EXAMINATION REPORT

OF

HIGHMARK BCBSD INC.

AS OF

DECEMBER 31, 2016

Trinidad Navarro
Commissioner

Delaware Department of Insurance

I, Trinidad Navarro, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of December 31, 2016 of the

HIGHMARK BCBSD INC.

is a true and correct copy of the document filed with this Department.

Attest By: _____

Date: June 4, 2018

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 20 day of June, 2018.

_____
Trinidad Navarro
Insurance Commissioner

Trinidad Navarro
Commissioner

Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

HIGHMARK BCBSD INC.

AS OF

DECEMBER 31, 2016

The above-captioned report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the company as reflected in the report.

This report is hereby accepted, adopted and filed as an official record of this Department.

Trinidad Navarro
Insurance Commissioner

Dated this 20th day of June, 2018

841 Silver Lake Blvd., Dover, DE 19904-2465 • www.delawareinsurance.gov
(302) 674-7300 Dover • (302) 739-5280 fax • (302) 577-5280 Wilmington

TABLE OF CONTENTS

SALUTATION

April 24, 2018

Honorable Trinidad Navarro
Commissioner of Insurance
Delaware Department of Insurance
Rodney Building
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner;

In compliance with instructions and pursuant to statutory provisions contained in Exam Authority No. 17.005, dated April 3, 2017, an examination has been made of the affairs, financial condition and management of

Highmark BCBSD Inc.

hereinafter referred to as the Company or BCBSD and incorporated under the laws of the State of Delaware as a non-stock company with its home office located at 800 Delaware Avenue, Wilmington, Delaware 19801. The examination was conducted at the administrative office of the Company located at 120 Fifth Avenue, Suite 924, Pittsburgh, Pennsylvania 15222. The report of examination thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Delaware Department of Insurance (Department) performed a risk-focused financial examination of the Company. The last examination was conducted as of December 31, 2012. This examination covered the period of January 1, 2013 through December 31, 2016 and encompasses a general review of transactions during the period, the Company's business policies and practices, as well as management and relevant corporate matters, with a determination of the

financial condition of the Company as of December 31, 2016. Transactions subsequent to the examination date were reviewed where deemed necessary.

The examination of the Company was performed as part of the multi-state coordinated examination of Highmark Inc. (Highmark), a group of health organizations, as of December 31, 2016. The Pennsylvania Insurance Department (PID) was the lead state. The examination was conducted concurrently with that of its Delaware domiciled subsidiary, Highmark BCBSD Inc. To the fullest extent, the efforts, resources, project material and findings were coordinated and made available to all examination participants.

We conducted our examination in accordance with the *National Association of Insurance Commissioners* (NAIC) *Financial Condition Examiners Handbook* (Handbook) and generally accepted statutory insurance examination standards consistent with the Insurance Code and Regulations of the State of Delaware. The NAIC Handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the company and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated both currently and prospectively.

All accounts and activities of the company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination an adjustment is identified, the impact of such adjustment will be documented separately following the Company's financial statements.

This examination report includes significant findings of fact, along with general information about the insurer and its financial condition. There may be other items identified during the examination that, due to their nature, are not included within the examination report but separately communicated to other regulators and/or the Company.

During the course of this examination, consideration was given to work performed by the Company's external accounting firm, PricewaterhouseCoopers, LLC (PwC). Certain auditor work papers for their 2016 audit have been incorporated into the work papers of the examiners and have been utilized in determining the scope, areas of emphasis in conducting the examination and in the area of risk mitigation and substantive testing.

SUMMARY OF SIGNIFICANT FINDINGS

There were no significant findings or material changes in financial statements as a result of this examination.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

Management Comments

Prior Exam Recommendation: As noted in the previous examination management comments, it is recommended the Company utilize procedures which comply with 12 *Del. C.* § 1197 Other Escheated Property.

Current Exam Finding: The Company has complied with this recommendation.

COMPANY HISTORY

The Company was originally incorporated, by the filing of a Certificate of Incorporation with the Secretary of State on August 16, 1935 as a private non-profit, non-stock corporation and is operated as a health service corporation in the State of Delaware. The Company, as a licensee of the Blue Cross and Blue Shield Association (BCBSA),

underwrites various indemnity and managed care health insurance products as well as Medicare supplemental, dental and vision products. The Company also provides Administrative Services Contracts (ASC) to self-funded plans.

On December 30, 2011 the Delaware Commissioner approved an affiliation between Highmark Inc. and the Company (Affiliation Approval) imposing 49 conditions on the affiliation that, among other things, were intended to preserve the Company's surplus and reserves and make it possible for the Company to disaffiliate if necessary. Effective January 1, 2012 Highmark became the sole member of the Company, which thereupon changed its name to Highmark BCBSD Inc. As the sole member of the Company, Highmark has the authority to elect the Company's Board of Directors. The Company is a separate legal entity and is not liable for Highmark's obligations. In accordance with its articles of incorporation, in the event of dissolution of the Company, the Directors shall cause any remaining assets of the Company to be distributed to a foundation created pursuant to Delaware law or to a federally tax-exempt organization.

On April 26, 2013 the Delaware Commissioner approved the indirect acquisition of the control of the Company by the Ultimate Parent Entity (UPE) if and when the PID approved the Highmark/West Penn Allegheny Health System (WPAHS) affiliation. That approval modified 5 of the 49 original conditions. The April 29, 2013 closing of the Highmark/WPAHS transaction resulted in the Company's ultimate controlling parent, UPE, later re-named Highmark Health.

Federal Affordable Care Act

The Federal Affordable Care Act (ACA) enacted significant reforms to various aspects of the U.S. health insurance industry, including the establishment of federally-facilitated or state-based exchanges which provide individuals and small businesses access to affordable and

quality health insurance. The Corporation participates in the Delaware health insurance exchange.

The ACA established three premium stabilization programs effective January 1, 2014. These risk spreading programs are applicable to certain commercial medical insurance products. In the aggregate, the Corporation's commercial medical insurance products subject to the premium stabilization programs represented approximately 45% and 43% of the total premiums for the years ended December 31, 2016 and 2015 respectively. These programs, commonly referred to as the 3Rs include a permanent risk adjustment program, a transitional reinsurance program and a temporary risk corridor program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and risk corridor programs are available for years 2014 through 2016.

As of December 31, 2016, the Company recorded amounts recoverable under the ACA reinsurance of $10.4 million and a payable of $0.6 million for the ACA risk adjustment program. The Company also recorded a risk corridor receivable of $56 thousand for the 2014 benefit year risk corridor based on the Centers for Medicare & Medicaid Services' (CMS) announcement that it had the ability to pay 3.3% of the amounts owed for the 2014 benefit year. As of December 31, 2016, the Company received $146 thousand of the $202 thousand of the risk corridor funds owed from CMS. A risk corridor receivable was not recorded for the amounts owed for the remainder of the 2014 benefit year, nor for amounts owed with respect to the 2015 and 2016 benefit years as risk corridor payments are not reasonably assured of collection since they are subject to the availability of risk corridor funds. The Company

anticipates calculating the risk corridor amount pursuant to CMS' methodology and filing the required information in 2017 for the 2016 benefit year.

On January 1, 2017, the Company was not subject to an annual fee under Section 9010 of the ACA. The annual fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1st of the year the fee is due. The collection of the assessment has been suspended for 2017 and therefore the Company did not reflect an amount in aggregate write-ins for special surplus in the statements of assets, liabilities and capital and surplus as of December 31, 2016.

Capitalization

In accordance with Article III, Section 3.1 of its Amended Bylaws which were effective December 16, 2015, the Company shall be a membership corporation, operated as a not-for-profit organization, and shall not have the authority to issue capital stock.

Dividends

The Company's organization structure does not allow for dividends to be paid.

MANAGEMENT AND CONTROL

Directors

Pursuant to the General Corporation Law of the State of Delaware, as implemented by the Company's Certificate of Incorporation and Bylaws, all corporate powers and its business property and affairs are managed by, or under the direction of, its Board of Directors (Board). The Board of the Company is elected by the sole member (Highmark).

The Board shall consist of nine members, consisting of four Class A Directors, four Class B Directors and the President of the Company. The initial Class A Directors, effective January 1, 2012 will serve respectively, until the third, fourth, fifth and sixth annual meetings following the affiliation. Subsequent Class A Directors shall hold office for a term of three years. Class A Directors shall not be directors or officers or employees of the sole member (Highmark) or any of its affiliates. Class B Directors shall hold office for a term of one year. A majority of the persons elected to the Board of Directors of the Company at any one time shall consist of: (i) persons not employed by the Company or any of its affiliates and (ii) persons who are residents of the State of Delaware and have been so for at least five (5) years prior to election.

The management and control of the Company is vested in the Board. The persons elected and serving as Directors of the Company as of December 31, 2016 were:

Directors	**Primary Business Affiliation**
Timothy J. Constantine Wilmington, DE	President, Highmark BCBSD Inc. Class A Director
Gregory B. Williams Esquire Wilmington, DE	Partner, Fox Rothschild Former President of the Delaware State Bar Association Class A Director
Randeep S. Kahlon, MD Newark, DE	Equity and Ownership Interest, First State Orthopedics, First State Surgical Center and Go Care Urgent Care. Class A Director
David P. Roselle, Ph.D. Wilmington, DE	Director, Winterthur Museum, Garden and Library Class A Director
William H. Willis, Jr. Wilmington, DE	President of Willis Chevrolet, Inc. , Willis Ford, Inc. and Willis Automotive Class A Director, Chairman of the Board
Frances M. West Wilmington, DE	Retired, State of Delaware Employee, Past President of the BBB of Delaware. Class B Director
*Kurt C. Small Pittsburgh, PA	SVP, Health Plan Operations Highmark Inc. Class B Director

Jean Rush Pittsburgh, PA	EVP, Government Markets Highmark Choice Companies. Class B Director
William D. Cronin Pittsburgh, PA	Senior Vice President of Treasury Services, Assistant Treasurer and Chief Risk Officer for Highmark Health Class B Director

*Michael G. Warfel replaced Kurt C. Small as Class B Director on March 6, 2017.

Officers

The Officers of the Company are elected by the Board. Those persons serving as of December 31, 2016 were:

Name	Title
Timothy J. Constantine	President
David E. Westervelt *	Treasurer
Gertrude C. McGowan, Esquire	Corporate Secretary

* The Board elected Heather Price to replace David E. Westervelt as Treasurer on May 12, 2017, effective May 15, 2017.

The minutes of the meetings of the Board and Committees, which were held during the period of examination, were read and noted. Attendance at meetings, election of directors and officers and approval of investment transactions were also noted.

Corporate Records

The recorded minutes of the shareholder and Board of Directors were reviewed for the period under examination. The recorded minutes of the Board of Directors adequately documented its meetings and approval of Company transactions and events including approval of investment transactions.

On May 13, 2016 the Board of Directors of the Corporation, upon the recommendation of the Audit & Compliance Committee, adopted the Highmark Health Corporate Integrity and Compliance Program, including the Highmark Corporate Compliance Policies and Code of Business Conduct, and adopted the Highmark Health Third Party Code of Business Conduct, as presented and as amended or supplemented from time to time throughout the year by the

Board of Directors of Highmark. Furthermore, the Board of Directors of the Company confirmed that the Chief Auditor and Compliance Officer of Highmark Health be designated as the authorized representative of the Company for the purposes of administering the Integrity and Compliance Program for and on behalf of the Company. Amendments to the Highmark Health Corporate Integrity and Compliance Program were approved May 12, 2017, and the Program is annually adopted and reaffirmed.

Committees

The Company's Audit and Compliance Committee Charter was amended March 8, 2016 and again on December 1, 2017.

The Board of Directors of Highmark BCBSD Health Options Inc. (DHOP) delegated to the Audit & Compliance Committee of the Board of Directors of BCBSD the responsibility to make certain audit-related recommendations to the Board of Directors of Health Options as the Audit & Compliance Committee deems necessary and appropriate to enable the Board of Health Options to perform its oversight responsibilities.

Members serving on the Audit and Compliance Committee as of December 31, 2016 were:

Randeep S. Kahlon, M.D. Chairperson
David P. Roselle, Ph.D.
Frances M. West, Esq.
William H. Willis, Jr.

The Company also has a Nominating Committee whose Charter was reaffirmed on June 12, 2014 with no changes. Members serving on the Nominating Committee as of December 31, 2016 were:

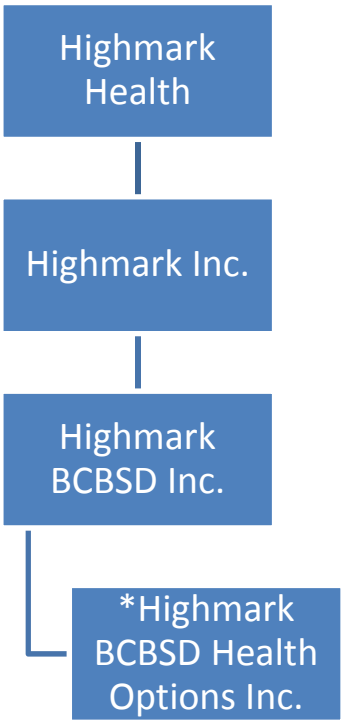
David P. Roselle, Ph.D., Chairperson
Randeep S. Kahlon, M.D.
William H. Willis, Jr.
Gregory B. Williams, Esq.

The Nominating Committee Charter was subsequently amended and approved on December 1, 2017 to include a diversity provision in the Charter.

Insurance Holding Company System

The Company is a member of an insurance holding company system as defined under 18 *Del. C.* § 5001 (4) Insurance Holding Company System. Although there is no ownership of a non-stock corporation, the Company is a direct subsidiary of Highmark.

The following is an abbreviated organization chart as of the examination date:



*Highmark BCBSD Health Options Inc. ("DHOP"), a Delaware nonprofit of which the Corporation is the sole corporate member.

The examiners have reviewed the Company's most recently filed Form B Insurance Holding Company Registration Statement. Based on that review, it appears that the Company

has disclosed all intercompany arrangements and in turn has filed the applicable information/agreements with the Department.

The Company's total premium and annuity considerations for the year ended December 31, 2016 were as follows:

Direct Accident and Health	$ 575,174,052
Federal Employee Program	128,954,288
Total Direct Written Premium	$ 704,128,340

Affiliated Agreements

Administrative Services Agreement with Highmark Inc.

The Company entered into an Administrative Service Agreement with Highmark Inc. effective January 1, 2012 in connection with the Affiliation Approval. The agreement establishes a plan of systems conversion and integration priorities, performance standards, budgets and timelines. The scope of services and plan of systems integration includes, but is not limited to, services in the following areas:

- Executive management
- Finance, financial administration, accounting and investment management
- Payroll, employee benefits management and human resource/employee relations
- Corporate training
- Procurement
- Corporate communications
- Audit, compliance and integrity
- Computer and data processing
- Marketing and sales
- Actuarial and underwriting
- Pharmacy/prescription drugs
- Customer service
- Enrollment and membership
- Claims adjudication and administration
- Spending/reimbursement account administration
- Broker and agent administration
- Credentialing
- Utilization management
- Quality assurance

- Grievances and complaints
- Member agreements and literature
- Provider relations; and
- Such other services as the parties may agree from time to time

The Company and Highmark are to implement the plan of systems conversion referred to in the Affiliation Agreement between the companies. Costs charged or allocated to the Company by Highmark for integration services are to be capped at $42 million. Costs in excess of $42 million, which was reached in 2013, are to be paid or absorbed by Highmark. No further charges were made and amortization of those costs ended in 2016.

The Company is to compensate Highmark's provision of services in an amount equal to the Company's fair and reasonable allocable share of the total actual cost without provision for profit to Highmark. Such costs shall include without limitation, employee salaries, employee benefits and other direct and indirect administrative costs including reasonable charges for corporate overhead. The Company's allocable share of the cost of the services shall be determined in accordance with Highmark's established cost accounting practices as in effect from time to time. The Company also shall reimburse Highmark for any and all direct third-party costs incurred by Highmark for the benefit of the Company.

Highmark is to invoice the Company on a regular basis for amounts due, and the Company shall pay all amounts due to Highmark upon receipt of the invoice. The Company shall pay a service charge of 1% per month on the amount of any invoice remaining unpaid more than 30 days following the due date. The agreement was initially in effect for one year and renewable automatically for successive terms of one year each subject to prior written notice of termination.

The Companies amended the Services Agreement to add a Service Level Amendment (SLA) thereto, for the purpose of defining, managing and measuring performance levels of support which will be provided by Highmark to the Company.

Administrative Service and Network Access with United Concordia

The Company entered into an Administrative Service and Network Access Agreement with United Concordia Companies, Inc., (United Concordia), effective May 29, 2013. The Company desires to engage United Concordia to provide certain services to administer the Company's Blue Cross Blue Shield-branded dental business. This Agreement applies to administration of dental products that are branded and written by BCBSD.

United Concordia will provide BCBSD with those support services as specified below:

- Dental Director
- Peer Review/Quality Review
- Business Systems, and Records relations
- Benefit Determinations
- Member Services (services related to dental claims and benefits)
- Underwriting
- Claims Management and Administration
- Claims Management Standards and Compliance Obligations
- Performance Standards
- Product Development

United Concordia agrees to provide members who are covered under the BCBSD Dental Products with access to (a) its Concordia Advantage Plus and Concordia Advantage networks and (b) any future or additional networks that United Concordia may acquire or develop that the parties mutually agreed upon.

United Concordia shall obtain and maintain all credentialed dental network certificates required by applicable law through the term of this Agreement.

United Concordia shall notify providers that BCBSD Members have been granted access to its provider network in accordance with this Agreement. The Company's obligation under the agreement is as follows:

- Billing
- Member Services (billing, enrollment, producer commissions and usage)
- Delinquencies
- Enrollment
- Enrollment Data, Services and Follow-up
- Responsibility for Accuracy of Enrollment Data
- Marketing
- Producer Management and Compensation
- Misrouted Claims
- Payment of Claims

This agreement was last amended on January 1, 2015.

Administrative Services Agreement with Highmark Inc.

The Company entered into an Administrative Service Agreement with Highmark effective July 9, 2014. The Company is prepared to provide certain administrative and corporate services, and to make available certain facilities and equipment to Highmark for its business operations. The services will or may include, but are not necessarily limited to, services in the following areas:

- Executive Management
- Finance, financial administration, accounting, and investment management
- Employee benefits management and human resource/employee relations
- Corporate training
- Procurement
- Corporate communications
- Audit, compliance and integrity
- Facility management, operations, and floor space
- Network infrastructure
- Data processing services
- Application support and development services
- Marketing and sales
- Actuarial and underwriting
- Customer service

- Enrollment and membership
- Claims adjudication and administration
- Broker and agent relationships
- Utilization management
- Quality assurance
- Grievances and complaints
- Member agreements and literature
- Provider relations
- Administrative and regulatory compliance; and
- Such other services as the parties may agree from time to time

The Company will invoice Highmark on a monthly basis for amounts due under this Agreement, and Highmark shall pay all amounts due to the Company upon receipt of the invoice, but in no event later than 30 days after receipt of the invoice. Highmark shall pay the Company a service charge in the amount of one percent (1%) per month of the amount of any invoice remaining unpaid more than 30 days following the date thereof until such invoice shall be paid in full. The agreement was initially in effect for one year and renewable automatically for successive terms of one year each subject to prior written notice of termination.

Agreement for Vision Administrative Services

The Company entered into an agreement effective January 1, 2008 with Davis Vision, Inc. (Davis) whereby Davis agrees to provide the Company those administrative services as specified in the contract. Such services shall apply to all vision business sold by the Company, as well as such other vision lines of business as mutually agreed to by the parties from time to time. The Company will provide data and support to Davis as detailed in the agreement. This agreement was amended effective January 1, 2015, January 1, 2016 and January 1, 2017.

Administrative Services Agreement with Gateway Health Plan®, LP (Gateway)

The Company's subsidiary, DHOP, entered into an Administrative Service Agreement with Gateway, effective November 1, 2014. DHOP requires and Gateway will provide DHOP,

with administrative services with respect to Delaware Medicaid programs known as Diamond State Health Plan (DSHP) and the Diamond State Health Plan Plus (DSHP Plus), with enrollment beginning November 1, 2014 and membership services beginning January 1, 2015. The parties acknowledge that the Company, Highmark and Highmark Health also provide services to DHOP under separate agreements and to embody their agreements with respect to the matters referred to in this Agreement.

During the term of this Agreement, Gateway shall provide to DHOP, such services as the parties may determine from time to time are necessary for DHOP, and appropriate for Gateway to provide to assist DHOP, in the conduct of its Health Options business operations (such services collectively, the Services). The Services include both administrative functions and delegated operational functions identified as integral to managed care operations. Made part of the amended and restated Agreement were fully executed Business Associate Agreement (BAA), a Non-Disclosure Agreement and Exhibit V, effective October 28, 2015. The BAA was for one or more arrangements or agreements which require the Company's Business Associates to perform functions or activities on behalf of, or services for, a Covered Entity which involves the access, use or disclosure of Protected Health Information (PHI). The purpose of the BAA was to set forth the obligations of the Parties with respect to such PHI. The Non-Disclosure Agreement was originally entered October 31, 2014. Currently the Agreement provides provisions for the use of confidential information between the parties. Exhibit V set forth additional financial terms as agreed by the parties and included an assumption of financial risk by the Company. This agreement was amended effective January 1, 2016.

Administrative Services Agreement with DHOP

The Company entered into an Administrative Service Agreement with DHOP effective January 1, 2015. Under the Agreement, the Company provides certain administrative and corporate services, facilities and equipment for DHOP to conduct its business.

Stop Loss Preferred Carrier Agreement

The Company has selected HM Life Insurance Company (HM LIFE) to be its preferred stop loss carrier and has entered into an agreement effective the 1st day of January 2012, along with its first amendment. Company provides certain administrative services to self-funded employee welfare benefit plans which are sponsored by and/or funded in whole or in part by an employer (Employer). For the purposes of this Agreement, the term Employer refers only to those employers that have entered or may enter into an administrative services agreement with the Company and may purchase or have purchased stop loss coverage from HM LIFE (Policy or Policies).

Non-affiliated Agreements

Letter of Credit

In compliance with Condition 47 of the Affiliation Approval, Final Order dated April 26, 2013, Highmark obtained an Irrevocable Letter of Credit from PNC Bank, in favor of the Company for an aggregate total sum of $27.5 million which shall be made available if disaffiliation occurs as a result of a triggering event within the first 5 years after the closing of the Highmark/WPAHS affiliation. The Letter of Credit has not been utilized during the examination period.

There were no other material non-affiliated agreements.

TERRITORY AND PLAN OF OPERATION

The Company is licensed to solicit business as a Health Service Corporation in the State of Delaware only. The Company writes primarily Comprehensive (medical and hospital) business. A significant portion of the Company's business (approximately 57%) is "non-underwritten", meaning there is no insurance risk to the Company. For large, self-insured accounts, the Company processes claims payments and receives reimbursement for claims and expenses from the account. The ACA business represents approximately 9% of Highmark's business in Delaware.

The Company offers a comprehensive portfolio of health insurance products and administrative services to individuals and accounts throughout the State of Delaware. The administrative services provided include management of benefits, adjudication and payment of claims, response to inquiries from covered individuals and health care providers and providing Plan Sponsors with information enabling them to manage their health benefit programs. The Company's core health insurance products are categorized into 2 major segments:

1. **Delaware Group Business**
   Traditional
   - Comprehensive Major Medical

   Senior
   - Medigap

   Managed Care
   - Exclusive Provider Organization, (EPO)
   - Federal Employee Program (FEP)
   - Preferred Provider Organization (PPO)

2. **Individual Business**
   Managed Care
   - Exclusive Provider Organization, (EPO)
   - Preferred Provider Organization (PPO)

Senior

- Medigap Blue

The total for underwritten business and Federal Employee Program (FEP) business is broken down by the following lines of business:

Line of Business	Direct Premiums Written	Percent Premiums
Individual Business	$178,192,112	25.31%
Group Business	378,703,893	53.78%
Total Comprehensive (Medical and Hospital)	$556,896,005	79.09%
Medicare Supplement	15,218,216	2.16%
Dental Only	1,917,621	0.27%
Vision Only	833,108	0.12%
FEP *	128,954,288	18.32%
Other Health	309,102	0.04%
Total Premiums	$704,128,340	100.00%

* Note: The FEP Business is non-underwritten business; however, the NAIC Annual Statement has certain reporting requirements with regards to FEP business on certain schedules within the Annual Statement. As a result, the Company must include the FEP business on the statutory balance sheet so that the balance sheet will tie to the supporting schedules of the Annual Statement.

REINSURANCE

The Company reported the following distribution of premiums written for the year ended December 31, 2016 and the prior examination date of December 31, 2012:

	2016	% GPW	2012	% GPW
Direct business	$ 704,128,340	100.0%	$ 536,600,893	100.0%
Reinsurance assumed from affiliates	-	0.0%	-	0.0%
Reinsurance assumed from non-affiliates	-	0.0%	-	0.0%
Gross premiums written	$ 704,128,340	100%	$ 536,600,893	100%
Reinsurance ceded to affiliates	$ -	0.0%	$ -	0.0%
Reinsurance ceded to non-affiliates	977,866	100.0%	-	0.0%
Total ceded	$ 977,866	100.0%	$ -	0.0%
Net premiums written	$ 703,150,474	99.9%	$ 536,600,893	100.0%

During 2016, the Company ceded less than 1% of direct gross premium written. As of December 31, 2016 the Company reported total gross reinsurance recoverable of $10,413,964. The gross reinsurance recoverable consisted of $10,122,990 recoverable for paid claims due to ACA Reinsurance program and $290,974 claims unpaid due to ACA Reinsurance program.

The Company is party to an agreement with MedAmerica Insurance Company (MedAmerica), for 100% coverage of risk to reinsure the Corporation's long-term care (LTC) insurance. The Company's agreement with MedAmerica permits either party the right to terminate the agreement with a two-year notice for new and renewal policies.

The total amount of net reinsurance credits taken, whether as an asset or as a reduction of liability, for reinsurance arrangements were as follows as of December 31, 2016:

LTC reinsurance	$ 5,446,960
U.S. Department of Health and Human Services	$ 9,733,571
Total reinsurance credits	$15,180,531

These accounts include agents' balances and uncollected premiums including non-admitted balances, reinsurance payable on paid losses and loss adjustment expenses, provision for reinsurance and certain other underwriting-related receivables.

FINANCIAL STATEMENTS

The following financial statements, as reported and filed by the Company with the Department, are reflected in the following:

- Statement of Assets as of December 31, 2016
- Statement of Liabilities, Capital and Surplus as of December 31, 2016
- Statement of Income for the year ended December 31, 2016
- Reconciliation of Capital and Surplus

Statement of Assets
As of December 31, 2016

	Assets	Non admitted Assets	Net Admitted Assets	Notes
Bonds	$ 150,526,228	$ 0	$ 150,526,228	1
Common stocks (stocks)	69,912,772		69,912,772	2
First liens - mortgage loans on real estate	161,089		161,089	
Cash, Cash Equivalents and Short-term Investments	31,953,646		31,953,646	1
Other invested assets	6,848,518	3,000,000	3,848,518	
Receivables for securities	112,299		112,299	
Securities lending reinvested collateral assets	5,251,401	-	5,251,401	
Subtotals, cash and invested assets	$ 264,765,953	$ 3,000,000	$ 261,765,953	
Investment income due and accrued	1,499,983		1,499,983	
Uncollected premiums and agents' balances in the course of collection	20,843,391	247,606	20,595,785	
Accrued retrospective premiums	941,457		941,457	
Amounts recoverable from reinsurers	0		0	
Other amounts receivable under reinsurance companies	10,122,990		10,122,990	
Amounts receivable relating to uninsured plans	37,789,525	239,005	37,550,520	
Current federal and foreign income tax recoverable and interest thereon	2,382,006		2,382,006	
Electronic data processing equipment and software	15,702		15,702	
Furniture and equipment; including health care delivery assets	1,871,880	1,871,880	-	
Receivable from parent, subsidiaries and affiliates	10,228,392	883,444	9,344,948	
Health care and other amounts receivable	20,738,716	1,927,223	18,811,493	
Aggregate write-ins for other-than-invested assets	17,908	17,908	-	
Totals	$ 371,217,903	$ 8,187,066	$ 363,030,837	

Statement of Liabilities, Capital and Surplus
As of December 31, 2016

		Notes
Claims unpaid (less reinsurance ceded)	$ 73,915,314	3
Accrued medical incentive pool and bonus amounts	290,980	
Unpaid claims adjustment expenses	2,562,258	4
Aggregate health policy reserves, including the liability of $0 for medical loss ratio rebate per the Public Health Service Act	4,048,278	5
Premiums received in advance	10,570,848	
General expenses due or accrued	84,144,506	
Current federal and foreign income taxes	-	
Ceded reinsurance premiums payable	680,393	
Amounts withheld or retained for the account of others	157,302	
Dividends declared and unpaid to Policyholders	-	
Amounts due to parent, subsidiaries and affiliates	6,000	
Payable for securities lending	5,251,401	
Liability for amounts held under uninsured plans	12,215,637	
Aggregate write-ins for other liabilities (including $0 current)	19,622,828	
Total liabilities	$ 213,465,745	
Unassigned funds (surplus)	$ 149,565,092	
Surplus as regards policyholders	$ 149,565,092	
Totals	$ 363,030,837	

Statement of Income
For the Year Ended December 31, 2016

	Uncovered	Total	Notes
Member months		1,486,799	
Net premium income		$ 703,150,474	
Change in unearned premium reserves and reserve for rate credits		2,660,061	
Total revenues		$ 705,810,535	
Hospital/medical benefits	-	$ 492,243,168	
Prescription drugs	-	133,735,289	
Aggregate write-ins for other hospital and medical	-	1,769,817	
Incentive pool, withhold adjustments and bonus amounts	-	2,264,271	
Subtotal	-	$ 630,012,545	
Net reinsurance recoveries	-	9,010,427	
Total hospital and medical	-	$ 621,002,118	
Claims adjustment expenses, including $9,369,052 cost containment expenses	-	19,612,559	
General administrative expenses	-	62,090,400	
Increase in reserves for life and accident and health contracts (less)	-	(6,525,000)	
Total underwriting deductions	-	$ 696,180,077	
Net underwriting gain or (loss)		9,630,458	
Net investment income earned	-	6,530,098	
Net realized capital gains or (losses) less capital gains tax of $0	-	13,896	
Net investment gains or (losses)	-	$ 6,543,994	
Net gain or (loss) from agents' or premium balances charged off	-	-	
Aggregate write-ins for other income or expenses	-	5,682,277	
Net income or (loss); after capital gains tax and before all other federal income taxes		$ 21,856,729	
Federal and foreign income taxes incurred		2,786,931	
Net income (loss)		$ 19,069,798	
Capital and surplus prior reporting year		$ 120,838,870	
Net income or (loss) from Line 32		19,069,798	
Change in net unrealized capital gains (losses) less capital gains tax		3,917,197	
Change in net deferred income tax		2,248,195	
Change in nonadmitted assets		3,491,032	
Net change in capital and surplus for the year		$ 28,726,222	
Surplus as regards policyholders, December 31, 2016		$ 149,565,092	

Reconciliation of Capital and Surplus
For the Period from the Prior Examination
As of December 31, 2012 to December 31, 2016

Surplus as regards to policyholders, December 31, 2012	$ 168,660,304
Net Income	(20,030,627)
Change in net unrealized capital gains/(losses)	13,814,786
Change in unrealized foreign exchange capital gains	
Change in net deferred income taxes	(24,671,217)
Change in non-admitted assets and related items	43,365,097
Change in liability for reinsurance in unauthorized companies	
Change in reserve on account change in valuation basis	
Change in asset valuation reserve	
Cumulative effect of changes in accounting principles	
Dividends to stockholders	
Aggregate write-ins *	(31,573,251)
Net change in surplus as regards to policyholders	(19,095,212)
Surplus as regards to policyholders, December 31, 2016	$ 149,565,092

* 2013 Impact of SSAP 92 and SSAP 102 adoption, net tax.

ANALYSIS OF CHANGES IN FINANCIAL STATEMENTS RESULTING FROM THE EXAMINATION

There were no changes made to the Financial Statements as a result of this Examination.

COMMENTS ON FINANCIAL STATEMENT ITEMS

Note 1:

Bonds	$150,526,228
Short-term Investments	$ 36,292,053

As of December 31, 2016, the Company's investment in bonds which are reported at values adopted and approved by the Securities Valuation Office (SVO) of the NAIC. The Company's bonds were comprised of the following classes:

	Statement Value	% of Total
U.S. Government Bonds	$ 68,166,380	36.5%
U.S.States, Territories and Possessions	$ 1,490,747	0.8%
U.S. Political Subdivisions of States and Territories	$ 383,102	0.2%
U.S. Special Revenue - Issuer Obligations	40,103,937	21.5%
Industrial & Miscellaneous	75,337,730	40.3%
Hybrid Securities	1,336,385	0.7%
Total Bonds (Schedule D)	$ 186,818,281	100.0%

Of the Company's total bond holdings, 76.0% and 10.7% were categorized as Class 1 and Class 2 respectively, with respect to NAIC credit quality. The Bond holdings were 90.4% publicly traded and 9.6% privately placed securities. Bond maturities were heavily weighted to the short-term relative to maturity with 27.0%, 41.7%, 19.2%, 6.3% and 5.9% maturing in less than one year, one to five years, five to ten years, ten to twenty years, and over twenty years respectively.

Note 2:

Common Stock	$69,912,772

As of December 31, 2016, the Company held common stocks securities as follows:

Type	Statement Value
Industrial and miscellaneous (unaffiliated)	$ 1,527,934
Mutual Funds	68,384,838
Total	$ 69,912,772

Note 3:
Claims Unpaid $73,915,314

The Pennsylvania Insurance Department retained the services of Taylor-Walker Consulting LLC (Taylor-Walker), to conduct an independent review of the Company's loss and LAE reserves as of December 31, 2016. The Taylor-Walker analysis was performed using a risk- focused approach according to the guidelines contained in the NAIC Handbook. Their review does not address the collectability of reinsurance recoverable.

The conclusions set forth in Taylor-Walker report are based on information provided by the Company, including the 2016 Annual Statements and the related 2016 Statement of Actuarial Opinion with underlying actuarial work papers.

The Department appointed INS Consultants, Inc. (INS) to review the lead state's actuarial report. No material exceptions were noted during INS' actuarial review of the Company's reserves. The examination determined the Company's Claims Unpaid and Unpaid Claims Adjustments Expenses and the Aggregate Health Policy Reserves were properly stated without material exception as of December 31, 2016.

Note 4:
Unpaid Claims Adjustment Expenses $2,562,258

The amount is established to cover expenses associated with the claims unpaid liability for the Company's insured business. INS reviewed the lead state's actuarial report provided by the Company for the unpaid claims adjustment expenses. The unpaid claims adjustment expense of $2,562,258 is 3.47% of the unpaid claims liability of $73,915,314. The 3.47% factor falls within the accepted industry range of 2%-10%. INS also performed a trend analysis which

indicated a reasonable trend over the examination period. Consequently, INS concluded that the unpaid claims adjustment expenses were fairly stated.

Note 5:

Aggregate Health Policy Reserves	$4,048,278

This reserve is primarily for unearned premiums relating to Federal Employee Program (FEP). INS concluded that the Aggregate Health Policy Reserves were fairly stated.

The Company participates in the Blue Cross and Blue Shield FEP, which is one of the plans offered through the Federal Employee Health Benefits Program (FEHBP), administered by the Office of Personnel Management (OPM). Claims incurred on behalf of FEP are reported as revenues during the period in which the claims are incurred. The related administrative fees are recognized as revenues as they are earned during the contract period. The Blue Cross and Blue Shield Association (BCBSA) contracts directly with OPM to administer the FEP and subcontracts with CFMI, GHMSI and BCBSD. BCBSA also provides information to the Company for inclusion in the accompanying consolidated financial statements. The BCBSA contract and the Company's subcontract are experience rated and could result in losses to the Company under certain circumstances. OPM conducts periodic audits to verify compliance with FEHBP requirements. OPM holds certain reserves on behalf of the Company to provide funding, if necessary, for excess claims costs, subject to certain limitations. The Company records its allocable share of amounts held by OPM as an asset, with an equivalent amount recorded as unearned revenues.

SUBSEQUENT EVENTS

There were no material subsequent events.

SUMMARY OF RECOMMENDATIONS

There were no recommendations as a result of this examination.

CONCLUSION

The assistance and cooperation of examiners representing the states on the coordinated examination is acknowledged. In addition, the assistance of the consulting actuarial firm, INS Consultants, Inc., the consulting information systems specialist firm, INS Services, Inc., the Company's outside audit firm, PricewaterhouseCoopers LLP, and the Company's management and staff was appreciated and is acknowledged.

Respectfully submitted,

Greg Taylor, CFE
Examiner-In-Charge
State of Delaware

Respectfully submitted,

Anthony Cardone, CFE
Supervising Examiner
State of Delaware