EXAMINATION REPORT
of
ANTHEM HEALTH PLANS OF VIRGINIA, INC.
Richmond, Virginia
as of
December 31, 2007

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

ALFRED W. GROSS
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

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I, Alfred W. Gross, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Examination Report of Anthem Health Plans of Virginia, Inc. as of December 31, 2007, is a true copy of the original report on file with this Bureau.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed to the original the seal of the Bureau at the City of Richmond, Virginia this 11th day of March, 2009

Alfred W. Gross
Commissioner of Insurance

(SEAL)

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Richmond, Virginia
December 5, 2008

Honorable Alfred W. Gross
Commissioner of Insurance
Richmond, Virginia

Dear Sir:

Pursuant to your instructions and by the authority of Section 38.2-1317 of the Code of Virginia, an examination of the records and affairs of

ANTHEM HEALTH PLANS OF VIRGINIA, INC.
Richmond, Virginia

hereinafter referred to as the Corporation, has been completed. The report thereon is hereby submitted for your consideration.

DESCRIPTION

The Corporation is a stock accident and sickness insurance company licensed under and subject to the general insurance laws contained in Title 38.2 of the Code of Virginia. The Corporation was converted from a mutual insurer, doing business as Trigon Blue Cross and Blue Shield, pursuant to Section 38.2-1005.1 of the Code of Virginia. The Corporation was last examined by representatives of the State Corporation Commission's ("Commission") Bureau of Insurance ("Bureau") as of December 31, 2004. This examination covers the period from January 1, 2005 through December 31, 2007.

HISTORY

The Corporation was initially chartered on October 14, 1935 as the Richmond Hospital Service Association and its name was eventually changed to Blue Cross of Virginia in 1968. Blue Shield was chartered on October 21, 1944 as the Associated Doctors of Virginia and its name was eventually changed to Blue Shield of Virginia in 1968. On March 31, 1982, Blue Shield of Virginia was merged into Blue Cross of Virginia. In 1986, Blue Cross and Blue Shield of Southwestern Virginia was reorganized and merged into Blue Cross and Blue Shield of Virginia.

On May 31, 1989, as part of a corporate reorganization, Virginia Healthcare Foundation, the sole member of the Corporation at that time, contributed its 100% ownership of the common stock of Consolidated Healthcare Inc. to the Corporation. Several acquisitions were subsequently made to expand the Corporation's business in the managed care market. The acquisitions included two health maintenance organizations, Peninsula Health Care, Inc. ("Peninsula") and Priority Health Care, Inc. ("Priority") and Primary Care First, L.L.C., a company that manages and develops primary care physician networks.

During 1996, the Corporation submitted a plan of demutualization to the Commission under which it would be converted to a stock insurance corporation, change its name to Trigon Insurance Company and become a wholly-owned subsidiary of a newly formed holding company, Trigon Healthcare, Inc. ("THI"). After the review process was completed, the Commission approved the plan effective in February, 1997. The plan included the sale of 17.8 million shares of common stock through an initial public offering and the distribution of 24.4 million shares of common stock to the existing membership. After the conversion, the Corporation and its affiliates underwent a major reorganization with the intent of streamlining the corporate structure. Several subsidiaries were disposed of by dividend and then merged with and into other affiliates.

In April, 2002, the Corporation's ultimate parent, THI, announced an agreement in principle to merge with Anthem, Inc. ("Anthem"), an Indiana domiciled insurance holding company specializing in Blue Cross and Blue Shield type organizations. This transaction consisted of an exchange of Anthem stock plus cash for each share of THI stock. Under the agreement and plan of merger, THI merged into a wholly owned subsidiary of Anthem and changed its name to Anthem Southeast, Inc. ("Anthem Southeast"). The acquisition of THI by Anthem was approved by the Commission and was finalized effective July 31, 2002.

On October 27, 2003, Anthem and WellPoint Health Networks, Inc. (WellPoint) announced an agreement and plan of merger in which WellPoint and all WellPoint subsidiaries would merge into a wholly owned subsidiary of Anthem. The transaction consisted of an exchange of Anthem stock plus cash for each share of WellPoint's stock. Pursuant to the merger, WellPoint merged with and into Anthem Holding Corp., a direct and wholly-owned subsidiary of Anthem, with Anthem Holding Corp. being the surviving entity. The merger was approved by the Commission and the transaction was finalized effective November 30, 2004. In connection with the merger, Anthem amended its articles of incorporation to change its name to WellPoint, Inc. At December 31, 2007, the Corporation is a wholly-owned subsidiary of Anthem Southeast.

MANAGEMENT AND CONTROL

The bylaws of the Corporation provide that the affairs of the Corporation shall be managed by a board of three directors. A majority of the directors shall constitute a quorum for the transaction of business.

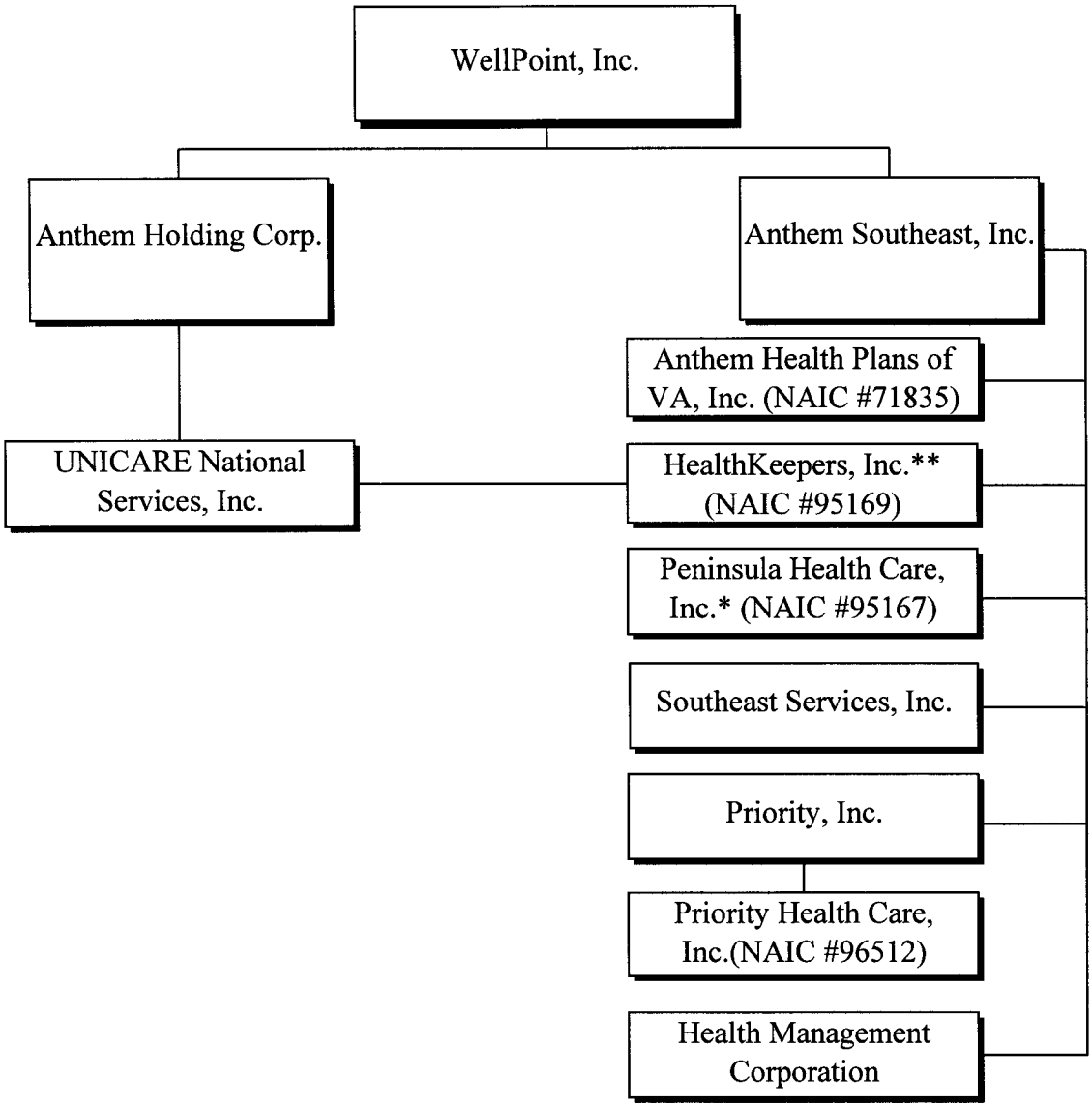
The officers of the Corporation shall consist of a Chairman of the Board, a President, a Secretary, a Treasurer, and such other officers as the board may from time to time deem necessary. The Chairman of the Board shall have the authority to appoint administrative officers such as Vice Presidents, Assistant Secretaries and Assistant Treasurers and to perform such functions and duties as prescribed and approved by the President. The President shall be the Chief Executive Officer and shall perform such duties as may be required by law or as may be delegated to him by the Board of Directors.

At December 31, 2007, the Board of Directors and Officers of the Corporation were as follows:

Director	Principal Occupation
Thomas R. Byrd	President Anthem Health Plans of Virginia, Inc. Richmond, Virginia
Wayne S. DeVeydt	Executive Vice President and Chief Financial Officer WellPoint, Inc. Indianapolis, Indiana
Sandra H. Miller	Senior Vice President and Deputy General Counsel WellPoint, Inc. Indianapolis, Indiana

Officers	
Thomas R. Byrd	Chairman and President
Nancy L. Purcell	Secretary
S. Owen Hunt	Assistant Secretary
R. David Kretschmer	Treasurer

The Corporation is a member of an insurance company holding system as defined in Section 38.2-1322 of the Code of Virginia. The chart on the following page illustrates the organizational structure of the Corporation and selected affiliated entities at December 31, 2007.



* Peninsula Health Care, Inc. is 51% owned by Anthem Southeast, Inc. and 49% owned by Riverside Healthcare Association, Inc.("RHA"). Effective July 7, 2008 Anthem Southeast purchased the outstanding shares of common stock owned by RHA. Following this purchase Anthem Southeast owns 100% of Peninsula Health Care Inc.'s outstanding common stock.

** HealthKeepers, Inc. is 88.89% owned by Anthem Southeast, Inc. and 11.11% owned by UNICARE National Services, Inc.

TRANSACTIONS WITH AFFILIATES

Master Administrative Services Agreement

Effective January 1, 2006, the Corporation entered into a Master Administrative Services Agreement with WellPoint and its subsidiaries and affiliates (collectively referred to as the "affiliates"). According to the agreement, each affiliate that is party to the agreement may provide certain administrative, consulting and support services to another affiliate upon request. The affiliate rendering services shall be reimbursed for the direct and indirect costs and expenses incurred in providing such services and reimbursement is due within 30 days upon receipt of a statement for the services rendered. The term of the agreement is one year and shall be automatically renewed for additional one-year periods unless terminated upon 90 days written notice. The Corporation incurred $81,387,106 in fees related to the agreement in 2007.

Accounts Payable Agreement

Effective October 8, 2004, the Corporation entered into an Accounts Payable Agreement with and among Anthem, Inc. (currently WellPoint, Inc.), Anthem Insurance Companies, Inc., The Anthem Companies, Inc., Southeast Services, Inc., HealthKeepers, Inc., Peninsula and Priority. According to the agreement, each of the above parties can act as a transfer agent for any of the other parties in order to achieve administrative efficiencies. As such, the transfer agent takes on the responsibility for transmitting or receiving payment with respect to an account receivable owed by or to another party, affiliate or non-affiliate. The transfer agent agrees to transmit any payment it receives on behalf of a party with respect to an account receivable within the month following the date payment is received by the transfer agent. Likewise, a party for whom a transfer agent has made payment of an account receivable on its behalf will reimburse the transfer agent within the month following the payment. No service fee will be charged and the transfer agent will bear its own cost in performing its services pursuant to the agreement. The initial term of the agreement is one year and it shall renew automatically for one-year terms. A party may terminate its participation in the agreement by giving written notice to all other parties six months in advance.

Administrative Services Agreement

Effective January 1, 2003, the Corporation entered into an Administrative Services Agreement with The Anthem Companies, Inc. (TAC). Pursuant to the agreement, TAC shall provide the Corporation with administrative, clerical, executive, technical and operational skills and the staff to provide such skills. As compensation, the Corporation pays TAC its cost in providing such staff, including salaries, wages, workers' compensation, disability, illness or sickness benefits, social security obligations and all

other compensation related obligations. The Corporation reimburses TAC monthly within thirty days of the end of the month. The agreement shall remain in effect until terminated by either party upon thirty days written notice. The Corporation incurred $199,264,345 in fees related to the agreement in 2007.

Excess Medical Stop Loss Agreement

Effective January 1, 2000, the Corporation entered into separate Excess Medical Stop Loss Agreement with HealthKeepers, Peninsula and Priority (hereinafter collectively referred to as the "affiliated HMOs"). Pursuant to these agreements, the Corporation shall reimburse the affiliated HMOs 100% of the losses paid during the annual twelve-month policy period ending December 31 in excess of the deductibles specified within each agreement.

For the purposes of these policies, losses are defined as amounts that are actually paid by the affiliated HMOs for medical expenses covered under the contract; in settlement of claims for medical expenses covered under the contracts; or in satisfaction of judgments for medical expenses covered under the contracts. Medical expenses are defined as covered charges for inpatient services rendered by hospitals, rehabilitation and skilled nursing facilities to persons enrolled under contracts and transplant service fees. For hospital, rehabilitation, skilled nursing facility or transplant service expenses, each expense shall be deemed to be incurred upon the date of admission to the hospital, rehabilitation or skilled nursing facility.

These agreements contain a provision that requires the affiliated HMOs to pay the Corporation up to a maximum of 30% of the initial premium in the event that the paid losses exceed 85% of that premium. Conversely, the Corporation is required to return to the affiliate HMOs up to 30% of the initial premium when paid losses are less than 85% of that premium.

The maximum lifetime excess insurance indemnity payable under these agreements for any one member shall not exceed $2,000,000. These agreements include a continuation of coverage clause and a benefits conversion clause in the event of the affiliated HMO's insolvency. Premiums and claims assumed by the Corporation related to the HealthKeepers Excess Medical Stop Loss Agreement during 2007 were $2,801,225 and $1,300,603, respectively. Premiums and claims assumed by the Corporation related to the Peninsula Excess Medical Stop Loss Agreement during 2007 were $1,635,749 and $2,697,144, respectively. Premiums and claims assumed by the Corporation related to the Priority Excess Medical Stop Loss Agreement during 2007 were $731,960 and $70,516, respectively.

Consolidated Federal Income Tax Agreement

Effective December 31, 2005, the Corporation became a party to a Consolidated Federal Income Tax Agreement with WellPoint and selected subsidiaries. The agreement establishes methods for allocating the consolidated federal income tax liability of the consolidated group among its members, for reimbursing WellPoint for payment of such tax liability, for compensating any member for use of its tax losses or tax credits and to provide for the allocation and payment of any refund arising from a carry back of losses or tax credits for subsequent taxable years. In accordance with the agreement, for each consolidated federal return year each member shall pay WellPoint an amount equal to the federal income tax payments it would incur if it were filing a separate federal income tax return. Such payments shall be made to WellPoint no later than 30 days after these payments would be due to the federal government if the subsidiary were filing a separate return. For each consolidated federal return year, WellPoint shall pay each member an amount equal to the reduction in the federal income tax liability of the consolidated group, if any, resulting from the use in any taxable year of tax benefits attributable to such member, including the use of net operating losses or tax credits. In the event of a refund, WellPoint shall pay each member its proportional share within 30 days after the refund is received.

Solvency Guarantee Agreement

The Corporation guarantees the performance, obligations, and solvency of HealthKeepers, Peninsula and Priority through a solvency guarantee agreement that was originally entered into effective April 9, 1986. This agreement remains in effect unless and until reasonable prior written notice has been given by either party to the other and the Commissioner of Insurance of the Commonwealth of Virginia has granted prior approval for such termination.

This solvency guarantee agreement was amended September 1, 1987 to include the Corporation's agreement that in the event HealthKeepers, Peninsula and Priority shall cease operations for any reason, the Corporation's coverage will be offered to all of HealthKeepers', Peninsula's or Priority's members without exclusions, limitations, or conditions based on health reasons.

Pharmaceutical Service Agreement

Effective January 1, 2004, the Corporation entered into a Pharmaceutical Service Agreement with Anthem Prescription Management, LLC ("APM") to provide covered pharmacy services to the Corporation's members. As compensation for these services, the Corporation shall pay APM an ingredient cost and a dispensing fee per covered pharmaceutical, which is dependent on whether the pharmaceutical is a brand or generic

pharmaceutical and whether it is dispensed through APM's national network of participating retail pharmacies, through APM's network of participating retail pharmacies in Virginia or through APM's mail order pharmacy. Either party may terminate the agreement upon three months advance written notice. The Corporation incurred $0 in fees related to the agreement in 2007.

Services Agreement with Health Management Corporation

Effective January 1, 2002, the Corporation entered into a Services Agreement with Health Management Corporation ("HMC") to administer its Family Health Program. The Family Health Program includes a 24-hour toll free nurse line, the Corporation's Baby Benefits Maternity Management and Chronic Disease Management products. As compensation, the Corporation pays a predetermined per member, per month amount to HMC. The agreement had an initial term of one year and renews automatically for one-year terms thereafter. Either party may terminate the agreement upon three months advance written notice. The Corporation incurred $15,635,393 in fees related to the agreement in 2007.

Services Agreement with HealthKeepers, Inc.

Effective January 1, 1996, the Corporation entered into a Services Agreement with HealthKeepers whereby the Corporation shall provide certain services as outlined in the agreement. During 2007, the Corporation provided claims processing, marketing, underwriting, actuarial, management, accounting, legal and information systems support to HealthKeepers. For these services, the Corporation shall receive all direct costs and indirect allocable costs monthly. Reimbursement pursuant to this agreement during 2007 were $5,438,578.

Information Technology Services Agreement with Anthem Insurance Companies, Inc.

Effective January 1, 2005, the Corporation entered into an Information Technology Services Agreement with Anthem Insurance Companies, Inc. ("AICI"). Pursuant to the agreement, AICI shall provide information technology services for desktop applications, security and disaster recovery, user support, applications maintenance and support, voice and data networks, internet infrastructure and eBusiness support, specific project programming, data center and data warehouse storage. For theses services, the Corporation shall pay the actual monthly costs incurred by AICI that are allocated to the Corporation based on employee headcount or direct use percentage. The Corporation incurred $45,612,612 in fees related to the agreement in 2007.

Inter-Company Service Agreement with Community Insurance Company

Effective September 1, 2005, the Corporation entered into an Inter-Company Service Agreement with Community Insurance Company ("CIC") whereby CIC shall provide certain administrative and benefit management services to support the Corporation's offering of Medicare Advantage health benefit plans to its covered members. For these services, the Corporation shall reimburse CIC a monthly fixed cost and a variable cost based on projected administrative expenses per covered member per month. Within 90 days after the end of the calendar year, a review of CIC's actual expenses incurred to support the Corporation shall be conducted. If the Corporation's monthly fixed and variable cost fees for the calendar year exceed CIC's actual costs then CIC shall refund the excess to the Corporation. If CIC's actual costs exceed the Corporation's monthly fixed and variable cost fees for the calendar year then the Corporation shall pay CIC the difference. The Corporation incurred $1,857 in fees related to the agreement in 2007.

Surplus Notes

The Corporation holds subordinated debt in its affiliate, HealthKeepers, with principal balances of $8,716,141 at December 31, 2007.

Dividends to Stockholders

The Corporation paid cash dividends of $250,000,000, $400,000,000 and $600,000,000 in 2005, 2006 and 2007, respectively. Each of the dividends was considered extraordinary and was pre-approved by the Commission. The dividends were paid to the Corporation's sole shareholder, Anthem Southeast.

CONFLICT OF INTEREST

The Corporation has adopted WellPoint's corporate conflict of interest policy. The policy states that directors, officers, and associates must discharge their business responsibilities in a manner that furthers the interest of the Corporation and must not compromise the interests of the Corporation because of a conflict of interest with their other business or personal interests. Directors, officers and certain employees are required to complete a conflict of interest disclosure form in order to disclose business and personal interests that could be adverse to the interests of the Corporation. The objective of the disclosure is to protect the interests of the Corporation and alert its directors, officers and its responsible employees to business decisions and activities for which they must exercise special care or in which they should not participate.

FIDELITY BOND AND OTHER INSURANCE

At December 31, 2007, the Corporation was listed as a named insured on WellPoint's financial institution bond with a $10,000,000 limit of liability, subject to a $750,000 deductible, to insure against losses arising from dishonest acts of its officers and employees. In addition, the Corporation was listed as a named insured on a commercial property insurance policy, a general liability policy, a business automobile liability policy, an umbrella liability policy, a workers compensation and employers liability policy, a directors and officers liability policy, a fiduciary liability policy, a managed care professional liability policy and a financial institution electronic and computer crime policy.

OFFICERS AND EMPLOYEES WELFARE AND PENSION PLANS

Prior to January 1, 2006, Anthem Insurance Companies, Inc. (Anthem Insurance) sponsored a defined benefit pension plan covering substantially all employees of the Corporation. Effective January 1, 2006, benefits were curtailed under the plan. Employees hired on or after January 1, 2006 were not eligible to participate in the plan. Most of the plan participants no longer earn pay credits; however, their existing account balances continue to earn interest, and those participants continue to earn years of pension service for vesting purposes. Certain participants were "grandfathered" into the plan based on age and years of service in previously merged pension plans. Those participants continue to receive pay credits under the plan formula. Anthem Insurance allocates a share of the total accumulated income/cost of these retirement benefits to the Corporation based on the number of allocated employees. During 2007, this income totaled $221,981. The Corporation has no legal obligation for the benefits under this plan. Effective December 31, 2007, Anthem Insurance transferred sponsorship and legal obligation for benefits under the plan to an affiliate, ATH Holding Company, LLC (ATH Holding).

Anthem Insurance sponsored a postretirement medical benefit plan which provided certain health, life, vision and dental benefits to eligible retirees. Effective December 31, 2006, Anthem Insurance transferred sponsorship of the postretirement plan to ATH Holding. ATH Holding allocates a share of the total accumulated costs of this plan to the Corporation based on the number of allocated employees. During 2007, these costs totaled $2,784,722. The Corporation has no legal obligation for the benefits under this plan.

The Corporation participates in a deferred compensation plan sponsored by WellPoint (previously sponsored by Anthem Insurance through January 1, 2006) which covers certain employees of the Corporation. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. WellPoint allocates to the Corporation a share of the cost of the plan.

During 2007, $190,831 was allocated to the Corporation. The Corporation has no legal obligation for the benefits under this plan.

The Corporation participates in the WellPoint 401(k) Retirement Savings Plan, sponsored by ATH Holding (previously sponsored by Anthem Insurance through December 31, 2006) and covering substantially all of its employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of the plans to the Corporation based on the number of allocated employees. In 2007, the amount allocated to the Corporation was $6,261,483. The Corporation has no legal obligation for benefits under this plan.

In addition to the plans outlined above, the Corporation makes available to its employees other traditional benefits such as health, life and disability income insurance.

The Corporation has also entered into "at will" employment agreements with several of its executives. Certain of these agreements provide, among other things, for a compensation package of twelve month's salary if the executive is discharged for any reason other than for cause. The agreements also contain a one year "no compete" clause.

TERRITORY AND PLAN OF OPERATION

At December 31, 2007, the Corporation was authorized to transact the business of accident and sickness insurance throughout the Commonwealth of Virginia except for a small area of Northern Virginia.

The Corporation markets its products and services to both individuals and groups. The individual products, which total approximately 14% of total enrollment as of December 31, 2007, are marketed principally through direct marketing initiatives and through brokers. The group market is approximately 86% of total enrollment as of December 31, 2007 and includes small, medium and large group employers. The Corporation also uses a salaried direct sales staff to market the full range of products and services. Sales offices are located in the following cities: Bristol, Chantilly, Charlottesville, Lynchburg, Newport News, Richmond, Roanoke, Staunton, and Virginia Beach.

The Corporation contracts with various health care providers in the area served. These include, among others, hospitals, physicians, lab services, behavioral health providers and facilities, vision services, nursing homes, home health care facilities, alcohol or drug treatment facilities, pharmacies and dentists. These contractors are designated as participating providers and as such render services to subscribers of health care plans administered by the Corporation in accordance with the agreements. Hospital providers are generally paid on the basis of fixed rate DRGs (Diagnosis Related Groups),

per diems (i.e., fixed fee schedules where the daily rate is based on the type of service and is the primary method of in-patient reimbursement), per case per admission (i.e., fixed fee schedules for all services during a member's hospitalization), or in a few cases, a percentage of covered charges with limits on the subsequent year increases. The average rates negotiated with hospitals under these arrangements are lower than the hospital's average standard retail charges. Services not subject to special per case or per diem payment arrangements are generally paid according to a fee schedule or as a percentage of covered charges. Outpatient hospital payments are based on a fixed fee schedule or 90% of billed services. The outpatient fee schedule uses Ambulatory Procedure Code relative weights. Physician contracts employ fixed fee schedules, which are below standard billing rates. The Corporation uses three basic components to establish the physician fee schedule payments: The Center For Medicare/Medicaid Services' (CMS) Resource Based Relative Value System methodologies, competitor reimbursement rates and ongoing reviews of specific allowances to determine if suitable payment levels are in place. Contracts are adjusted when considered appropriate in accordance with the Fair Business Practices Act.

The administration of group contracts and claims is primarily handled at the principal office in Richmond. This responsibility includes rating, underwriting, issuing, billing and collecting for all subscriber agreements and the processing and payment of all claims. The Roanoke office is responsible for individual business and member services for some group accounts. The Federal Employee Program (FEP) is primarily administered from WellPoint's office in Mason, Ohio.

The Corporation offers health insurance (at risk) for both individuals and groups and also administers uninsured (not at risk or administrative services only) business for qualifying groups and organizations. The amount of business is approximately equal between risk and not at risk. Group coverage is the most prevalent.

The Corporation has four basic methods of funding the group health care programs. The various means are briefly described below.

1. Fully-insured funding is limited to groups with 2 or more enrollees. The Corporation retains 100% of the risk. The premium is fixed and guaranteed for a term of 12 months assuming no more than a 10% change in the total enrollment or enrollment distribution by location, product, or membership tier, no change in products, or no change in requested services from those assumed when setting the premiums. For accounting purposes, the groups are pooled; gains and losses are not carried forward nor is a formal accounting prepared. The Corporation holds the claim

reserves for incurred but not reported liabilities. An individual excess claim pooling limit is required. There is no financial settlement at termination.

2. Aggregate Stop Loss funding is limited to groups with 100 or more enrollees. The risk is shared by the group and the Corporation. The group is responsible for its claims, reinsurance fees and retentions costs; however, claims are capped at an aggregate stop loss limit. Specific stop loss coverage is required. An annual cash settlement is made and no additional balance or deficit is carried forward. The group holds its own claim reserve. If the agreement is cancelled on the anniversary date, there is no stop loss coverage on the run out claims and the group assumes 100% of the risk for its run out exposure. If the agreement is cancelled at any time other than the anniversary date, the specific and aggregate stop loss coverage is terminated retroactively to the beginning of the policy year. Any qualified group may purchase a cap on the incurred but not reported claims, but decision to purchase this aggregate stop loss coverage on run out claims must be made prior to the effective date of the policy.

3. Minimum Premium funding is limited to existing groups with 100 or more enrollees. This funding is being phased out; while the Corporation is grandfathering existing groups, the funding is not available to new groups. The risk is shared by the Corporation and the group. Unlike the aggregate stop loss funding that caps claims and capitation, the minimum premium funding caps claims and capitation, as well as, retention charges. All other aspects of the funding are similar to those under the aggregate stop loss funding.

4. ASO (Administrative Services Only) funding is limited to groups with 250 or more enrollees. The group is 100% at risk. There is no stop loss coverage on claims paid during the policy period or during the run out period. The group holds the claim reserves. An individual specific stop loss limit is recommended, but is optional. At termination, cash settlements are made for any deficit that exists plus the run out of claims.

Payment methods for funding other than fully insured fall into three categories:

1. Billed rates with year-end settlement. Interest is credited on surplus balances or charged on deficit balances monthly.
2. Weekly or monthly prepayments with the balance due upon receipt of the accounting statement prepared and sent by the third Monday of the following month. An annual accounting is prepared within 90 days of the end of the policy year.
3. Weekly claim payments with the balance due upon receipt of the accounting statement prepared and sent by the third Monday of the following month. An annual accounting is prepared within 90 days of the end of the policy year.

The underwriting practices with regard to waiting periods, exclusions and eligibility for individual or group coverage are defined in each type of contract offered. Only administrative fees from not at risk business are to be reflected in the Corporation's annual operating results.

AFFILIATIONS WITH OTHER PLANS

As a controlled health affiliate of WellPoint, Inc., the Corporation participates in the Blue Cross and Blue Shield Association (Association), a non-profit Illinois corporation, which is the national coordinating agency for member plans. The Association promotes public acceptance of the principle of health service, assists in maintaining public and professional support, supplements activities for carrying out enrollment, advertising and research, administers the service mark and trade name license agreement, and exerts influence on the quality and availability of health services. Control of the Association is vested in a board elected by the members.

The Corporation, if legally able, assumes certain obligations, including participation in the following national agreements:

Inter-Plan Transfer Agreement

This agreement provides a means of ensuring continuing health service benefits to subscribers of participating plans when they move from one service area to another. Each plan agrees to cancel coverage held by subscribers who move out of their area. A supplement to this agreement is the Inter-Fund Transfer Agreement of the International Federation of Voluntary Health Service Funds, which provides continuing membership to subscribers who transfer their residence from one country to another.

National Accounts Agreement

National accounts are groups of subscribers located in different areas serviced by more than one participating plan. The national account groups are enrolled through a participating plan called a control plan. The control plan is usually the plan servicing the geographical area of the group's headquarters. National accounts are handled under a local benefit agreement.

Federal Employee Program

Under a plan participation agreement with the Association, the Corporation provides health care benefits as described by the Government-wide Service Benefit Plan to those employees, annuitants and their dependents in Virginia who are enrolled under the contract between the Association and the United States Office of Personnel Management.

GROWTH OF THE CORPORATION

The following data represents the growth of the Corporation for the ten-year period ending December 31, 2007. The data is compiled from the Corporation's filed Annual Statements, previous examination reports and the current examination report.

	Admitted Assets	Liabilities	Capital Paid-Up	Surplus Paid-In & Unassigned	Premium Income	Net Income
1998	$1,106,206,407	$619,012,395	$1,000,000	$486,194,012	$1,435,377,735	$93,124,687
1999	1,235,823,580	701,582,717	1,000,000	533,240,863	1,578,845,776	92,300,540
2000	1,152,556,430	662,556,225	1,000,000	489,000,205	1,851,988,408	88,508,455
2001	1,152,654,095	695,089,011	1,000,000	456,565,084	2,154,260,212	77,603,303
2002	1,476,410,257	916,019,388	1,000,000	559,390,869	2,424,670,452	135,229,737
2003	1,677,115,403	988,405,284	1,000,000	687,710,119	2,666,614,823	172,153,513
2004	1,762,788,874	896,908,230	1,000,000	864,880,644	3,033,826,224	269,292,589
2005	2,001,502,769	1,017,859,919	1,000,000	982,642,850	3,265,473,360	307,085,077
2006	1,907,326,279	973,224,856	1,000,000	933,101,423	3,482,432,362	349,705,539
2007	1,602,923,557	939,990,755	1,000,000	661,932,802	3,736,268,884	330,513,216

REINSURANCE

Ceded

At December 31, 2007, the Corporation had a 100% quota share reinsurance agreement in force with Med-America Insurance Company. This agreement covered all of the Corporation's long term care business which is a very small portion of its overall business. The reserve credits taken by the Corporation pursuant to this agreement were immaterial at December 31, 2007.

Assumed

The Corporation provides excess medical stop loss coverage for its affiliates, HealthKeepers, Peninsula and Priority. Pursuant to the agreements, the Corporation shall reimburse the affiliates 100% of the losses paid during the policy year in excess of deductibles ranging from $25,000 to $500,000 per loss depending on the type of contract. The maximum lifetime excess indemnity payable under these agreements for any one member shall not exceed $2,000,000. Premiums and claims assumed by the Corporation during 2007 were $5,628,958 and $4,068,263, respectively.

All agreements were reviewed and found to contain an insolvency clause.

SCOPE

This is a full scope financial condition examination initiated and conducted under the provisions of Article 4, Chapter 13 of Title 38.2 of the Code of Virginia. The examination covers the period January 1, 2005 through December 31, 2007. Assets were verified and liabilities were established at December 31, 2007. A review of income and disbursements for the period was made to the extent deemed necessary.

The items comprising the Balance Sheet for which Specific Risk Analyses (SRA) were required had medium or low risk assessments as determined from the NAIC Examiners Handbook. Analytical review procedures were applied for non-SRA items.

In addition, the following items were reviewed, several of which are discussed separately under their respective captions in this report.

History
Management and control
Corporate records
Fidelity bonds and other insurance
Welfare and pension plans
Territory and plan of operation
Growth of the Corporation
Reinsurance
Accounts and records
Financial statements

FINANCIAL STATEMENTS

There follows a statement of financial condition of the Corporation at December 31, 2007; a summary of operations for the year ended December 31, 2007; a reconciliation of capital and surplus for the period under review; and a statement of cash flows for the year ending December 31, 2007. The financial statements are presented in accordance with Statutory Accounting Principles.

ASSETS

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$807,655,949		$807,655,949
Common stocks	199,272,269		199,272,269
Properties occupied by the company	32,235,441		32,235,441
Cash and short-term investments	27,032,199		27,032,199
Other invested assets	74,501,723	10,019,862	64,481,861
Receivable for securities	261,252		261,252
Subtotals, cash and invested assets	$1,140,958,833	$10,019,862	$1,130,938,971
Investment income due and accrued	11,244,189		11,244,189
Uncollected premiums and agents' balances in the course of collection	31,153,140	1,569,566	29,583,574
Deferred premiums, agents' balances and installments booked but deferred and not yet due	117,124,525		117,124,525
Other amounts receivable under reinsurance contracts	460,024		460,024
Amounts receivable relating to uninsured plans	45,746,958	140,843	45,606,115
Net deferred tax asset	74,552,139	35,254,977	39,297,162
Electronic data processing equipment and software	26,137,617	12,657,396	13,480,221
Furniture and equipment	28,001,689	28,001,689	0
Receivables from parent, subsidiaries and affiliates	7,177,590		7,177,590
Health care and other amounts receivable	37,585,151	18,874,401	18,710,750
Aggregate write-ins for other than invested assets	193,906,229	4,605,793	189,300,436
Total assets	$1,714,048,084	$111,124,527	$1,602,923,557

LIABILITIES, CAPITAL AND SURPLUS

	Covered	Uncovered	Total
Claims unpaid	$332,441,011		$332,441,011
Accrued medical incentive pool and bonus amounts	302,540		302,540
Unpaid claim adjustment expenses	13,229,752		13,229,752
Aggregate health policy reserves	101,143,538		101,143,538
Aggregate health claim reserves	579,837		579,837
Premiums received in advance	58,262,386		58,262,386
General expenses due or accrued	18,527,994		18,527,994
Current federal income tax payable	21,777,034		21,777,034
Amounts withheld or retained for the account of others	26,147,794		26,147,794
Remittances and items not allocated	12,430,158		12,430,158
Amounts due to parent, subsidiaries and affiliates	114,765,268		114,765,268
Payable for securities	6,219,632		6,219,632
Liability for amounts held under uninsured plans	57,698,898		57,698,898
Aggregate write-ins for other liabilities	176,464,913		176,464,913
Total liabilities	$939,990,755	$0	$939,990,755
Common capital stock			$ 1,000,000
Gross paid in and contributed surplus			617,998,945
Unassigned funds (surplus)			43,933,857
Total capital and surplus			$662,932,802
Total liabilities, capital and surplus			$1,602,923,557

STATEMENT OF REVENUE AND EXPENSES

	Uncovered	Total
Net premium income	XXX	$3,736,268,884
Change in unearned premium reserves and reserve for rate credits	XXX	2,757,413
Aggregate write-ins for other non-health revenues	XXX	(110,107)
Total revenues	XXX	$3,738,916,190
Hospital and Medical:		
Hospital/medical benefits		$1,707,112,875
Emergency room and out-of-area		34,739,156
Prescription drugs		626,613,027
Aggregate write-ins for other hospital and medical		671,321,636
Incentive pool, withhold adjustments and bonus amounts		165,063
Subtotal		$3,039,951,757
Less:		
Net reinsurance recoveries		(4,589,347)
Total hospital and medical		$3,044,541,104
Claims adjustment expenses		43,426,566
General administrative expenses		184,770,276
Increase in reserves for life and accident and health contracts		(165,979)
Total underwriting deductions	$0	$3,272,571,967
Net underwriting gain	XXX	$466,344,223
Net investment income earned		$63,538,537
Net realized capital gains		(7,395,360)
Net investment gains		$56,143,177
Miscellaneous income		$2,072,147
Net income before federal income taxes	XXX	$524,559,547
Federal and foreign income taxes incurred	XXX	194,046,331
Net income	XXX	$330,513,216

RECONCILIATION OF CAPITAL AND SURPLUS

	2005	2006	2007
Capital and surplus prior reporting year	$865,880,644	$983,642,850	$934,101,423
GAINS AND LOSSES TO CAPITAL AND SURPLUS			
Net income	307,085,077	349,705,539	330,513,216
Change in net unrealized capital gains and (losses)	(1,329,435)	18,266,425	(2,386,276)
Change in net deferred tax income	3,632,323	70,928	11,349,223
Change in nonadmitted assets	27,273,648	(17,584,319)	(10,644,784)
Cumulative effect of changes in accounting principles	31,100,593		
Dividends to stockholders	(250,000,000)	(400,000,000)	(600,000,000)
Net change in capital and surplus	$117,762,206	($49,541,427)	($271,168,621)
Capital and surplus end of reporting year	$983,642,850	$934,101,423	$662,932,802

CASH FLOW

Cash from Operations

Premiums collected net of reinsurance	$3,716,286,129
Net investment income	69,188,756
Miscellaneous income	(110,107)
Total	$3,785,364,778
Benefit and loss related payments	$3,010,620,727
Commissions, expenses paid and aggregate write-ins for deductions	262,654,676
Federal income taxes paid	196,197,746
Total	$3,469,473,149
Net cash from operations	$315,891,629

Cash from Investments

Proceeds from investments sold, matured or repaid:	
Bonds	$783,763,666
Stocks	86,716,071
Other invested assets	7,037,726
Net gains on cash and short-term investments	27,615
Miscellaneous proceeds	6,484,132
Total investment proceeds	$884,029,210
Cost of investments acquired (long-term only):	
Bonds	$598,374,707
Stocks	115,135,768
Real Estate	1,410,769
Other invested assets	56,532,146
Miscellaneous applications	217,300
Total investment acquired	$771,670,690
Net cash from investments	$112,358,520

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Dividends to stockholders	($600,000,000)
Other cash provided	95,555,279
Net cash from financing and miscellaneous sources	($504,444,721)

RECONCILIATION OF CASH AND SHORT-TERM INVESTMENTS

Net change in cash and short-term investments	($76,194,572)
Cash and short-term investments:	
Beginning of the year	103,226,771
End of the year	$27,032,199

SUBSEQUENT EVENTS

On September 25, 2008, the Corporation paid a dividend on its common stock of $330,500,000 to Anthem Southeast. This dividend was considered extraordinary and was pre-approved by the Commission.

CONCLUSION

The courteous cooperation extended by the officers and employees of the Corporation during the course of the examination is gratefully acknowledged.

In addition to the undersigned, Bryan Almond, Chris Collins, AFE, John Drean, CFE, David Fiden, Kevin Knight, AFE, Hai Nguyen, Ern Johnson, FSA, MAAA, and Michael Peterson participated in the work of the examination.

Respectfully submitted,

John E. Bunce, CFE
Assistant Chief Examiner
Commonwealth of Virginia

C. Burke King
President
Virginia Market

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Anthem

February 13, 2009

Mr. David H. Smith, CFE, CPA, CPCU
Chief Examiner
State Corporation Commission
Bureau of Insurance
Tyler Building, 6th Floor
1300 Main Street
Richmond, VA 23219

RE: Anthem Health Plans of Virginia Financial Examination Report
as of December 31, 2007

Dear Mr. Smith:

This letter is to confirm receipt of the above report. We noted there are no recommendations of corrective action to address. Thank you for the cooperation extended by your team during this examination.

Sincerely,

C. Burke King
President
Virginia Market