief Executive Officer or the President to sign such contracts. Routine operating contracts with its subscribers may be signed by the facsimile signatures of the Chief Executive Officer, the President and the Secretary and may bear the facsimile seal of the Corporation. All checks, drafts, bills of exchange, notes or other obligations or orders for

payment of money shall be signed in the name of the Corporation by such Officer, or Officers, as the Board of Directors may from time to time designate by resolution.

ARTICLE VIII

AMENDMENT

SECTION 8.1. AMENDMENT. These Bylaws may be altered, amended or repealed and new Bylaws made, only by the affirmative vote of a majority of the Members at any regular or special meeting.

ARTICLE IX

CORPORATE SEAL

SECTION 9.1. CORPORATE SEAL. The Corporate Seal shall be circular in form, shall be in the name of the Corporation, the year of its incorporation and the words Corporate Seal and Delaware. If the Corporation is required to place its corporate seal to a documents, it is sufficient to meet the requirement of any law, rule or regulation relating to a corporate seal to place the word "Seal" adjacent to the signature of the person authorized to sign the document on behalf of the Corporation.

ARTICLE X

FISCAL YEAR

SECTION 10.1. FISCAL YEAR. The fiscal year of the Corporation shall be the first day of January to the 31st day of December inclusive in each year.

ARTICLE XI

NATIONAL STATE OF EMERGENCY

SECTION 11.1. NATIONAL STATE OF EMERGENCY. National emergencies as used in these Bylaws shall mean a state of emergency declared by the President of the United States during which it is impracticable for the Corporation to conduct its business in strict accord with its Bylaws. In the event of the occurrence of a national emergency, the Board need not consist of more than three (3) Directors: (a) two (2) Directors shall constitute a quorum for the transaction of business at all meetings of the Board; (b) any vacancy in the Board may be filled by a majority of the remaining Directors though less than a quorum or by a sole remaining Director; (c) if there are no surviving Directors but at least three (3) Officers of the Corporation survive, the three (3) highest ranking (first, the Chief Executive Officer; next, the President; next, the

Executive Vice Presidents; next, the Senior Vice Presidents; next, the Treasurer; next, the Secretary; next, all other Officers) shall be the Directors and shall possess all of the powers of the previous Board of Directors. By a majority vote, such emergency Board of Directors may elect other Directors. If there are not at least three (3) surviving among the Officers of the Corporation, the Insurance Commissioner or his duly designated person exercising the powers of such Commissioner shall appoint three (3) persons as Directors until the regular annual or a special meeting of the Members of the Corporation shall be held at which meeting Directors shall be elected to succeed those holding office under this paragraph.

ARTICLE XII

INDEMNIFICATION

SECTION 12.1. RIGHT TO INDEMNIFICATION. The Corporation shall indemnify and hold harmless, to the fullest extent permitted by applicable law as it presently exists or may hereafter be amended, any person who was or is made or is threatened to be made a party or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative (a "proceeding"), by reason of the fact that he, or a person for whom he is the legal representative, is or was a director or officer of the Corporation or is or was serving at the request of the Corporation as a director, officer, employee or agent of another Corporation or of a partnership, joint venture, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans (an "indemnitee"), against all liability and loss suffered and expenses (including attorneys' fees) reasonably incurred by such indemnitee. Notwithstanding the foregoing, but subject to Section 12.3 hereof, the Corporation shall be required to indemnify an indemnitee in connection with a proceeding (or part thereof) initiated by such indemnitee only if the initiation of such proceeding (or part thereof) by the indemnitee was authorized by the Board of Directors of the Corporation.

SECTION 12.2. PREPAYMENT OF EXPENSES. The Corporation shall pay the expenses (including attorneys' fees) incurred by an indemnitee in defending any proceeding in advance of its final disposition, provided, however, that the payment of expenses incurred by a Director or Officer in advance of the final disposition of the proceeding shall be made only upon receipt of an undertaking by the Director or Officer to repay all amounts advanced if it should be ultimately determined that the Director or Officer is not entitled to be indemnified under this Article XII or otherwise.

SECTION 12.3. CLAIMS. If a claim for indemnification or payment of expenses under this Article is not paid in full within sixty days after a written claim therefore by the indemnitee has been received by the Corporation, the indemnitee may file suit to recover the unpaid amount of such claim, and, if successful in whole or in part, shall be entitled to be paid the expense of prosecuting such claim. In any such action, the Corporation shall have the burden of proving that the indemnitee was not entitled to the requested indemnification or payment of expenses under applicable law.

SECTION 12.4. NONEXCLUSIVITY OF RIGHTS. The rights conferred on any person by this Article shall not be exclusive of any other rights which such person may have or hereafter acquire under any statute, provision of the certificate of incorporation, these bylaws, agreement, vote of Members or disinterested Directors or otherwise.

SECTION 12.5. OTHER INDEMNIFICATION. The Corporation's obligation, if any, to indemnify or advance expenses to any person who was or is serving at its request as a director, officer, employee or agent of another Corporation, partnership, joint venture, trust, enterprise or nonprofit entity shall be reduced by any amount such person may collect as indemnification or advancement from such other Corporation, partnership, joint venture, trust, enterprise or nonprofit entity.

SECTION 12.6. AMENDMENT OR REPEAL. Any repeal or modification of the foregoing provisions of this Article shall not adversely affect any right or protection hereunder of any person in respect of any act or omission occurring prior to the time of such repeal or modification.

ARTICLE XIII

CONSTRUCTION

SECTION 13.1. CONSTRUCTION. Whenever the singular number is used in these Bylaws and when required by context, the same shall include the plural and vice versa, and the masculine gender shall include the feminine gender and vice versa

EXHIBIT C: OCTOBER 20, 2003 DRAFT CERTIFICATE OF AMENDMENT AND RESTATEMENT OF THE CERTIFICATE OF INCORPORATION OF BCBSD

CERTIFICATE
OF
AMENDMENT AND RESTATEMENT
OF THE
CERTIFICATE OF INCORPORATION
OF
BCBSD, INC.

1. The name of the Corporation is BCBSD, Inc. (the "Corporation"). The name under which the Corporation was originally incorporated on August 16, 1935 is Group Hospital Service, Incorporated.

2. This Certificate of Amendment and Restatement of the Certificate of Incorporation of BCBSD, Inc. was duly adopted pursuant to Sections 242 and 245 of the General Corporation Law of the State of Delaware.

3. The Corporation's Certificate of Incorporation is hereby amended and restated in its entirety to read as follows:

FIRST: The name of the Corporation is BCBSD, Inc.

SECOND: The registered office of the Corporation in the State of Delaware is 201 West 14th Street, Wilmington, New Castle County, Delaware. The Corporation shall act as its own registered agent at such address.

THIRD: The purposes of the Corporation shall be: (a) to develop, market and underwrite all types of health insurance and other employee benefit programs at reasonable costs; (b) to promote policies and programs which foster effective health care cost containment; (c) to act as underwriter or administrator for the administration of governmental health care programs; (d) to provide all types of health services; (e) to assist individuals in defraying the costs of all types of health services; (f) to do all things in any way related to or connected with these purposes; and (g) to engage in any lawful act for which corporations may be organized under the General Corporation Law of the State of Delaware (the "DGCL").

FOURTH: The Corporation shall be a membership corporation, operated as a private not-for-profit corporation, and shall not have authority to issue capital stock.

FIFTH: The Members of the Corporation shall be one or more individuals, corporations, partnerships, or other legal entities, the exact number and qualifications of which shall be as set forth in the Bylaws of the Corporation or as determined by the Members in office at the time of such determination, except as otherwise designated in this Certificate of Incorporation or the DGCL. The Members shall be divided into Class A Members and one Class B Member. The Class A Members shall be entitled to elect Class A Directors to the Corporation's Board of Directors, and the Class B Member shall be entitled to elect one Class B Director to the Corporation's Board of Directors. The

Class A Directors shall be entitled to elect a Class A Director to fill any vacancy for the unexpired term of a Class A Director occurring between annual meetings of Members. The Class B Member shall be entitled to elect a Class B Director to fill any vacancy for the unexpired term of the Class B Director occurring between annual meetings of Members.

Except for votes concerning the election or removal of Directors, as provided in this Fifth Article, in the Twelfth Article and in the Bylaws, all Members and all Directors shall vote as one class of Members, and one class of Directors, respectively, on all matters to be decided by the Members or Directors, respectively. Unless otherwise provided in the Bylaws, or required by the DGCL, all matters requiring a vote of Members or Directors shall be decided by majority vote of those Members or Directors entitled to vote and voting.

SIXTH: The existence of the Corporation shall be perpetual.

SEVENTH: No Member, Director or Officer of the Corporation shall be personally liable for the payment of the debts of the Corporation, except to the extent otherwise required by law.

EIGHTH: The business and affairs of the Corporation shall be managed under the direction of a Board of Directors. The qualifications, election, number, tenure, powers and duties of the Directors shall be as provided in the Bylaws. Directors need not be elected by written ballot.

NINTH: The Board of Directors shall have the whole and sole control of the property and business of the Corporation, except as shall be otherwise provided by the laws of the State of Delaware.

TENTH: In the event of dissolution of the Corporation, after the payment of all debts, the Directors shall cause any remaining assets of the Corporation to be distributed to or for the use of one or more corporations, trusts, community chests, funds or foundations, which at the time of distribution are qualified as a corporation described in Section 501 (c) (3) or Section 501 (c) (4) of the U. S. Internal Revenue Code of 1954 (or the corresponding provision of any future U. S. Internal Revenue Law). The Directors shall have absolute discretion as to which qualified organization or organizations shall receive the distribution.

ELEVENTH: The Corporation reserves the right to amend, alter, change or repeal any provisions contained in this Amended and Restated Certificate of Incorporation in the manner now or hereafter prescribed by the laws of the State of Delaware, upon the approval of the Board of Directors and a majority of the Members, and all of the rights conferred upon Officers, Directors and Members are granted subject to this reservation.

TWELFTH: The Corporation shall have power to remove any or all of the Class A Directors, with or without cause at any time, by a vote of a majority of the Class A Members then in office; and shall further have the power to remove the Class B Director, for cause at any time, by a majority vote of the Class A Members. The Corporation shall have the power to remove the Class B director, with or without cause at any time, at the discretion of the Class B Member.

THIRTEENTH: A Director or Officer of the Corporation shall not be personally liable to the Corporation or its Members for monetary damages for breach of a fiduciary duty as a Director or Officer or breach of any other duty or legal obligation as a Director or Officer, except to the extent otherwise required by law. It is the intent of this Article that the liability of Directors and Officers shall be limited to the fullest extent permitted by the laws of the State of Delaware, as amended and restated from time to time. Any amendment, repeal or modification of this Article shall not adversely affect any right or protection of a Director or Officer of the Corporation existing at the time of such amendment, repeal or modification in respect to any act or omission occurring prior to the time of such amendment, modification or repeal.

IN WITNESS WHEREOF, said BCBSD, Inc. has caused its corporate seal to be hereunto affixed and this certificate to be signed by _____, its President, and attested by its Secretary, this ____ day of December, 2003.

By: _____ [Seal]
President

Attest: _____
Secretary

EXHIBIT D: STATEMENT OF INVESTMENT POLICY

Statement of Investment Policy

Effective Date: October 28, 1999
Revised: February 28, 2002
Adopted by Blue Cross Blue Shield of Delaware, Inc.: July 31, 2002

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Statement of Investment Policy

I. SCOPE AND PURPOSE

Included in the scope of this document is the policy for management of the marketable securities of CareFirst, Inc., its' affiliates and related companies ("CareFirst").

Blue Cross Blue Shield of Delaware, Inc. (BCBSD)

The purpose of this document is to state the objectives, asset allocation, guidelines, limits, and processes of the investment policy.

II. INVESTMENT OBJECTIVE

The primary investment objective of the Consolidated Portfolio of CareFirst is to maximize the long-term growth of each company's surplus subject to the constraints specified in this policy. However, if a company's surplus deteriorates to the point that the company could not withstand a loss on the portfolio, then the investment objective becomes capital preservation for that company.

Attainment of the long-term capital growth objective is necessary to satisfy the following goals:

A. Ensure that adequate liquidity/capital is maintained to meet each company's fiduciary responsibility to its policyholders.

B. Provide each company and CareFirst in aggregate, with a solid capital foundation for long-term stability and financial flexibility.

C. Provide each company with a stable cash flow stream while managing investment risk based on both CareFirst's and each company's total risk profile.

To take maximum advantage of the Consolidated Portfolio, the assets will be structured into portfolios designed to maximize total returns for a given level of risk. Construction will occur after considering historical and projected market returns, the variability of returns, and correlation of returns between asset classes.

III. ASSET ALLOCATION

A. Risk Tolerance

Investment risk must be considered in conjunction with the risk from each company's business operations. Investment risk is part of each company's total business risk. The volatility of operating surplus, or the amount of surplus over what is legally required, will be the dominant factor considered in determining the company's risk tolerance and appropriate asset allocation strategies to be used by CareFirst.

When the amount in operating surplus is adequate to protect against both adverse business conditions and adverse capital market conditions, the company will be considered financially strong. Under this scenario, the investment portfolio will be structured to maximize the long-term growth of corporate surplus (Capital Growth Portfolio). Should the surplus of a company deteriorate to the point that the loss of operating surplus associated with the Capital Growth Portfolio could not be tolerated, the investment portfolio will be restructured to reduce investment risk (Capital Preservation Portfolio). It is recognized that, on average, the Capital Preservation Portfolio structure will underperform the Capital Growth Portfolio. However, the company is willing to forego investment opportunities in order to maintain and protect capital adequacy.

B. Portfolio Structure

More than any other factor, the asset allocation decision determines the risk and return of a portfolio. Since the investing function is integrated with the Company's operations, asset allocation decisions cannot be made without first considering the results and expectations of business operations.

The following tables incorporate both the Capital Growth Portfolio and the Capital Preservation Portfolio. The Capital Growth Portfolio is expected to be the structure used most frequently and represents the target asset allocation for BCBSD, [illegible] It is designed to maximize the long-term growth of corporate surplus of each company, and thus the aggregate surplus of CareFirst. The Capital Preservation Portfolio would be used when a company has little tolerance for risk. It is designed to minimize the possibility of experiencing a negative total return over a twelve-month period. Under the Capital Preservation Portfolio, the allocation to equities and convertible securities would most likely be reduced and the allocation to cash and core bonds would be increased, all within the established ranges listed on the table. The Capital Preservation Portfolio is considered an interim measure until the company's capital surplus improves.

Due to both state regulations and the difference in asset size of each company's investment portfolio, one asset allocation strategy for all affiliates is not feasible. As such, the Capital Growth Portfolio and Capital Preservation Portfolio will be modified for each company based on those constraints. At least annually, Treasury

staff will review the asset allocation strategy for each company and make any necessary recommendations for approval by the CareFirst Finance Committee.

As indicated in the tables on the following page, each portfolio has an allocation target and a range. Allocation within the range will be a function of the results of a determination of each company's surplus level, risk tolerance and the opportunities in the capital markets as determined by the Treasury staff and the Companies' investment advisor.

The target Core Bond allocation of 80% consists of the following target sector weightings; government and agency bonds 15%, mortgages 27% and corporate bonds 38%. The target sector weightings were determined by multiplying the internally and externally managed sector benchmarks of the Core Bond portfolio by the percentage of the portfolio managed by internal and external managers. The sector weightings will change as the Core Bond ranges are either minimized or maximized. Core Bond managers are permitted a limited amount of discretion in the management of the sector weightings of the portfolio. External managers may over or under weight any sector benchmark by +/- 20%. Internal managers may over or under weight any sector benchmark by +/- 10%.

Blue Cross Blue Shield of Delaware, Inc.

Asset Class	*Target Allocation*	*Minimum*	*Maximum*
Short-Term Fund	5%	2%	20%
Fixed Income Portfolio			
Core Bonds	80%	70%	85%
Convertible Bonds	5%	0%	5%
Total Fixed Income	85%	70%	90%
Equity Portfolio			
Domestic Large Cap Equity	5%	0%	8%
Domestic Small Cap Equity	5%	0%	7%
Total Equity	10%	0%	15%

C. Performance Measurements and Benchmarks

Performance results and policy compliance will be monitored no less frequently than quarterly. Portfolio performance results will be prepared by the Company's Investment Advisor and provided to the CareFirst Finance Committee quarterly. The assessment of results versus benchmarks will provide the foundation for future actions. Key characteristics to be monitored include the effectiveness of the policy, the effectiveness of internal management decisions, and internal and external manager results.

Performance of the various asset classes will be compared to the following benchmarks:

Short Term Fund	Donoghue Money Market Index
Fixed Income Portfolio	
Core Bonds Internally Managed	40% Leh AA Credit/30% Leh Mort/30% Leh Gov't
Core Bonds Externally Managed	50% Leh Credit/40% Leh Mort/10% Leh Gov't
Convertible Bonds	ML Investment Grade Convertible Index
Equity Portfolio	
Domestic Large Cap Equity	S&P 500
Domestic Small Cap Equity	Russell 2000 Value

D. Short-Term Investment Fund (STIF) Guidelines

Objective

The objective of the STIF is to provide liquidity to meet short-term cash flow needs and to reduce the market value volatility of the consolidated portfolio. The balance of the STIF for , BCBSD, FSHP and will be no less than 2.0% of the total investment portfolio, with a target allocation of 5.0%. The STIF allocations will be higher for the other companies that have more volatility in daily cash flow. The maximum maturity of securities held in the STIF will be one year.

Permitted Holdings

Generally, the STIF will be dominated by money market type securities issued by the U.S. Government, its agencies, and U.S. based corporations. A high degree of liquidity and credit quality will be the dominant characteristics of the holdings. The following types of securities are approved for use in the STIF:

1. Repurchase Agreements
2. Treasury and Agency Bills, Notes and Bonds
3. Commercial Paper

4. Certificates of Deposit
5. Bankers Acceptances
6. Tax Exempt Commercial Paper
7. Municipal Adjustable Rate Bonds
8. Money Market Funds
9. Corporate and U.S. Government Agency Floating Rate Notes
10. Corporate Notes and Bonds
11. Other investments approved by CareFirst Finance Committee

Quality and Other Restrictions

The quality and other restrictions on the STIF are summarized as follows:

1. Repurchase agreements must be collateralized with delivered U.S. Government or Agency securities with a market value of at least 102% of the amount of the investment.
2. Repurchase agreements with any one broker or issuer will be limited to $20 million and a maximum term of one year.
3. Commercial paper will be limited to a minimum rating of A-1 by Standard & Poor's and P-1 by Moody's. The maximum maturity on commercial paper will be 185 days from the date of purchase.
4. Bankers acceptances will be limited to paper issued by banks and bank holding companies whose commercial paper qualifies for purchase and whose long term debt is rated AA by Standard & Poor's and/or Aa by Moody's. The maximum maturity on bankers acceptances will be 185 days from the date of purchase.
5. With the exception of NAIC Exempt or Class One money market funds, up to 10% of the STIF may be invested in any one money market fund issued by the Company's custodian bank. However, it is the responsibility of Treasury staff to ensure that in aggregate no more than 5% of admitted assets are invested in any one non-Exempt or Class One money market fund (includes all external managers).
6. A maximum of $100,000 (FDIC insurance limit) may be invested in certificates of deposit issued by domiciled banks that do not meet the minimum rating requirements. Maximum maturity of such issues will be limited to one-year.
7. Certificates of Deposit will be limited to $5,000,000. Maximum maturity of such issues will be limited to one-year.
8. Municipal adjustable rate bonds must be rated AA or better by Standard & Poor's and/or Aa or better by Moody's.
9. Corporate notes, and corporate floating rate notes must be rated AA or better by Standard & Poor's and Aa or better by Moody's. The maximum maturity will be limited to one year.
10. Investments failing to meet the quality restrictions following their purchase may be held to maturity. The manager shall review a credit report on all non-investment grade securities on a quarterly basis and communicate findings to Treasury staff. Based on the credit report, the Treasury staff, under the guidance of the CareFirst CFO, has the discretion to either direct the manager to liquidate

the security or continue to hold it. The actions of the CareFirst CFO will be reported to CareFirst Finance Committee at the following committee meeting.

11. The maximum maturity on U.S. Treasury and Agency securities will be 1 year.
12. A maximum of 5% of the STIF may be invested in any one Company (excluding U.S. Government issues).

E. Domestic Core Bond Portfolio Guidelines – Internally/Externally Managed

Objective

The objective of the Core Bond Portfolio is to outperform a custom fixed income benchmark over a market cycle. The internally managed Core Bond Portfolio benchmark will consist of a 40% allocation to the Lehman AA Credit Index, 30% allocation to the Lehman Mortgage Index and a 30% allocation to the Lehman Government Bond Index. The externally managed Core Bond Portfolio benchmark will maintain a 50% allocation to the Lehman Credit Index, 40% allocation to the Lehman Mortgage Index and a 10% allocation to the Lehman Government Bond Index.

Permitted Holdings

The following security types are approved for use in the Core Bond Portfolio:

1. Corporate Notes and Bonds including equipment trust certificates, capital (trust preferred) securities and REIT obligations
2. Canadian Notes and Bonds
3. U.S. Treasury and Agency Bills, Notes and Bonds
4. Securities Eligible for the Short-Term Investment Fund
5. Listed Fixed Income Mutual Funds or units of Commingled Trust Funds
6. Mortgage-Backed Securities (MBS) including Collateralized Mortgage Obligations (CMOs) and Commercial Mortgage Backed Securities (CMBs)
7. Asset-Backed Securities
8. Fixed Income Futures Contracts and Options on Futures Contracts (For Duration Management)
9. Derivatives (replication or hedging purposes only)
10. Yankee Bonds
11. Put/Callable Bonds
12. Municipal Notes and Bonds
13. Securities issued under SEC rule 144a
14. Other Investments Approved by CareFirst Finance Committee

Quality and Other Restrictions

The quality and other restrictions on the internally managed Core Bond Portfolio Follows. Additional security types, quality and other restrictions permitted in the externally managed Core Bond Portfolio are provided in parenthesis:

1. All of the restrictions listed for short-term investments, except that the maturity limits will be one year on Bankers Acceptances and two years on Certificates of Deposit.
2. The overall market value dollar-average quality rating of the Core Bond Portfolio will be AA (A) and will comply with the constraints of this section. The calculation of the portfolio weighted average quality will be based on the lower of Standard & Poor's and Moody's ratings and shall apply at all times.
3. All corporate notes and bonds (municipal notes and bonds) must be rated A- (BBB- and/or Baa3) or better by Standard & Poor's and Moody's. Split-rated issues are not permitted if one rating falls below quality restrictions. If an issue is rated by only one service, that rating may be used. (Non-rated issues may be purchased after the external fixed income manager reviews their internal credit report with Treasury staff.) Investments failing to meet quality restrictions following their purchase may be held to maturity. The manager shall review a credit report on all non-investment grade securities on a quarterly basis and communicate findings to Treasury staff. Based on the credit report, the Treasury staff, under the guidance of the CareFirst CFO, has the discretion to either direct the manager to liquidate the security or continue to hold it. The actions of CareFirst CFO will be reported to the CareFirst Finance Committee at the following committee meeting.
4. A maximum of 20% of the Core Bond Portfolio is permitted to be invested in securities rated A- (BBB- and/or Baa3) by Standard & Poor's and Moody's.
5. A maximum of 2.5% (5%) of the Core Bond Portfolio may be invested in any one Company (excluding U.S. Government issues).
6. Portfolio duration should fall within a range of 0.80 and 1.20 times the duration of the custom index.
7. Permitted CMO Investments are limited to the following categories: PAC (Planned Amortization Class), TAC (Targeted Amortization Class), VADM (Very Accurately Defined Maturity Class), Sequential and Floating Rate CMOs. Permitted CMO Investments are limited to 5% of the Core Bond Portfolio on an issue basis and 30% of the Core Bond Portfolio in aggregate. Investments in Leveraged or Inverse Floating Structures, Mortgage Interest Only (IO) or Principal Only (PO) CMO derivatives are not permitted. No derivatives are permitted, except as previously discussed.
8. CMBS are not permitted in the internally managed portfolio. A maximum of 5% of the externally managed portfolio may be invested in CMBS rated A- or better.
9. Net Realized Losses shall not exceed the greater of 5% of market value of the externally managed Domestic Fixed Income Portfolio or $1 million annually without prior approval. The manager shall notify Treasury staff before any individual loss in excess of $100,000 is incurred.

F. Convertible Bond Portfolio Guidelines

Objective

The objective of the Convertible Bond Portfolio is to outperform the Merrill Lynch Investment Grade Convertible Index over a market cycle.

Permitted Holdings

The following security types are approved for use in the Convertible Bond Portfolio:

1. Convertible Bonds
2. U.S. Dollar Denominated Foreign Convertible Bonds
3. 144A Convertible Bonds and Preferred Stocks
4. Convertible Preferred Stock
5. Exchangeable Convertible Bonds
6. Synthetic Convertible Bonds
7. Money Market Fund
8. Other Investments Approved by CareFirst Finance Committee

Quality and Other Restrictions

The quality and other restrictions on the Convertible Bond Portfolio are as follows:

1. All issues are to be denominated in U.S. dollars.
2. Maximum of 5% of the Convertible Bond Portfolio may be allocated to cash and short-term securities.
3. All convertible bonds and convertible stocks must be rated Baa3 or better by Moody's and BBB- by Standard & Poor's. Split-rated issues are not permitted if one rating falls below quality restrictions. Investments failing to meet quality restrictions following their purchase may be held to maturity. The manager shall review a credit report on all non-investment grade securities on a quarterly basis and communicate findings to Treasury staff. Based on the credit report, the Treasury staff, under the guidance of the CareFirst CFO, has the discretion to either direct the manager to liquidate the security or continue to hold it. The actions of CareFirst CFO will be reported to the CareFirst Finance Committee at the following committee meeting.
4. A maximum of 5% of an investment manager's Convertible Bond Portfolio may be invested in any one company.
5. A maximum of 10% of an investment manager's Convertible Bond Portfolio may be invested in dollar denominated securities issued by foreign domiciled companies.
6. A maximum of 40% of an investment manager's Convertible Bond Portfolio may be invested in 144A Convertible Bonds and Preferred Stocks. Upon registration, a security which was originally issued under SEC rule 144a will no longer be considered a 144a security for purposes of these guidelines.

7. A maximum of 10% of an investment manager's Convertible Bond Portfolio may be invested in Synthetic Convertible Bonds.
8. Conversions to common stock must be liquidated from the Convertible Bond Portfolio by the end of the calendar quarter immediately following the month in which the conversion occurred. However, if conversion takes place near the calendar quarter end, there may not be enough time to permit prudent liquidation of the security. Treasury staff, after approval from the CareFirst CFO, may extend the time limit to liquidate the converted security, but in no event will an extension beyond the following calendar quarter be granted.
9. Net Realized Losses shall not exceed the greater of 5% of market value of the Convertible Bond Portfolio or $1 million annually without prior approval. The manager shall notify Treasury staff before any individual loss in excess of $100,000 is incurred.

G. Equity Portfolio Guidelines – Domestic Large Cap and Small Cap

Objective

The objective of the Large Cap Domestic Equity Portfolio is to replicate the performance of the S&P 500 Stock Index. The Small Cap Domestic Equity Portfolio is expected to outperform the Russell 2000 Value Index over a market cycle.

Permitted Holdings

The following security types are approved for use in the equity Portfolio:

1. Domestic (U.S.-listed) and Canadian Common and Preferred Stock
2. American Depository Receipts (ADRs)
3. Stock Index Futures Contracts
4. Mutual Fund Shares or Units of Commingled Trust Funds
5. Money Market Instruments
6. Other Investments Approved by CareFirst Finance Committee

Quality and Other Restrictions

Decisions as to individual security selection, security size and quality, number of industries and holdings, current income levels, turnover and other tools employed by active managers are left to manager discretion, subject to the usual standards of fiduciary prudence and quality and other restrictions as follows:

1. All of the restrictions listed for short-term investments.
2. Maximum of 5% of each equity portfolio may be allocated to cash and short-term securities.
3. All preferred stocks must be rated BBB- and/or Baa3 or better by Standard and Poor's and Moody's. Split-rated issues are not permitted if one rating falls below quality restrictions. Investments failing to meet quality restrictions following their purchase may be held to maturity. However, on a quarterly basis the manager will review a credit report on all non-investment grade securities. Based on the credit report, the Treasury Department, under the guidance of the CareFirst CFO, has the discretion to either direct the manager to liquidate the security or continue to hold it. The actions of CareFirst CFO will be reported to CareFirst Finance Committee at the following committee meeting.
4. A maximum of 5% of an investment manager's portfolio may be invested in any one Company.
5. A maximum of 5% invested in the outstanding shares of any one corporation.
6. A minimum market capitalization of $50 million for each Company.
7. No more than 15% of the portfolio shall have a market capitalization in excess of the largest capitalization stock within the benchmark.

8. Portfolio's allocation to any one sector may not exceed the greater of 125% of the benchmark's sector allocation or 2% of the absolute weight in the sector.
9. The use of derivatives will be restricted to replication or hedging purposes only. Leveraged derivatives, or derivatives used for speculative investments are prohibited.
10. The use of stock index futures is limited to 5% of an investment manager's portfolio.
11. All Common and Preferred Stock in the Small Cap Domestic Equity Portfolio shall be dividend paying at the time of purchase.
12. Net Realized Losses shall not exceed the greater of 5% market value of the Small Cap Portfolio or $1 million annually without prior approval. The manager shall notify Treasury staff before any individual loss in excess of $100,000 is incurred.

H. Investment Constraints

Boundaries on investment decision-making formally called "investment constraints" include liquidity, time horizon, regulation/legal restrictions, taxes, and the unique needs of the company and/or CareFirst. Two of the five constraints, liquidity and regulatory/legal restrictions, will significantly affect the way the portfolio will be managed on an ongoing basis.

Liquidity – Defined as the ability of each company to fund its cost of care and administrative obligations, is paramount to policyholders, regulators and rating agencies. To ensure that these obligations are met, the availability of cash must be addressed prior to allocating funds to longer-term assets. Cash and short-term investments will be managed internally by Treasury staff. Sources of liquidity include dividend and interest income received, inter-company lines of credit, reverse repurchase agreements, short-term bank lines of credit, and management of asset allocation strategies. Reverse Repurchase Agreements may be utilized to temporarily meet short-term operational cash demands. The purpose of the reverse repurchase agreements is to minimize the ongoing allocation to lower yielding short-term assets. The CareFirst CFO has the authority to arrange the amount and terms of the reverse repurchase agreements for the companies, and will report the utilization of such sources to the CareFirst Finance Committee quarterly.

Regulatory/Legal Restrictions – The primary regulator of investing activities is the Department of Insurance within each company's state of domicile. Certain of the companies also maintain a reporting relationship with the National Association of Insurance Commissioners and the BlueCross BlueShield Association (BCBSA). Regardless of the regulatory entity, each company will comply with their individual state regulations and BCBSA.

IV. ADMINISTRATION

A. Safekeeping

STIF (internal) and long-term (external) fund securities which are eligible will be held in book-entry form by the custodian bank through the Depository Trust Company (DTC), the Participants Trust Company (PTC), Euroclear Clearance Systems, or the Federal Reserve. Securities which are not eligible for the services of the clearinghouses mentioned above and mature in less than 95 days from the date of purchase will be held in safekeeping for the company in bearer form in the account of the custodian bank. All other securities will be registered in the company's name and will be held in the company's state of domicile by the company's sub-custodian bank.

B. Transaction Approval

State regulations require that all transactions be approved by the Board of Directors or their designees, to the extent permissible by law. At least quarterly, the CareFirst Treasurer will submit a transaction report to the CareFirst Finance Committee for their approval.

C. Brokerage Policy

As part of its fiduciary responsibility, it is important that CareFirst maintain a prudent policy pertaining to brokerage commissions paid on securities transactions. CareFirst hereby delegates discretion over placement and execution of securities transactions to its managers subject to the following constraints:

1. Brokerage Commissions

   CareFirst believes that electronic crossing networks are an increasingly efficient and cost-effective means of equity trading. In order to encourage their use, CareFirst requires that its equity managers closely monitor their brokerage commission expenses. Brokerage commissions vary with investment styles and philosophies; some transactions are more or less difficult to execute than others.

   On at least an annual basis and more frequently if requested by staff, each investment manager shall provide staff with a report showing all brokerage transactions effected on behalf of the portfolio. For domestic large cap managers, the average commissions on listed securities shall not exceed three cents per share. For domestic non-large cap managers, the average commissions on listed securities shall not exceed five cents per share. In the event that the average commission exceeds the manager's threshold, a detailed explanation of the reasons why must also be provided.

2. Directed Commissions/Brokerage

It is the intention of CareFirst that all securities transactions be effected through brokerage firms to the best advantage of the portfolio regarding price and execution. Given that some transactions are less difficult to execute than others, and that large institutional discount brokers are positioned to efficiently execute the more easily executed trades at very competitive commission rates, the investment managers shall be required to use large discount brokers in securities transactions for the portfolio when the objective of best price and execution will not be compromised.

3. Soft Dollars

CareFirst requires its managers to provide accounting of soft dollar transactions involving securities of the portfolio. CareFirst believes it is possible to make a reasonable, though admittedly imprecise, allocation of these commission dollars across manager accounts. On at least an annual basis and more frequently if requested by staff, each investment manager shall provide a report that summarizes the dollar amount of soft dollar commissions generated within the portfolio, the brokerage firms to which they were directed, and an explanation of the goods or services received.

D. Administrative Expenses

Dividend and interest may be utilized to offset annual administrative expenses associated with the investment management function.

E. Securities Lending

A securities lending program may be utilized with either the current custodian bank, or other appropriate third party lending agent. The lending agent may lend eligible securities, including but not limited to, U.S. equities, corporate bonds, and government bonds. The lending agent shall have full discretion over the selection of the borrowers and shall continually review credit worthiness of borrowers.

All loans shall be fully collateralized with cash, government securities of a similar duration, or irrevocable bank letters of credit. Collateralization of such loans shall be no less than 102% for domestic government bonds. Such collateralization procedures should be marked-to-market on a daily basis.

V. PROHIBITED TRANSACTIONS

The following transactions are prohibited:

1. Investments in companies who engage in the production and/or distribution of tobacco related products except if part of a passively managed vehicle
2. Dollar rolls
3. High Yield Bonds
4. Derivatives other than as specified elsewhere in this policy
5. Non-Dollar Fixed Income securities
6. No use of leverage in the portfolio
7. Non-U.S. Listed EquitiesOther transactions as outlined in the Department of Insurance Regulations

EXHIBIT E: MANAGEMENT BIOGRAPHIES

Timothy J. Constantine

Professional Experience

CareFirst Blue Cross Blue Shield of Delaware, Inc., Wilmington, Delaware

- President – September 2001 to Present
- Vice President, Network and Medical Management – August, 1998 to September, 2001

Union Hospital of Cecil County Health System, Inc. and Affiliates, Elkton, Maryland

- Chief Financial Officer – June, 1995 to August, 1998

St. Francis Hospital, Wilmington, Delaware

- Vice President, Community Health Services – January, 1985 to June, 1995

Arthur Andersen & Company, Baltimore, Maryland

- Manager, Audit and Operational Consulting Division – January, 1985 to December, 1992

Education/Licensing

- Loyola College, Baltimore, Maryland – Bachelor of Business Administration Degree in Accounting; Magna Cum Laude; 1986
- Certified Public Accountant; 1987

Memberships/Activities

- Wilmington Renaissance Corp. Board of Directors – 2001 to Present
- Delaware Health Resources Board (Delaware Governor Appointed) – 1999 to Present
- Delaware Business Roundtable Member – 2001 to Present
- Delaware Business Roundtable Executive Committee – 2002 to Present

Christine L. Alrich

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc., Wilmington, Delaware

- Vice President, Corporate Marketing – November, 1999 – Present

CareFirst Blue Cross Blue Shield (Maryland)

- Director, Marketing/Product Development, National Business – 1996-1999
- Director, Broker Sales – 1994-1996
- Director, State of Maryland Business Unit – 1989-1994
- Manager, Group Underwriting – 1988-1989
- Manager, Gold Option Team – 1987-1988
- Manager, Marketing Research Product Development – 1982-1987
- Manager, Resource Management – 1980-1981
- Various positions – 1970-1980

Education/Licensing:

- Bachelor of Science, Business Administration – Towson State University – 1979
- MBA Program, 30% complete – Loyola College
- HIAA Group Health and Life Insurance – Parts A, B, C
- Health and Life License

Memberships/Activities:

- Baltimore Association Health Underwriters
- Maryland Association Health Underwriters
- Cardinal Club – Calvert Hall College – 1995-1998
- Board of Directors, YWCA – 1985-1987
- Wilmington West Rotary, Director Club Services – 2002 to present

George H. English, Jr.

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Vice President, Operations – June, 2002 to present
- Director, Claims - 1984 to June, 2002

Blue Cross Blue Shield of Southwestern Virginia

- Manager, Medicare Operations – June, 1978-Dec., 1983
- Supervisor CHAMPUS Beneficiary Services

Education:

- Virginia Western Community College – Accounting
- Leadership Delaware - 1986
- Blue Cross Blue Shield Association National Management Development Institute - 1987

Memberships/Activities:

- Medical Care Advisory Committee – 2001-present
- Children's Advocacy – 1998-2003

William E. Kirk, III

Professional Experience:

Blue Cross Blue Shield of Delaware, Inc., Wilmington, Delaware

- Vice President, General Counsel, Corporate Secretary
- Employed with company since 1980
- Responsibilities include legal, regulatory and government relations, board relations, corporate services

State of Delaware

- Deputy Attorney General, 1978-1980

Associate

- Young, Conaway, Stargatt & Taylor, 1976-1978

Law Clerk

- Delaware Court of Chancery, 1975-1976

Education:

- B.A., St. Joseph's University, Philadelphia, Pennsylvania
- J.D., M.A., University of Virginia, Charlottesville, Virginia

Current Community & Volunteer Activities:

- Member of Delaware Perinatal Board
- Member of Diocesan Review Board
- Assistant Scoutmaster

Iris L. Pointer Carr

Professional Experience:

Over 20 years of underwriting experience.

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Director, Underwriting, January 2000 to Present

CareFirst, Inc., Owings Mills, Maryland

- Director, Underwriting, 1997 to 2000

Independence Blue Cross, Philadephia, Pennsylvania

- Held various Underwriting management positions during ten and one-half years with the company.

Other

- Several years of experience with other commercial carriers

Education:

- University of Pennsylvania, Master of Science Degree in Organizational Behavior, 1995
- Drexel University – Bachelor of Science Degree in Business Administration, 1979

Memberships/Activities:

- National Underwriters Association
- Urban League Civic Association
- Finance and Budget Committee of parish community

Phillip A. Carter

Professional Experience:

30 years of diversified financial experience with 25 years of financial management experience.

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Corporate Controller (current position)
- Manager, Corporate Accounting
- Manager, Cost & Budget
- Supervisor, Financial Controls

Other

- Senior Governmental Accountant
- General Accountant
- Junior Auditor

Education:

- Antioch University – Masters Degree in Health Care Administration, 1979
- Delaware State University – Bachelor of Science Degree in Accounting, 1972

Memberships/Activities:

- American Association of Accountants – Member
- Non-Profit Agencies
  - Walnut Street YMCA – Board of Directors
  - Arthritis Foundation
  - Read Aloud Delaware

Paul A. Kaplan, M.D.

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Chief Medical Officer (current position)

Other

- Worked in private practice in South Africa prior to enrolling in a family practice residency. Upon completion of his residency training, worked in private practice for seven years before joining BCBSD, Inc.

Education:

- M.B., Ch.B (M.D. equivalent) Degree, 1984
- Board-Certified Family Physician

Memberships/Activities:

- Fellow of the American Academy of Family Physicians
- Member of the Board of the Disease Management Association of America
- Member of the Board of the Delaware Academy of Family Physicians
- Member of the Board of the Blood Bank of Delaware and Eastern Shore
- Past President of the Delaware Academy of Family Physicians
- Lectures both regionally and nationally on Quality Improvement, Patient Safety, Predictive Modeling and Disease Management
- Active in various community initiatives

Eileen Masterson-Carr

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Director, Provider Relations & Contracting – September 2003 to Present

Horizon Blue Cross and Blue Shield of New Jersey

- Director, Provider Relations – March 1999 to August 2003

Other

- Also worked with several hospitals and provider offices in the Philadelphia/South Jersey Region.

Education:

- Lasalle University – Master's Degree in Business Administration
- Eastern Collge – Bachelor of Science Degree in Business

Memberships/Activities:

- Bayard House – Vice President of Board of Directors

Sally A. Retzko

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Director of Information Technology (reporting to CIO of CareFirst, Inc. and President of BCBSD, Inc.), April 1998 to Present
- Manager of Claims Systems, February 1988 to March 1998

Education:

- Widener University, Wilmington, Delaware – M.B.A. Program, 2002 to Present
- University of Delaware, Newark, Delaware – B.S. Degree in Mathematics, Minor in Computer Science, 1971 to 1974
- Extensive Management and Technical Training
- Fellow, Life Management Institute
- Fellow, Academy for Healthcare Management

Memberships:

- Network of Women in Computer Technology, Philadelphia, PA
- Blue Cross and Blue Shield Information Technology Roundtable

Deborah M. Sweeney

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Director, Quality Improvement (current position)

Other

- Nine and one-half years working in management positions in Utilization, Case and Quality Management at two Pennsylvania-based managed care organizations.
- Two years providing classroom and clinical instruction in pediatrics to senior-level nursing students at a diploma nursing program.
- Four years with an HMO as a Continuing Care Coordinator and Manager of Provider Services.
- Two years in the home care field.
- Six years providing direct patient care at a tertiary pediatrics center.

Education:

- Widener University – currently pursuing Masters in Business Administration in Health and Medical Service Administration.
- Gwynedd Mercy College, M.S. in Nursing, 1989
- Gwynedd Mercy College, B.S. in Nursing, 1981
- Gwynedd Mercy College, A.D. in Nursing, 1979

R. Foster (Terry) Seaton, A.S.A., M.A.A.A.

Professional Experience:

CareFirst Blue Cross Blue Shield of Delaware, Inc. Wilmington, Delaware

- Manager of Actuarial Support, 1999 to Present
- Manager of Actuarial Services, 1994 to 1999

Blue Cross and Blue Shield of Texas

- Director of Health Consulting and Analysis, 1990 to 1994
- Associate Health Consulting Actuary, 1989 to 1990

Blue Cross and Blue Shield of New Mexico

- Associate Actuary, 1987 to 1989
- Corporate Statistician, 1980 to 1986

Education:

- Society of Actuaries Curriculum for Associate Membership, 1981 to 1986
- University of New Mexico – B.S. in Mathematics and Statistics, 1979

HIGHMARK®

BCBSD DUE DILIGENCE REQUESTS

May 26, 2011

EXHIBIT
JOINT-76.1

April 2011 Membership by Region

2 Request 1 – Current membership by region, in addition to membership located in DE & accessing benefits via BlueCard

	Western	Central	NEPA	Southeastern	WVA	Delaware [1]	Other	Total
Health Business								
Dental [2]								
Vision [3]								

Notes:
1. Enrollment represents Highmark & UCCI members that reside in Delaware.
2. Dental membership represents contracts (not members) and represents only UCCI business.
3. Vision membership represents HVHC members for March. Delaware Vision membership is forthcoming.

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Provider Network

3 Request 2 – Number of physicians and health care professions in provider network

	Participating	Premier Blue	KHPW	WV	Medicare Advantage (PA and WV)
PCPs	[redacted]				
Specialist					
Other Professional Providers (Non MDs, DOs)					
Unique Provider Totals					

Schedule as of May 23, 2011

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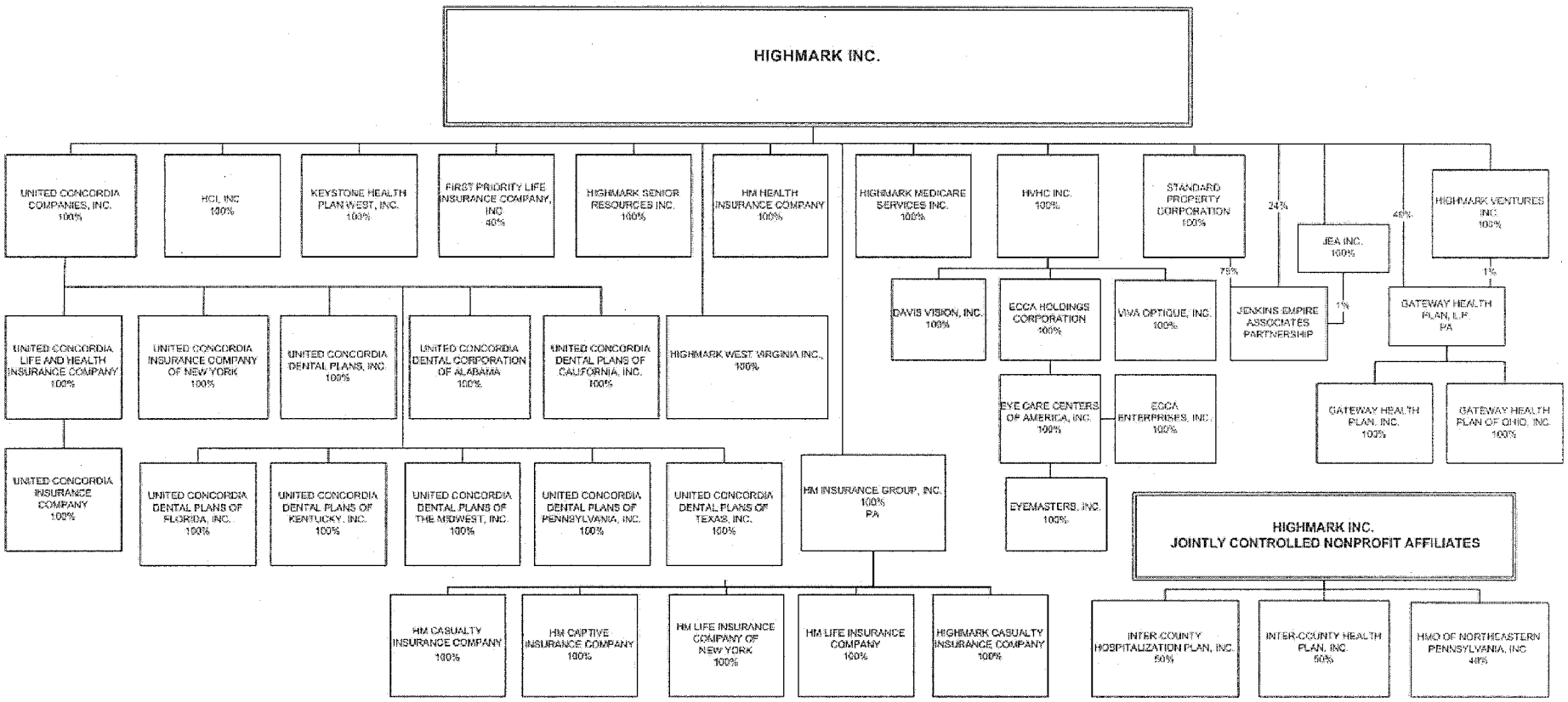
Organizational Structure

4 Request 3 – Current organizational structure



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Legal Insurer, Subsidiary & Affiliates

5 Request 3 continued – Brief description of each legal insurer, subsidiary and affiliate

- Highmark's core markets include western and central Pennsylvania and West Virginia.
  - Highmark offers products in Pennsylvania through **Highmark, HM Health Insurance Company, Keystone Health Plan West, and Highmark Senior Resources.**
  - Highmark also controls the Blue Cross Blue Shield brand license for West Virginia where our controlled affiliate, **Highmark West Virginia,** operates.
- Highmark jointly offers various health insurance products in northeastern PA and southeastern PA through joint arrangements with **BC of Northeastern PA** and **Independence BC.** We also offer comprehensive managed care services to Medicaid and Medicare recipients through **Gateway Health Plan,** a limited partnership that we jointly own with Mercy Health Plan.
- Highmark's wholly-owned subsidiary **Highmark Medicare Services** (HMS), is the Medicare Administrative Contractor for region J12 (PA, DE, NJ, MD and the District of Columbia).
- **United Concordia Companies, Inc. ('UCCI')** provides high-quality, cost-effective dental benefits programs to small local businesses, regional companies and global organizations. UCCI offers a wide range of dental insurance products including both active and passive PPOs, exclusive provider organizations, dental HMOs ('DHMOs'), traditional indemnity, voluntary products and programs and administrative services.
- **HVHC** provides fully-integrated vision care benefits and services through a national provider network, 58 proprietary retail establishments and five optical laboratories.
- **HM Insurance Group** provides ancillary employee benefits across all lines of coverage, including employer medical stop loss, group life, group disability and workers compensation.

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Commercial Health

- Highmark entities offer Commercial Health products;
  - Highmark
  - HM Health Insurance Company
  - Keystone Health Plan West
  - Highmark West Virginia
  - Inter-County Hospitalization Plan (50% ownership)
  - Inter-County Health Plan (50% ownership)
  - First Priority Health (40% ownership)
  - HMO of Northeastern Pennsylvania (40% ownership)
- Commercial Market Segments
  - Offers Health Maintenance Organization (HMO)
  - Preferred Provider Organization (PPO)
  - Indemnity and Consumer Driven Health Plans (CDHPs) products

GAAP & STAT Financials

Request 5 – GAAP & STAT financials for EOY 2006-2010 (operating results, balance sheet, cash flow statement, reserves, MD&A)

Refer to the following attachments;

- 5 – Highmark GAAP 2006
- 5 – Highmark GAAP MD&A 2006
- 5 – Highmark STAT 2006
- 5 – Highmark STAT MD&A 2006

- 5 – Highmark GAAP 2007
- 5 – Highmark GAAP MD&A 2007
- 5 – Highmark STAT 2007
- 5 – Highmark STAT MD&A 2007

- 5 – Highmark GAAP 2008
- 5 – Highmark GAAP MD&A 2008
- 5 – Highmark STAT 2008
- 5 – Highmark STAT MD&A 2008

- 5 – Highmark GAAP 2009
- 5 – Highmark GAAP MD&A 2009
- 5 – Highmark STAT 2009
- 5 – Highmark STAT MD&A 2009

- 5 – Highmark GAAP 2010
- 5 – Highmark GAAP MD&A 2010
- 5 – Highmark STAT 2010
- 5 – Highmark STAT MD&A 2010

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Operating Segments

8 Request 6 – Detailed description of operating segments and detailed financials for operating segments EOY 2009-2010

- In addition to the table below, please refer to the following attachment;
  - 6 – Description of business segments

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For The Years Ended 2010 and 2009

(thousands)

	COMMERCIAL HEALTH	SENIOR MARKETS	DENTAL (UCCI and HIGHMARK)	VISION (HVHC and HIGHMARK)	HM INSURANCE GROUP
RISK					
Premium Revenue					
Other Vision Revenue					
Claims Expense					
Operating Expense					
Reported Risk Gain/(Loss)					
Non-Risk					
Management Services Revenue					
Other Non Risk Revenue					
Operating Expense					
Reported Non-Risk Gain/(Loss)					
Total Reported Gain / (Loss)					

Revenue Growth Assumptions

Request 7 – Latest revenue growth assumptions for ancillary products to be distributed in Delaware

- Information as it pertains to this request is forthcoming.

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Refer to the following attachments for Request support;

10 Request 8 –Anticipated synergies & administrative charges, as shown in BCBSD pro-forma affiliated financials & relevant assumptions

- 8 - Anticipated Synergies and Admin Charges - Financials & Assumptions

Request 9 – Schedule outlining Total Adjusted Capital for year 2006-2010

- 9 - Highmark Schedule of Adjusted Capital

Request 10 – Risk Based Capital schedule for EOY 2010

- 10 - Highmark RBC Schedule 2010

Request 11 – Mountain State statistics showing change in performance and financial condition from per & post full affiliation in 2004

- 11 - WVOIC 2009 Presentation Final

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Business in the State of Delaware

11 Request 12 – Annual premiums written and reported members in the state of Delaware by NAIC product categories

- In addition to our verbal response, please refer to the table below;

Commercial Group - Unique	
PPO	
Indemnity	
Comprehensive	
Total	
Over 65 Group - Unique	
Medigap	
Medicare Advantage	
Drug Part D	
Total	
Individual - Unique	
Special Care	
Total	
Over 65 Individual - Unique	
Medigap	
Medicare Advantage	
Total	
Total	
Commercial Group	
Over 65 Group	
Individual	
Over 65 Individual	
Grand Total	

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Long-term Service Agreement with BCBSD

- Refer to the following attachment;
  - 13 –Administrative Services Agreement (Exhibit 4) to Statement of Affiliation 10-7-10

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BCBSD DUE DILIGENCE REQUESTS

June 10, 2011

EXHIBIT
JOINT-77.1

Commercial Health – Results

2 Request 1 – 2009A and 2010A Premium Revenue, Management Services Revenue, Other Revenue, Claims Expense and Net Operating Expense by customer segment (Small Group, Large Group, Individual, Non-Risk) within Commercial Health business

	INDIVIDUAL	MEDIGAP	SMALL GROUP	EXPERIENCE	PROCESSING ARRANGEMENT NETWORK FEES	TOTAL
RISK						
Premium Revenue	[redacted]					
Claims Expense						
Operating Expense						
Reported Risk Gain/(Loss)						
Non-Risk						
Management Services Revenue						
Other Non Risk Revenue						
Operating Expense						
Reported Non-Risk Gain/(Loss)						
Total Reported Gain / (Loss)						

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Senior Markets – Results

3	Request 2 – 2010A Senior Markets Premium Revenue breakdown by segment (i.e. Highmark Direct Pay – Medigap, KHPW Security Blue HMO, Highmark Senior Resources Part D, HM Health Insurance Co. PPO, Gateway Health Plan – PA and OH, & other relevant categories)

	SECURITYBLUE	FREEDOMBLUE WEST & CENTRAL	FREEDOMBLUE WEST VIRGINIA	BLUE Rx	PROCESSING ARRANGEMENT	TOTAL
RISK						
Premium Revenue	[redacted]					
Claims Expense						
Operating Expense						
Reported Risk Gain/(Loss)						
Non-Risk						
Management Services Revenue						
Other Non Risk Revenue						
Operating Expense						
Reported Non-Risk Gain/(Loss)						
Total Reported Gain / (Loss)						

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Medicaid – Results

4

Request 3 – 2009A and 2010A Premium Revenue, Management Services Revenue, Other Revenue, Claims Expense and Net Operating Expenses for Medicaid
Request 4 – 2010A Medicaid Premium Revenue breakdown by state

($ thousands)	Medicaid 2010	Medicaid 2009
Revenues		
Revenue, Gross		
MCO Assessment		
Total Revenues		
Total Health Care Costs		
Gross Margin		
PDR		
General & Admin. Expenses		
General Administration		
Operating Income		
Other Income		
Net Investment Income		
Net Income Before Taxes		
Income Taxes		
Net Income		
Enrollment ('000s)		

* Gateway's financial results are not consolidated in our financial statements, but are recorded on the equity income method as *Other revenue.*

- We offer Medicaid products through our affiliate, Gateway Health Plan ("GHP")
- GHP is a limited partnership which we jointly own with Mercy Health Plan
- All December 2010 earned Medicaid Premium revenue was in the state of Pennsylvania

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December 2010 RBC Build-Up

5 Request 5 – Build up of 2010A year-end RBC (including Asset Risk – Affiliates, Asset Risk – Other, Underwriting Risk, Credit Risk, Business Risk, RBC After Covariance, and other relevant figures)

- In addition to the table below, refer to the following attachment for further detail;
  5 - 2010 4Q RBC Summary

H0 - ASSET RISK - AFFILIATES W/RBC		**$ 517,012,392**
H1 - ASSET RISK - OTHER		383,525,747
H2 - UNDERWRITING RISK		380,342,866
H3 - CREDIT RISK		12,089,668
H4 - BUSINESS RISK		120,408,117
	RBC after Covariance	**$ 1,070,543,754**
	Authorized Control Level RBC	**$ 535,271,877**
Calculation of Total Adjusted Capital		
	Capital and Surplus	**$ 3,714,239,722**
	Asset Valuation Reserve - Life Subs	**4,056,601**
	Non-Tabular Discounts - P&C Subs	**(15,617,000)**
Total Adjusted Capital, Post Deferred Tax		**$ 3,702,679,323**
RBC Ratio		**691.74%**

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Projected Income Statements

6

Request 6 – Projected 2011E-2013E income statement financials
Request 7 – Discussion of 2011E-2013E projections and assumptions therein (recommend a conference call)
Request 8 – Discussion of recent trends impacting historical results (recommend a conference call)

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	2011	2012	2013
Subscription Revenue	12,641.7	13,347.7	14,487.9
Management Services Revenue	718.4	689.2	702.5
Other Operating Revenue	1,400.2	1,466.0	1,569.1
Total Operating Revenue	14,760.4	15,502.9	16,759.5
Claims Expense	11,088.3	11,930.2	12,993.6
Operating Expense	3,085.2	3,078.7	3,243.9
Total Operating Expense	14,173.6	15,008.9	16,237.5
Operating Gain	586.9	494.0	522.0
Change in Premium Deficiency Reserves	(9.4)	9.5	26.3
Adjusted Operating Gain	577.4	503.5	548.3
Investment Income	150.3	157.2	167.6
Interest Expense	(57.2)	(36.0)	(26.9)
Realized Gain	25.9	18.9	24.4
Other Expense	(236.2)	(240.0)	(225.0)
Equity Income of Affiliates	10.8	5.2	7.1
Income Before Income Tax	470.8	408.8	495.5
Income Tax Provision	165.7	141.9	173.6
Net Income	$ 305.1	$ 266.9	$ 321.9

UCCI Network and Membership

7 Request 9 – Number of locations in UCCI network

- Largest national PPO network is Advantage Plus, which represents 73,621 unique dentists in 50 states and 3 territories.
- Delaware has 66 dentist in the network.

* Metrics provided as of May 2011.

Request 10 – Number of UCCI members, as well as number of members in Tri-care dental program within UCCI

UNITED CONCORDIA

Commercial	**5,195,860**
TDP	**2,025,062**
FEDVIP	**384,581**
PHS	**6,517**
Gateway Medicaid	**251,910**
Gateway Medicare	**27,413**
FEP	**227,809**
Blue Branded Dental	**10,667**
TOTAL	**8,129,819**

* Metrics provided as of May 2011.

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Gateway and HMIG

8 Request 11 – Number of Gateway members and service counties

- GHP provides comprehensive managed care services to Medicaid and Medicare recipients.
- Under the Pennsylvania HealthChoices Program, GHP provides insurance to ~250,000 Medicaid and ~27,000 Medicare recipients in more than 20 counties across the state.
  - Refer to the following attachment for further detail; 11 - GHP Members and Service Counties

* Metrics provided as of May 2011.

Request 12 – Number of regional sales offices and employees in HM Insurance Group

- HM Insurance Group ("HMIG") provides ancillary employee benefits to employer groups in all 50 states through 25 strategic regional sales offices.
- 504 employees are employed at HMIG with 352 in Pittsburgh and the remaining 152 in remote offices.

* Metrics provided as of February 2011.

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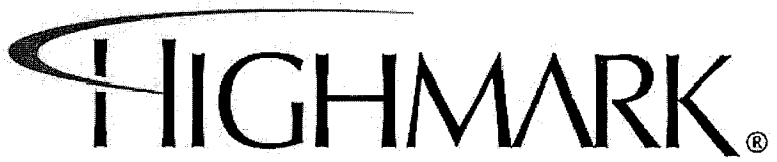


WEST VIRGINIA OFFICE OF INSURANCE COMMISSIONER

1124 Smith Street, Charleston, WV

BluePRINT Update/ Proposed Amended and Restated Administrative Services Agreement

Date: Monday, September 28, 2009

2:30 P.M. – 4:00 P.M.

EXHIBIT
JOINT-78.1

Attendees

MOUNTAIN STATE

Fred Earley
President

Mark Sengewalt
C.F.O.

HIGHMARK

Karen Hanlon
Sr. Vice President, Financial Planning & Analysis

Ken Gebhard
Vice President, Cost Analysis & Budget

Ed Bittner
Sr. Counsel

WVOIC

Jane Cline
Insurance Commissioner

Bill Kenny
Deputy Commissioner

Mike Riley
Assistant Commissioner/ Regulation

Greg Elam
Associate General Counsel

Victor Mullins
Associate Counsel

Robert Hrezo
Financial Analyst

Leah Cooper
Director/Chief Examiner

Agenda

I. **Highmark/Mountain State Relationship Overview** [Mark Sengewalt / Fred Earley]

II. **BluePRINT Update** [Mark Sengewalt / Ken Gebhard]

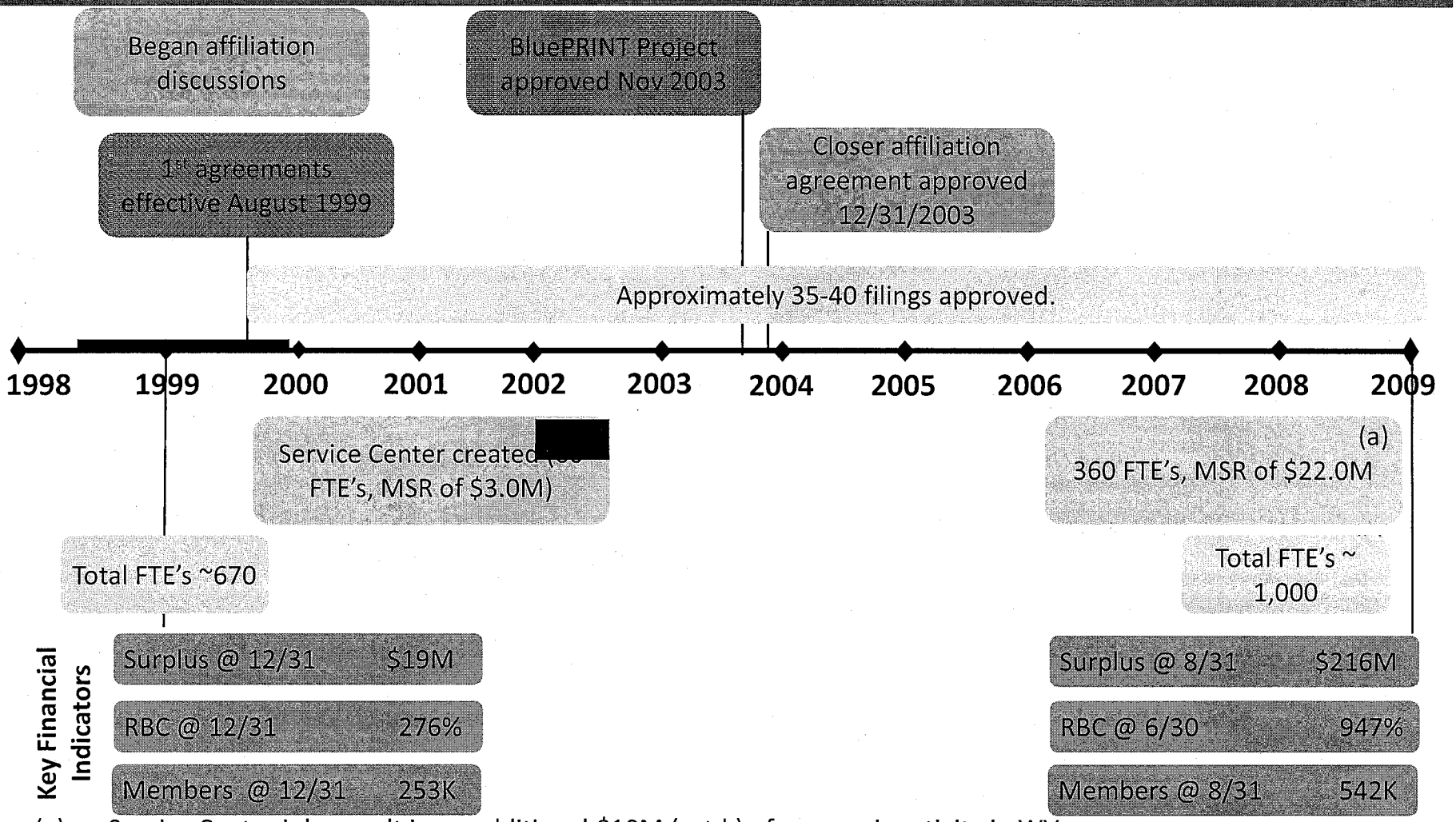
- **Review Original Justification**
- **BluePRINT Today**

III. **Proposed Amended and Restated Administrative Services Agreement** [Fred Earley / Ed Bittner]

- **Highmark Cost Allocation Overview**
- **Mountain State Cost Structure**

IV. **Next Steps** [Fred Earley / Ed Bittner]

I. Highmark/Mountain State Relationship



(a) Service Center jobs result in an additional $10M (estd.) of economic activity in WV.

(b) Note: 12/31/99 FTE count included 125 FTE's that worked on the PEIA account, which was lost in 2000. Those FTE's were redirected to other work, rather than displaced, due to the noted enrollment growth and creation of the service center.

II. BluePRINT Update

- Review Original Justification:

  - **Potential Cost Reductions –**
    - **Reduce staff by 40 FTE's**
    - **Eliminate Third Party software (GMIS)**
  - **Creation of Service Center**
  - **Increased Functionality, Automation**
  - **Improved Operational Service & Performance**
  - **Minimize Cost of Future Regulatory Compliance (Repeat of HIPAA/Y2K)**

BluePRINT Update - Today

BluePRINT has Exceeded Expectations ….

☑ **Potential Cost Reductions –**

- **Exceeded FTE reduction by 50%, without loss of any positions – Annual savings of $3.6M**
- **FTE efficiencies have been instrumental in providing capacity for BlueCard business, for which revenue has grown by almost 70%, or $12M, per year since 2003**

☑ **Creation of Service Center**

- **Positions eliminated via BluePRINT cost reductions were redirected to the Service Center**
- **Service center positions are reimbursed at cost + overhead**
- **360 FTE's in service center today, generating $22M of annual revenue**

BluePRINT Update - Today

Increased Functionality, Automation

- Capabilities expanded to approach new business that MSBCBS could not previously administer
  - Examples include specialist co-pays, $ limits on co-pays, HDHP, portability of lifetime max, coding of secondary procedure codes
  - Associated account wins: WVUHS, Camden Clark/St. Joe's, St. Francis, Thomas, Pleasant Valley, Stonewall Jackson (represents 18,000 new members)
- More efficient new product development
- More efficient interaction with customers and providers through portals
- Imaging Technology / OCR

BluePRINT Update - Today

Improved Operational Service & Performance

	Pre-BluePRINT	Current	Comments
Pass-thru rate	[redacted]		
% Claims Paperless - Institutional			
% Claims Paperless - Professional			

Minimize Cost of Future Regulatory Compliance (Repeat of HIPAA/Y2K)

- **Forward looking savings for ICD-10 and 5010 initiatives**

BluePRINT Update - Today

BluePRINT has Exceeded Expectations but….

- **The ongoing costs associated with sustaining this more efficient, compliant and innovative environment have not been fully charged to MSBCBS, leaving Highmark with unreimbursed costs.**
- **In 2009, approximately $[redacted] of allocated costs will not be reimbursed through the existing task order process**

	2006	2007	2008	2009 (est)
Total without Legacy Modernization:				
Allocated Expense				
Reimbursement				
Net Unreimbursed				
Legacy Modernization:				
Allocated Expense				
Reimbursement				
Net Unreimbursed				
Total Unreimbursed				

- **Unreimbursed costs are making it increasingly difficult to support further integration to drive additional efficiencies / improvements.**

III. Proposed Amended and Restated Administrative Services Agreement

Current Process:

Existing Administrative Services Agreement (ASA) with Separate Task Orders / Form D filings

Proposed Process (effective 1/1/10):

Global ASA which allows for fair and reasonable allocated costs, consistent with Highmark's allocations to all subsidiaries and affiliates

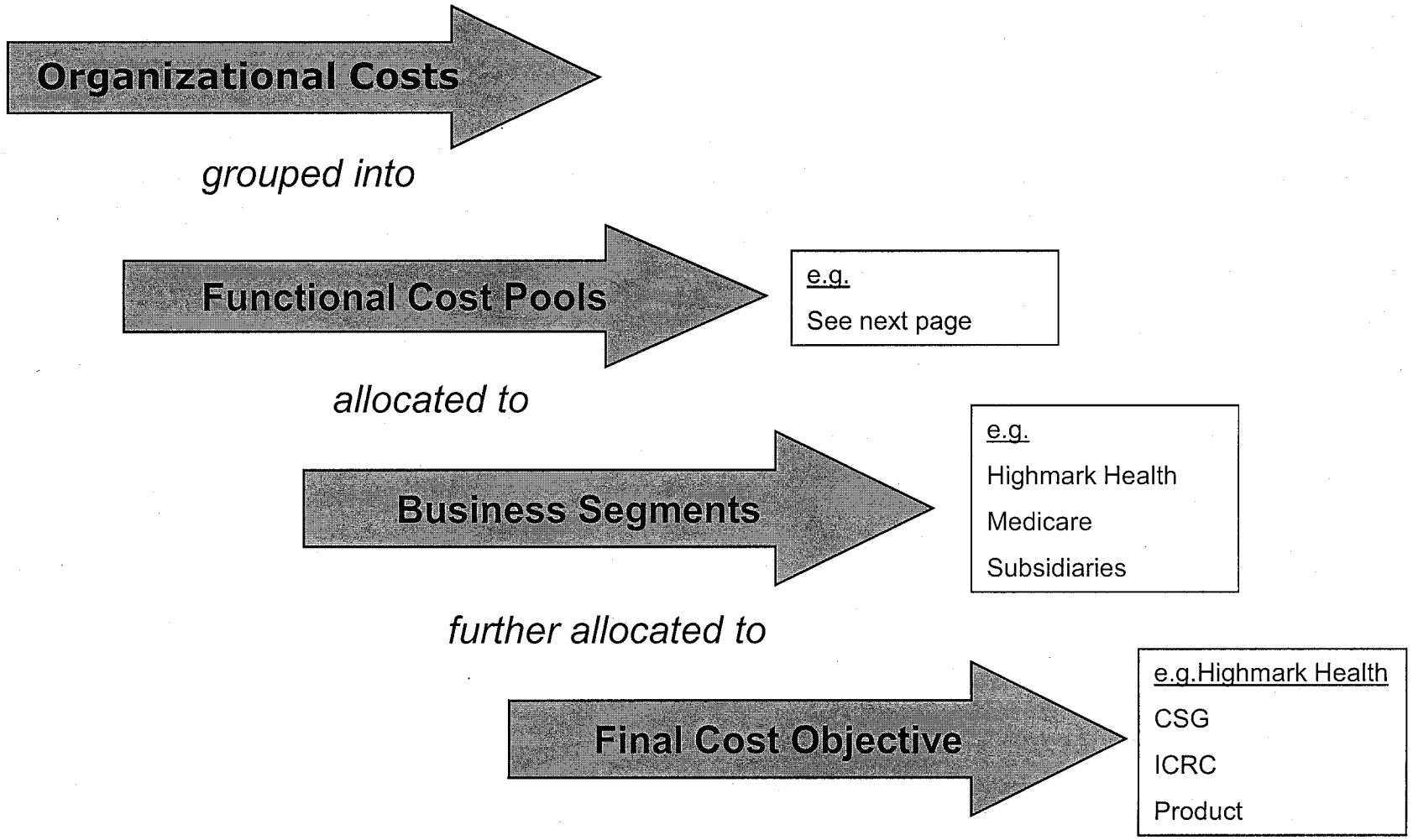
Highmark Cost Allocation - Overview

- **Objectives**
  - One consolidated costing process for Highmark
  - Fair and reasonable assignment of costs to business segment / final cost objectives
  - Compliance with Government regulations
  - Consistency

- **Scope**
  - 650 Highmark and subsidiary cost centers
  - 130 Cost pools
  - 1 Highmark Commercial Health Segment
  - 20 Subsidiary business segments

- **Regulatory / Government Compliance**
  - Highmark Medicare Services and United Concordia have contracts covered by federal Cost Accounting Standards (CAS)
  - CAS-covered contracts subject to ongoing disclosure of cost accounting practices and routine DCAA audits
  - Other contracts, e.g., FEP, subject to the Federal Acquisition Regulations (FAR)
  - Highmark cost allocations are subject to audit by multiple state regulators.

Highmark Cost Allocation - Process Flow



Highmark Cost Allocation

Functional Cost Pools (examples)

	Basis of Allocation
Home Office Expense:	
• Corporate	Weighted Salaries
• Governance	Salaries
• Human Resources	FTEs
Centralized Services:	
• Application Support	Actual Hours x Rate
• Computer Processing	Actual CPU Minutes x Rate
• Network Services	Actual FTEs x Rate
Direct Charges:	
• External charges paid by Highmark on behalf of subsidiaries	Pass-Thru at Actual Cost
Shared Services:	
• Claims Processing Systems	Claims Processed
• Enrollment and Billing Systems	Membership

MSBCBS Cost Structure Update

- Most of the unreimbursed cost is related to IT services. Upon full reimbursement (net of BluePRINT amortization, which ends in 2010), MSBCBS' IT costs will still be below Blue plan averages.

IT Cost PMPM	2007	2008	2009 Current	2009 Restated
Mountain State				
Highmark				
Sherlock Mean				

- MSBCBS total administrative costs, restated for the additional charges (net of BluePRINT amortization) will also still be below Blue plan averages.

2009 Total Admin Cost PMPM	MSBCBS		Highmark	Sherlock Mean*
	Current	Restated		
IT				
Non-IT				
Total				

* Represents 2008 Sherlock +2%

MSBCBS Cost Structure Update

Highmark and MSBCBS management will be challenged to produce savings to offset the additional charges within the next three years

Savings already being worked on include:

- Executive retirements, [redacted]
- [redacted] reduction in costs after original BluePRINT costs are fully amortized at 6/30/10.
- Restructuring associated with further integration with Highmark.
- Corporate initiatives centered around productivity improvements and staff sourcing.
- Changes to key benefit programs.

To minimize the financial impacts to MSBCBS, Highmark will phase-in the full allocation of costs over three years ([redacted]) to more closely align with the anticipated savings.

IV. Next Steps

1. Mid-October – Submit Draft Administrative Services Agreement (ASA) to the WVDOI for review / comment
2. Late-October – File ASA with the WVDOI
3. January 1, 2010 - Transition from task order reimbursement to allocated cost reimbursement