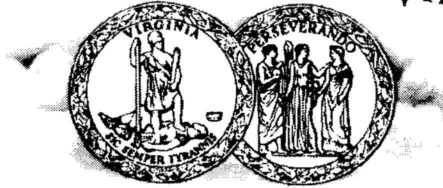
EXAMINATION REPORT
of
OPTIMA HEALTH PLAN
Virginia Beach, Virginia
as of
December 31, 2010

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA



JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
http://www.scc.virginia.gov/division/boi

I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Examination Report of Optima Health Plan as of December 31, 2010, 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 21st day of July, 2011

Jacqueline K. Cunningham
Commissioner of Insurance

(SEAL)

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Richmond, Virginia
May 5, 2011

Honorable Jacqueline K. Cunningham
Commissioner of Insurance
Richmond, Virginia

Dear Madam:

Pursuant to your instructions and by authority of Section 38.2-4315 of the Code of Virginia, an examination of the records and affairs of

OPTIMA HEALTH PLAN

Virginia Beach, Virginia

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

DESCRIPTION

The Plan became licensed in Virginia as a health maintenance organization ("HMO") pursuant to Chapter 43 of Title 38.2 of the Code of Virginia on August 31, 1984. The Plan operates as a capitated and fee-for-service individual practice association HMO. The Plan was last examined by representatives of the State Corporation Commission's Bureau of Insurance (the "Bureau") as of December 31, 2007. This examination covers the period from January 1, 2008 through December 31, 2010.

HISTORY

The Plan is a non-profit membership corporation without capital stock. The Plan was incorporated in the Commonwealth of Virginia on May 7, 1984. The initial member of the Plan was Alliance Health System (currently Sentara Healthcare and formerly Sentara Health System), which provided initial funding through Alliance Health Foundation. The Plan commenced business on December 1, 1984 and became federally qualified as an HMO on May 30, 1985. Through additional funding of the Plan, Maryview Hospital ("MH"), Sentara Hampton General Hospital ("SHGH"), and Virginia Beach General Hospital became members of the Plan.

Effective April 30, 1990, SHGH transferred its membership rights in the Plan to Sentara Healthcare ("SHC"). On July 20, 1990, SHC purchased Virginia Beach General Hospital's membership rights in the Plan. On December 30, 2003, SHC purchased MH's membership rights in the Plan. At December 31, 2010, SHC is the sole member of the Plan.

CAPITAL AND SURPLUS

At December 31, 2010, the Plan's capital and surplus was $183,018,996. Capital and surplus was comprised of gross paid in and contributed surplus of $13,000,000 and unassigned funds of $170,018,996. Gross paid in and contributed surplus was provided to the Plan by SHC.

NET WORTH REQUIREMENT

Section 38.2-4302 of the Code of Virginia states that an HMO licensed in Virginia shall maintain a minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4,000,000. 14 VAC 5-210-60 A requires that an HMO report the sum of its uncovered expenses for each three-month period ending December 31, March 31, June 30 or September 30. Because the sum of the Plan's uncovered expenses for the three-month period ending December 31, 2010 was $29,733,893 the Plan's minimum net worth requirement at December 31, 2010 was $4,000,000.

MANAGEMENT AND CONTROL

As of December 31, 2010, the amended and restated articles of incorporation provide that SHC shall be the sole member. The amended and restated bylaws provide that the property, affairs and business of the Plan shall be managed under the direction of the Board of Directors (the "Board"). The number of Directors shall not be less than three nor more than sixteen. The Directors shall be divided into three classes with each class to be as nearly equal in number as possible. Directors shall hold office for a three-year term and each director may be re-elected upon the expiration of the three-year term.

Officers of the Plan shall consist of a Chairman, a President, a Secretary and a Treasurer who shall be elected by SHC at its annual meeting and who shall hold office for such terms as the Board may prescribe. Other officers, including one or more Vice Presidents and assistant subordinate officers, may from time to time be elected by SHC. Officers shall hold their office until their successors are elected.

At December 31, 2010, the Board and Officers were as follows:

Directors	Principal Occupation
David L. Bernd	Chief Executive Officer Sentara Healthcare Norfolk, Virginia
Robert A. Broermann	Senior Vice President, Chief Financial Officer Sentara Healthcare Norfolk, Virginia
William K. Butler, II	Retired Virginia Beach, Virginia
Dian T. Calderone	Owner Hunt-Calderone PC Newport News, Virginia
Michael M. Dudley	System Vice President Sentara Healthcare Norfolk, Virginia
Vicky G. Gray	Senior Vice President, System Development Sentara Healthcare Norfolk, Virginia
George W. Hubbard, M.D.	Surgeon Norfolk, Virginia
John T. Kalafsky, M.D.	Physician Norfolk, VA
Howard P. Kern	President and Chief Operating Officer Sentara Healthcare Norfolk, Virginia
Charles F. Lovell, Jr. M.D	Physician Norfolk, Virginia

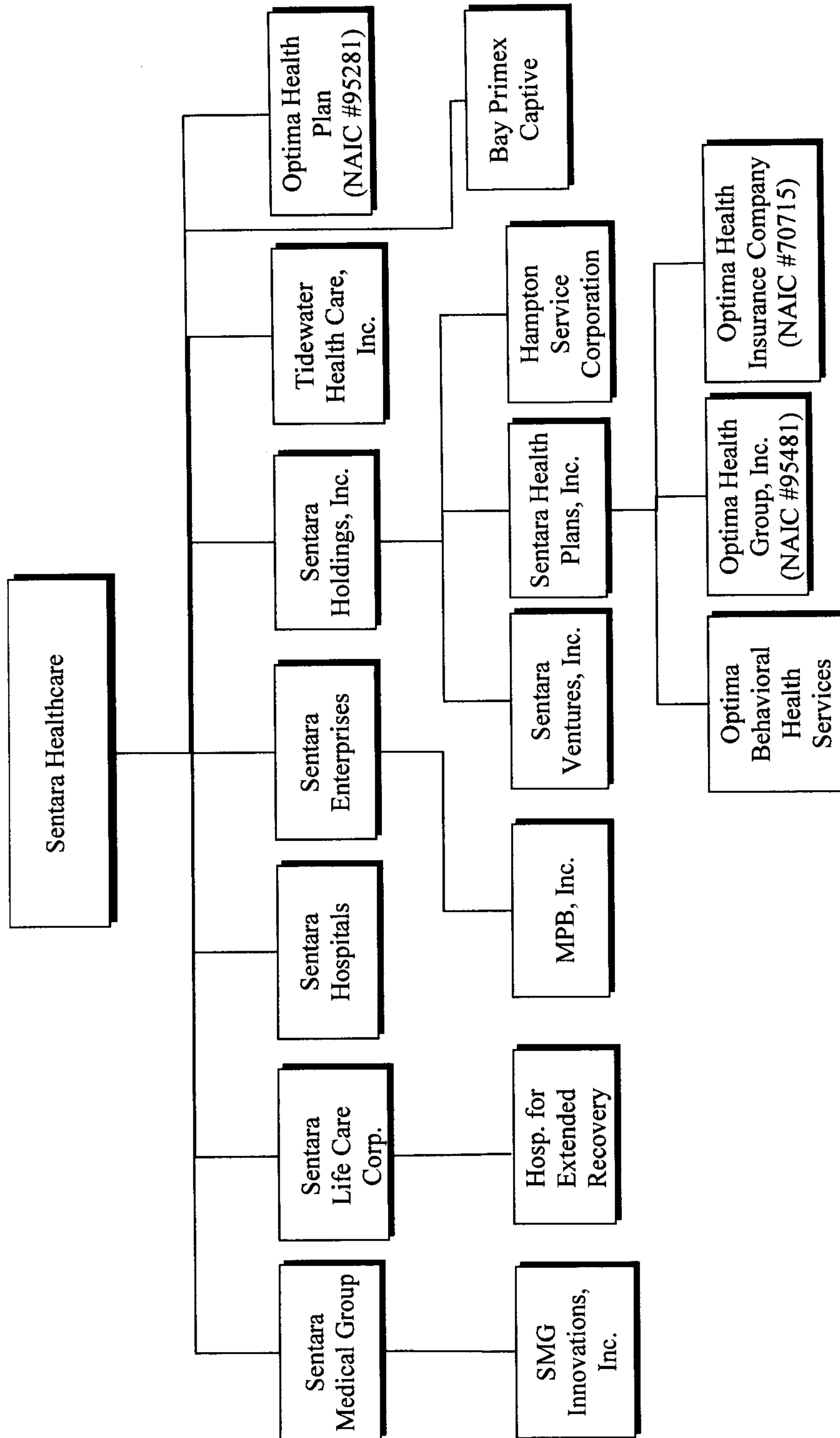
Darleen A. Mastin	Senior Vice President and Chief Operating Officer Sentara Health Plans, Inc. Norfolk, Virginia
David M. Pariser, M.D.	Physician Norfolk, Virginia
Meredith B. Rose, M.D.	Physician Virginia Beach, Virginia
Theodore M. Wille, Jr.	Retired Virginia Beach, Virginia
Gary R. Yates, M.D.	Chief Medical Officer Sentara Healthcare Norfolk, Virginia

Officers

David L. Bernd	Chairman of the Board
Michael M. Dudley	President
Howard P. Kern	Secretary/Treasurer
Robert A. Broermann	Assistant Treasurer
John E. DeGruttola	Senior Vice President, Marketing
James A. Hilbert	Senior Vice President, CFO
Darleen A. Mastin	Senior Vice President, Operations

AFFILIATED COMPANIES

As of December 31, 2010, the amended and restated articles of incorporation provide that SHC shall be the sole member. The chart on the following page illustrates the organizational structure of the Plan and selected affiliated entities at December 31, 2010:



Sentara Healthcare
Optima Health Plan (NAIC #95281)
Bay Primex Captive
Tidewater Health Care, Inc.
Sentara Holdings, Inc.
Hampton Service Corporation
Sentara Health Plans, Inc.
Optima Health Insurance Company (NAIC #70715)
Optima Health Group, Inc. (NAIC #95481)
Optima Behavioral Health Services
Sentara Ventures, Inc.
Sentara Enterprises
MPB, Inc.
Sentara Hospitals
Sentara Life Care Corp.
Hosp. for Extended Recovery
Sentara Medical Group
SMG Innovations, Inc.

TRANSACTIONS WITH AFFILIATES

Administrative Services and Marketing Agreement

Effective April 1, 2005, the Plan entered into an Administrative Services and Marketing Agreement with Sentara Health Plans, Inc. ("SHP"). According to the provisions of the agreement, SHP shall perform, or arrange for the performance of the administrative services necessary to fulfill the Plan's obligations under its Evidences of Coverage. The services include the following:

Underwriting Services
Enrollment Services
Claims Administration Services
Information Systems Services
Premium Billing and Collecting
Inquiries and Requests
Administrative Material
Investment Services
Medical Care Management
Provider Relations
Marketing Services

As compensation for these services, the Plan shall pay SHP a monthly administrative fee. The administrative fee shall equal the actual costs incurred by SHP in providing the services and shall include the direct costs as well as the allocable portion of costs incurred by SHP in connection with providing such services. SHP will develop and periodically revise a cost allocation model to allocate appropriate administrative costs among the SHP companies. During 2010, the Plan paid $74,462,660 in administrative fees related to this agreement.

HMO Excess Risk Policy

Effective October 1, 2001, the Plan entered into a HMO Excess Risk Policy with Optima Health Insurance Company ("OHIC"). The policy terminated June 30, 2010 but covers claims incurred October 1, 2001 through June 30, 2010. According to the terms of the policy, OHIC shall reimburse the Plan 100% of the eligible services incurred in excess of the $500,000 deductible per member per catastrophic event up to a maximum of $1,000,000 per member per year. Eligible services are defined as those acute care hospital services, approved by the Plan, rendered to a member who is registered as a bed patient at a licensed acute care hospital. Covered services also include hospital services for members approved for transplants, except transplants performed at Sentara Norfolk General Hospital which are specifically excluded under the policy. The Plan paid OHIC a

per member per month rate set forth in the policy to cover all excess risk claims. The policy includes a continuation of coverage endorsement in the event of the Plan's insolvency.

Mental Health Services Agreement

At December 31, 2010 the Plan contracts with Optima Behavioral Health Services ("OBHS"), a subsidiary of SHP, to provide mental health services to its subscribers. Pursuant to the terms of the capitated agreement, the Plan pays OBHS a fixed rate per member per month to cover the costs of these services. During 2010, the Plan paid OBHS $27,010,295 in capitation pursuant to this agreement.

Provider Agreements

The Plan contracts with several subsidiaries of SHC to provide hospital, mental health physician services, and other medical services to its members.

Dividends

The Plan paid the following cash dividends to SHC during the three-year period under review, January 1, 2008 to December 31, 2010:

Dividend Type	Amount	Dividend Request Date	Bureau Approval Date	Date Paid to SHC
Extraordinary	$70,000,000	06/06/08	07/07/08	07/11/08
Extraordinary	43,000,000	04/15/09	05/05/09	05/15/09
Extraordinary	18,000,000	10/27/10	11/30/10	12/01/10

TERRITORY AND PLAN OF OPERATION

At December 31, 2010, the Plan's service area, as reported in its 2010 Annual Statement, included the cities of Bedford, Buena Vista, Charlottesville, Chesapeake, Clifton Forge, Colonial Heights, Covington, Danville, Emporia, Franklin, Fredericksburg, Hampton, Harrisonburg, Hopewell, Lexington, Lynchburg, Martinsville, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg and Winchester. In addition, the service area included the counties of Accomack, Albemarle, Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford, Botetourt, Brunswick, Buckingham, Campbell, Caroline, Charles City, Charlotte, Chesterfield, Clarke, Craig,

Culpepper, Cumberland, Dinwiddie, Essex, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Greensville, Halifax, Hanover, Henrico, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Rockingham, Shenandoah, Southampton, Spotslvania, Stafford, Surry, Sussex, Warren, Westmoreland and York.

Medical services are provided by physicians in independent practice within the Plan's service area. Each member chooses a primary care physician ("PCP") from a list of the Plan's primary providers. All hospital admissions must be arranged by an attending physician and approved in advance by the Plan.

At December 31, 2010, the Plan had a contract with the Virginia Department of Medical Assistance Services to administer coverage to Medicaid enrollees which comprised 47% of its premium revenue in 2010.

CONFLICT OF INTEREST

The Plan has adopted a conflict of interest policy. The objective of this policy is to ensure that each director, officer, and employee faithfully serves the Plan and refrains from doing anything which is adverse or prejudicial to the Plan's interest. To ensure compliance with the policy, the Plan has established procedures which require directors, officers and members of a committee with Board delegated powers to sign a conflict of interest disclosure form annually.

FIDELITY BOND AND OTHER INSURANCE

At December 31, 2010, the Plan was listed as a named insured on a commercial crime policy with a $4,000,000 limit of liability, subject to a $100,000 deductible, to insure against losses arising from dishonest acts of its officers and employees. Additionally, the Plan was listed as a named insured on a professional/commercial general liability policy, an umbrella liability policy, a commercial property insurance policy, a business automobile liability policy, a directors and officers liability policy and a workers compensation and employers liability policy.

PROVIDER AGREEMENTS

Medical Services

The Plan has entered into agreements with numerous PCPs and specialist physicians to provide covered services to members. PCPs and specialist physicians are compensated on a fee for service basis at the lesser of billed charges or established fee schedules minus any applicable copayments.

Hospital Care

The Plan has entered into agreements with a number of hospitals in its service area to provide covered hospital services to members. The Plan compensates participating hospitals on either a discounted fee for service, a fixed per-diem, or a per case basis. The amounts paid to each hospital are based on terms disclosed in each individual agreement.

Other Health Care Services

The Plan provides other health care services to members through various ancillary agreements. These services include ambulance services, skilled nursing care, home health care, physical, occupational and speech therapy, laboratory and pharmaceutical services. Compensation is based on arrangements set forth in each agreement.

CONTRACT FORMS

The group contract agreement generally covers the following services provided by PCPs, participating specialists and other professional providers:

1. Physician Services
2. Allergy Care
3. Hospital Services
4. Maternity Services
5. Family Planning/Infertility Services
6. Skilled Nursing Services
7. Home Health Care Skilled Services
8. Orthopedic and Prosthetic Appliances
9. Ambulance Service
10. Emergency Services
11. Mental Health Services
12. Durable Medical Equipment

Exclusions generally include any services or supplies that were not authorized or arranged by the member's PCP or the Plan; any service, supply, or treatment not specifically covered in the Evidence of Coverage; personal comfort items; private duty nursing; cosmetic surgery; costs of services covered by a group insurance mechanism or governmental program; eye surgery to correct refraction errors; school physicals; physical examinations for employment or insurance; and experimental medical, surgical or mental health care procedures or services. Other exclusions include treatment or drugs for smoking cessation; services and drugs in connection with obesity; routine footcare and foot orthotics; immunizations related to foreign travel or employment; coverage for a newborn or other child of a dependent child; hearing aids, eyeglasses or contact lenses or the fitting thereof; and prescription drugs unless covered under a rider.

The above are abbreviated descriptions of the coverages and exclusions and each individual contract may vary.

GROWTH OF THE PLAN

The following data is representative of the growth of the Plan for the ten-year period ending December 31, 2010. The data is compiled from the Plan's filed Annual Statements, the previous examination reports and the current examination report.

Year	Total Admitted Assets	Total Liabilities	Total Capital & Surplus
2001	$56,054,763	$47,951,131	$8,103,632
2002	113,457,619	67,475,655	45,981,964
2003	152,871,591	72,501,798	80,369,793
2004	205,504,323	66,051,395	139,452,928
2005	233,599,422	72,163,743	161,435,679
2006	257,608,145	74,716,240	182,891,905
2007	264,820,340	83,040,432	181,779,908
2008	256,297,895	102,919,943	153,377,952
2009	247,387,830	116,605,200	130,782,630
2010	310,152,525	127,133,529	183,018,996

Year	Total Revenue	Net Investment Gains	Medical & Hospital Expenses	Administrative Expenses	Pre-Tax Income (Loss)
2001	$391,351,297	$2,349,145	$360,434,491	$33,377,885	($111,934)
2002	489,739,199	2,202,429	431,216,116	40,908,047	19,817,465
2003	534,287,050	1,902,654	438,855,003	49,946,139	47,388,562
2004	585,745,279	2,272,219	480,484,654	47,492,240	60,040,604
2005	696,319,534	6,315,294	570,400,927	49,896,775	82,337,126
2006	781,674,346	11,036,442	650,305,571	62,379,346	80,025,871
2007	791,620,394	12,527,076	662,428,044	73,444,808	68,274,618
2008	865,689,555	5,566,936	750,584,799	76,045,304	44,626,388
2009	985,089,183	3,281,486	891,949,599	77,374,917	19,046,153
2010	1,091,460,148	4,080,635	949,437,357	74,939,986	71,163,440

The Plan's enrollment data at year-end is illustrated as follows:

Year	Number of Members
2001	202,072
2002	200,312
2003	196,809
2004	221,777
2005	243,142
2006	244,010
2007	246,393
2008	267,154
2009	288,559
2010	294,114

EXCESS LOSS INSURANCE

Effective April 1, 2007, the Plan entered into an Excess Risk Insurance Agreement with HCC Life Insurance Company ("HCC"). For eligible expenses, the deductible is $1,000,000 per member for each contract year. Once the deductible has been reached in a contract year, HCC will reimburse the Plan 90% of all eligible expenses up to a maximum of $5,000,000 per member per contract year. The agreement includes a continuation of coverage endorsement in the event of the Plan's insolvency.

SPECIAL RESERVES AND DEPOSITS

At December 31, 2010, the Bureau required the Plan to maintain a minimum deposit of $2,700,000 with the Treasurer of Virginia.

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 from January 1, 2008 through December 31, 2010. Assets were verified and liabilities established at December 31, 2010.

The examination was conducted in accordance with the NAIC Financial Condition Examiners Handbook. The Handbook requires that the Bureau plan and perform the examination to evaluate the financial condition and identify prospective risks of the Corporation, assess corporate governance, identify and assess inherent risks within the Corporation, and evaluate system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statutory Accounting Principles and annual statement instructions when applicable to domestic state regulations.

All accounts and activities of the Plan were considered in accordance with the risk-focused examination process.

FINANCIAL STATEMENTS

There follows a statement of financial condition at December 31, 2010; a statement of revenue and expenses for the year ending December 31, 2010; a reconciliation of capital and surplus for the period under review; and a statement of cash flow for the year ending December 31, 2010. The financial statements are presented in accordance with Statutory Accounting Principles.

ASSETS

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$122,589,700		$122,589,700
Common stocks	13,361,278		13,361,278
Cash and short-term investments	113,455,843		113,455,843
Subtotals, cash and invested assets	$249,406,821	$0	$249,406,821
Investment income due and accrued	824,838		824,838
Uncollected premiums	59,420,708	2,253,260	57,167,448
Electronic data processing equipment and software	664,024		664,024
Furniture and equipment, including healthcare delivery assets	225,673	225,673	0
Receivables from parent, subsidiaries and affiliates	1,124,502		1,124,502
Health care and other receivables	2,647,138	1,694,599	952,539
Aggregate write-ins for other than invested assets	753,428	741,075	12,353
Total assets	$315,067,132	$4,914,607	$310,152,525

LIABILITIES, CAPITAL AND SURPLUS

	Covered	Uncovered	Total
Claims unpaid	$89,386,718	$4,488,693	$93,875,411
Unpaid claims adjustment expenses		1,430,287	1,430,287
Aggregate health policy reserves	180,220	9,050	189,270
Aggregate health claim reserves	2,137,597	107,343	2,244,940
Premiums received in advance	2,204,705		2,204,705
Amounts due to parent, subsidiaries and affiliates		4,121,956	4,121,956
Payable for securities		13,123,229	13,123,229
Aggregate write-ins for other liabilities	9,943,731		9,943,731
Total liabilities	$103,852,971	$23,280,558	$127,133,529
Gross paid in and contributed surplus			$13,000,000
Unassigned funds (surplus)			170,018,996
Total capital and surplus			$183,018,996
Total liabilities, capital and surplus			$310,152,525

STATEMENT OF REVENUE AND EXPENSES

	Uncovered	Total
Net premium income	XXX	$1,090,782,572
Change in unearned premium reserves and reserve for rate credits	XXX	276,413
Aggregate write-ins for other health care related revenues	XXX	401,163
Total revenues	XXX	$1,091,460,148
Hospital and Medical:		
Hospital/medical benefits	$37,367,481	$704,880,603
Outside referrals	645,891	645,891
Emergency room and out-of-area	7,384,383	61,732,468
Prescription drugs		169,498,274
Aggregate write-ins for other hospital and medical		12,645,054
Incentive pool, withhold adjustments and bonus amounts		857,712
Subtotal	$45,397,755	$950,260,002
Less:		
Net reinsurance recoveries		822,645
Total hospital and medical	$45,397,755	$949,437,357
Claims adjustment expenses	14,877,974	14,877,974
General administrative expenses	59,219,534	60,062,012
Total underwriting deductions	$119,495,263	$1,024,377,343
Net underwriting gain	XXX	$67,082,805
Net investment income earned		$2,701,808
Net realized capital gains		1,378,827
Net investment gains		$4,080,635
Net income before federal income taxes	XXX	$71,163,440
Federal income taxes incurred	XXX	1,186,955
Net income	XXX	$69,976,485

RECONCILIATION OF CAPITAL AND SURPLUS

	2008	2009	2010
Capital and surplus prior reporting year	$181,779,908	$153,377,952	$130,782,630
Adjustment for previous examination changes	$6,313,000		
Net income	43,379,582	18,304,165	69,976,485
Change in net unrealized capital gains		1,134,212	880,224
Change in nonadmitted assets	(1,815,236)	1,009,149	(591,673)
Dividends to stockholders	(70,000,000)	(43,000,000)	(18,000,000)
Aggregate write-ins for gains or (losses) in surplus	(6,279,302)	(42,848)	(28,670)
Net change in capital and surplus	($28,401,956)	($22,595,322)	$52,236,366
Capital and surplus end of reporting year	$153,377,952	$130,782,630	$183,018,996

CASH FLOW

Cash from Operations

Premiums collected net of reinsurance	$1,074,873,079
Net investment income	3,443,674
Miscellaneous income	2,660,214
Total	$1,080,976,967
Benefit and loss related payments	$944,469,667
Commissions, expenses paid and aggregate write-ins for deductions	74,852,471
Federal income taxes paid	1,186,955
Total	$1,020,509,093
Net cash from operations	$60,467,874

Cash from Investments

Proceeds from investments sold, matured or repaid:	
Bonds	$188,614,681
Miscellaneous proceeds	13,123,229
Total investment proceeds	$201,737,910
Cost of investments acquired (long-term only):	
Bonds	$207,898,564
Stocks	5,132,799
Miscellaneous applications	2,258,230
Total investment acquired	$215,289,593
Net cash from investments	($13,551,683)

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Dividends to stockholders	($18,000,000)
Other cash applied	(5,890,355)
Net cash from financing and miscellaneous sources	($23,890,355)

RECONCILIATION OF CASH AND SHORT-TERM INVESTMENTS

Net change in cash and short-term investments	$23,025,836
Cash and short-term investments:	
Beginning of the year	90,430,007
End of the year	$113,455,843

SUBSEQUENT EVENT

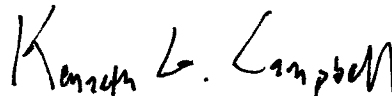
On May 6, 2011, the Plan filed a request with the Bureau to pay an extraordinary cash dividend of $69,000,000 to SHC. The Bureau approved the Plan's request on May 31, 2011 and the dividend was paid on June 14, 2011.

CONCLUSION

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

In addition to the undersigned, Darrin Bailey, CFE, John Bunce, CFE, Jack Drean, CFE, David Fiden, Kevin Knight, AFE, Hai Nguyen and Michael Peterson participated in the work of the examination.

Respectfully submitted,



Kenneth G. Campbell, CFE
Assistant Chief Examiner

OptimaHealth

Finance
4456 Corporation Lane
Suite 336
Virginia Beach, VA 23462
Tel: 757.252.8000
Fax: 757.252.8030
www.optimahealth.com

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July 6, 2011

David Smith, CFE, CPA, CPCU
Chief Examiner
State Corporation Commission
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218

RE: Optima Health Plan
Examination Report as of December 31, 2010

Dear Mr. Smith:

I am acknowledging receipt of the examination report as of December 31, 2010 for Optima Health Plan.

Please send me two copies of the final report.

Sincerely,

Michael M. Dudley
President

Cc: Andrew Palmer