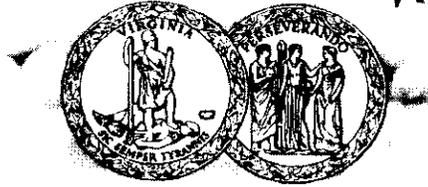


ASSOCIATION EXAMINATION REPORT
of
ANTHEM HEALTH PLANS OF VIRGINIA, INC.
Richmond, Virginia
as of
December 31, 2013

COMMONWEALTH OF VIRGINIA

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



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I, Jacqueline K. Cunningham, 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, 2013, 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 19th day of June, 2015

Jacqueline K. Cunningham
Commissioner of Insurance

(SEAL)

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Richmond, Virginia
May 15, 2015

Honorable Jacqueline K. Cunningham
Commissioner of Insurance
Richmond, Virginia

Dear Madam:

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, 2010. The current examination, which was called and conducted under the auspices of the NAIC, was conducted by Examiners from the Bureau in coordination with the Indiana Department of Insurance. This examination covers the period from January 1, 2011 through December 31, 2013.

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.

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 Health Networks") announced an agreement and plan of merger in which WellPoint Health Networks and all WellPoint Health Networks' 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 Health Network's stock. Pursuant to the merger, WellPoint Health Network 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. ("WellPoint"). At December 31, 2013, 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.

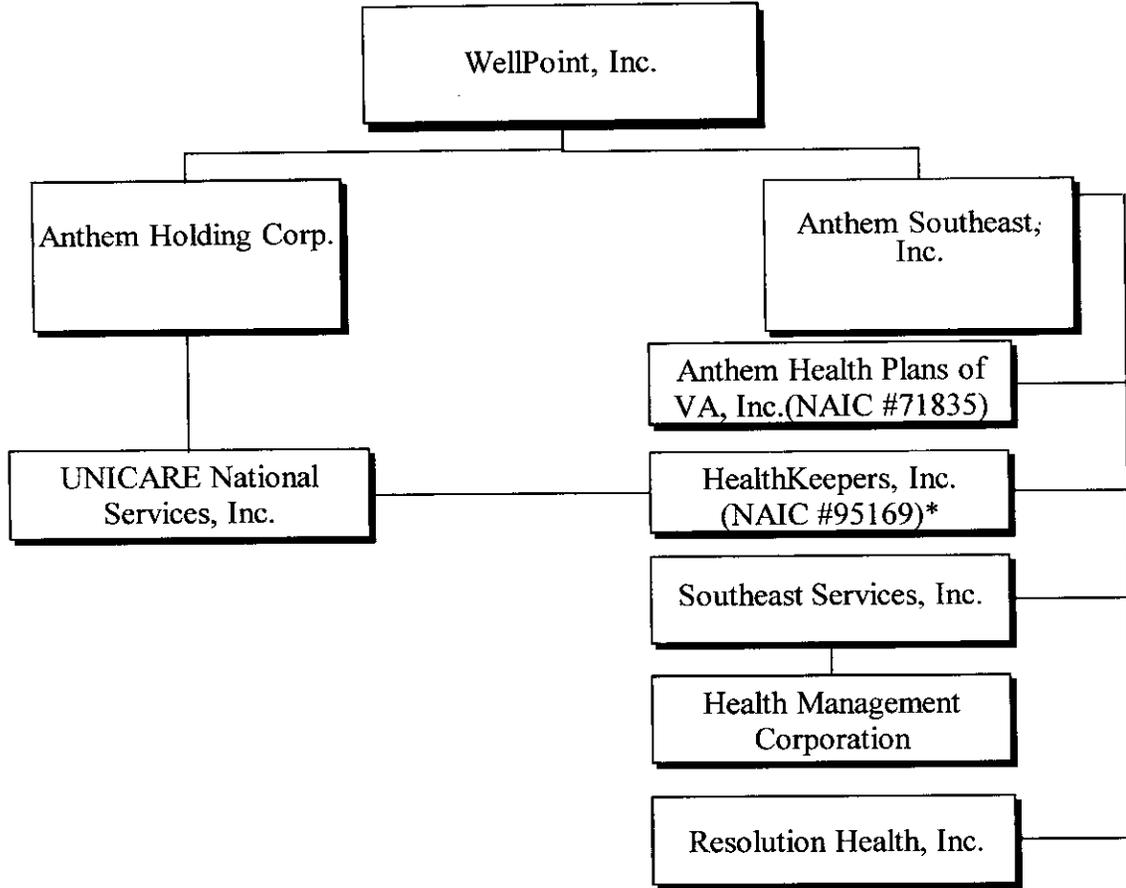
At December 31, 2013, the Board of Directors and Officers of the Corporation were as follows:

<u>Director</u>	<u>Principal Occupation</u>
Wayne S. DeVeydt	Executive Vice President and Chief Financial Officer WellPoint, Inc. Indianapolis, Indiana
Catherine I. Kelaghan	Vice President and Assistant Corporate Counsel WellPoint, Inc. Indianapolis, Indiana
Charles B. King	President Anthem Health Plans of Virginia, Inc. Richmond, Virginia

Officers

Charles B. King	Chairman and President
Kathleen S. Kiefer	Secretary
Sidney O. Hunt	Assistant Secretary
Robert D. Kretschmer	Treasurer
Eric K. Noble	Assistant 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, 2013.



* HealthKeepers, Inc. is 92.51% owned by Anthem Southeast, Inc. and 7.49% owned by UNICARE National Services, Inc.

TRANSACTIONS WITH AFFILIATES

Cash Concentration Agreement

Effective April 1, 2010, the Corporation entered into a Cash Concentration Agreement with WellPoint and its direct or indirect affiliates whereby WellPoint and certain affiliates are designated Cash Managers to handle the receipt and/or disbursement of funds on behalf of one or more affiliates. When a Cash Manager receives funds on behalf of an affiliate, an intercompany payable to the affiliate is established. When a Cash Manager disburses funds on behalf of an affiliate, an intercompany receivable from the affiliate is established. All resulting intercompany payables and receivables shall be settled within 30 days unless the parties mutually agree to settlement at a later date no later than 90 days after the intercompany payable or receivable was established. The Cash Manager shall be reimbursed monthly for all direct and indirect allocable costs it incurs in its capacity as Cash Manager.

Master Administrative Services Agreement

Effective January 1, 2006, the Corporation entered into a Master Administrative Services Agreement with WellPoint and its subsidiaries and 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 \$395,104,318 in fees related to the agreement in 2013.

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 carryback of losses or tax credits for subsequent taxable years. 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.

Excess Medical Stop Loss Agreement

Effective January 1, 2000, the Corporation entered into an Excess Medical Stop Loss Agreement with HealthKeepers, Inc. ("HealthKeepers"). Pursuant to the agreement, the Corporation shall reimburse HealthKeepers 100% of the losses paid during the annual twelve-month policy period ending December 31 in excess of the deductibles specified within the agreement.

For the purposes of this policy, losses are defined as amounts that are actually paid by HealthKeepers for medical expenses covered under the contract; in settlement of claims for medical expenses covered under the contract; or in satisfaction of judgments for medical expenses covered under the contract. 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 services fees charged by transplant service providers. 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.

This agreement contains a provision that requires HealthKeepers to pay the Corporation up to a maximum of 30% of the initial premium in the event that the paid losses exceed 85% of initial premium. Conversely, the Corporation is required to return to HealthKeepers up to 30% of the initial premium when paid losses are less than 85% of the initial premium.

The maximum lifetime excess insurance indemnity payable under this agreement for any one member shall not exceed \$2,000,000. The agreement includes a continuation of coverage clause and a benefits conversion clause in the event of HealthKeepers' insolvency. Premiums and claims assumed by the Corporation related to this agreement during 2013 were \$5,588,500 and \$6,604,777, respectively.

Solvency Guarantee Agreement

The Corporation guarantees the performance, obligations, and solvency of HealthKeepers 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 shall cease operations for any reason, the Corporation's coverage will be offered to all of HealthKeepers' members without exclusions, limitations, or conditions based on health reasons.

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 \$600,577 in fees related to the agreement in 2013.

Surplus Notes

The Corporation holds subordinated debt in its affiliate, HealthKeepers, with principal balances of \$8,716,141 at December 31, 2013.

Dividends to Stockholders and Return of Capital

On July 25, 2011, the Corporation's Board of Directors declared a return of capital of \$359,500,000 to its parent, Anthem Southeast. The Bureau approved the return of capital on September 19, 2011 and the Corporation made the return to its parent the same day. Additionally, the Corporation paid ordinary cash dividends of \$244,200,000 and \$333,200,000 in 2012 and 2013, respectively. 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, 2013, 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 \$1,500,000 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 managed care professional liability policy, an errors and omissions policy, a fiduciary liability policy and a computer crime policy.

OFFICERS AND EMPLOYEES WELFARE AND PENSION PLANS

The Corporation participates in the WellPoint Cash Balance Pension Plan (the Plan), a frozen noncontributory defined benefit pension plan sponsored by ATH Holding, Company, LLC (ATH Holding) covering most employees of WellPoint and its subsidiaries. ATH Holding allocates a share of the total accumulated costs of the Plan to the Corporation based on the number of allocated employees. During 2013, these costs totaled \$976,801. The Corporation has no legal obligation for the benefits under this plan.

The Company participates in a postretirement medical benefit plan, sponsored by ATH Holding, providing certain health, life, vision and dental benefits to eligible retirees. ATH Holding allocates a share of the total accumulated costs of this benefit plan to the Corporation based on the number of allocated employees. During 2013, these costs totaled \$1,282,051. The Corporation has no legal obligation for the benefits under this plan.

The Corporation participates in various deferred compensation plans sponsored by WellPoint which cover 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 a share of the total accumulated costs of these plans to the Corporation based on the number of allocated employees participating in these plans. During 2013, \$180,243 was allocated to the Corporation. The Corporation has no legal obligation for the benefits under these plans.

The Corporation participates in the WellPoint 401(k) Retirement Savings Plan, sponsored by ATH Holding 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. During 2013, the amount allocated to the Corporation was \$5,360,774. 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.

TERRITORY AND PLAN OF OPERATION

At December 31, 2013, 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 22% of total enrollment as of December 31, 2013, are marketed principally through direct marketing initiatives and through brokers. The group market is approximately 78% of total enrollment as of December 31, 2013 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, Lynchburg, Newport News, Richmond, Roanoke, 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 physician fee schedules: The Center For Medicare/Medicaid Services' 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 Code of Virginia §38.2-3407.15 (Ethics and Fairness in Carrier Business Practices).

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 split 39% for at risk and 61% for 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 the 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.

5. Administrative Service Agreement with Limited Risk Aggregate Stop Loss Coverage 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 retention costs. With Limited Risk

Aggregate Stop Loss funding, the Corporation establishes a fund to cover the terminal liability which is charged monthly to the group. Therefore, should the group terminate, it will not be billed for claims run out. 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 the decision to purchase this aggregate stop loss coverage on run out claims must be made prior to the effective date of the policy.

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 purpose of the Association is to serve as the cohesive force that brings the Blue Cross and Blue

Shield Plans ("Plans") together into a national system. The Association's role was defined more than 40 years ago when the Plans formed their separate, national coordinating bodies. The Association is governed by representatives of the Member Plans. The Board of Directors of the Association is the principal governing body. The Board of Directors consists of all Plan chief executive officers who wish to serve on the Board and the president of the Blue Cross and Blue Shield Association.

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

BlueCard Program

As a BCBSA licensee, the Company participates in the BlueCard program. BlueCard is a BCBSA nationwide program that enables members who need health care services while traveling or living in another Plan's service area to access their benefits through the local BCBS Plan's providers. It also allows the cost of the services to be calculated in accordance with the local Plan's contract with the providers.

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' benefits are paid based on the local plans' medical policy.

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, 2013. The data is compiled from the Corporation's filed Annual Statements, previous examination reports and the current examination report.

	<u>Admitted Assets</u>	<u>Liabilities</u>	<u>Capital Paid-Up</u>	<u>Surplus Paid-In & Unassigned</u>	<u>Premium Income</u>	<u>Net Income</u>
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
2008	1,627,260,654	1,085,840,955	1,000,000	540,419,699	3,848,435,660	321,357,975
2009	1,608,486,941	982,748,241	1,000,000	624,738,700	3,774,149,238	333,982,527
2010	1,872,584,841	1,195,197,556	1,000,000	676,387,285	3,829,772,062	393,216,049
2011	1,830,525,050	1,295,949,438	1,000,000	533,575,612	4,010,291,814	250,651,841
2012	1,986,897,662	1,262,940,094	1,000,000	722,957,568	4,149,674,296	345,138,781
2013	1,969,969,942	1,326,774,970	1,000,000	642,194,972	4,006,686,029	269,511,983

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, 2011 through December 31, 2013. Assets were verified and liabilities were established at December 31, 2013.

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.

The examination was conducted by the State of Indiana Department of Insurance on the Association Zone Plan with Indiana acting as the lead state. The examination of the Corporation was conducted concurrently with the examination of the following insurers:

Insurer**Domiciliary State**

CareMore Health Plan of Arizona, Inc.	Arizona
Anthem Blue Cross Life and Health Insurance Company	California
Anthem Insurance Companies, Inc.	Indiana
UNICARE Life and Health Insurance Company	Indiana
Anthem Life Insurance Company	Indiana
OneNation Insurance Company	Indiana
Anthem Health Plans of Maine, Inc.	Maine
AMERIGROUP Maryland, Inc.	Maryland
HealthLink HMO, Inc.	Missouri
Healthy Alliance Life Insurance Company	Missouri
HMO Missouri, Inc.	Missouri
Anthem Health Plans of New Hampshire, Inc.	New Hampshire
Matthew Thornton Health Plan, Inc.	New Hampshire
AMERIGROUP New Jersey, Inc.	New Jersey
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
Anthem Life and Disability Insurance Company	New York
Empire HealthChoice Assurance, Inc.	New York
Empire HealthChoice HMO, Inc.	New York
AMERIGROUP Ohio, Inc.	Ohio
Community Insurance Company	Ohio
AMERIGROUP Insurance Company	Texas
AMERIGROUP Texas, Inc.	Texas
UNICARE Health Plans of Texas, Inc.	Texas
Anthem Health Plans of Virginia, Inc.	Virginia
HealthKeepers, Inc.	Virginia
AMERIGROUP Washington, Inc.	Washington
UNICARE Health Plans of West Virginia, Inc.	West Virginia
Blue Cross Blue Shield of Wisconsin	Wisconsin
Compcare Health Services Insurance Corporation	Wisconsin

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

FINANCIAL STATEMENTS

There follows a statement of financial condition of the Corporation at December 31, 2013; a statement of revenue and expenses for the year ended December 31, 2013; a reconciliation of capital and surplus for the period under review; and a statement of cash flows for the year ending December 31, 2013. The financial statements are presented in accordance with Statutory Accounting Principles.

ASSETS

	<u>Assets</u>	Nonadmitted <u>Assets</u>	Net Admitted <u>Assets</u>
Bonds	\$616,047,329		\$616,047,329
Common stocks	295,677,268		295,677,268
Properties occupied by the company	23,930,603		23,930,603
Cash, cash equivalents and short-term investments	49,916,151		49,916,151
Other invested assets	206,956,437	96,550,928	110,405,509
Receivable for securities	6,501		6,501
Securities lending reinvested collateral assets	80,731,159		80,731,159
	<hr/>	<hr/>	<hr/>
Subtotals, cash and invested assets	\$1,273,265,448	\$96,550,928	\$1,176,714,520
Investment income due and accrued	6,450,805		6,450,805
Uncollected premiums and agents' balances in the course of collection	45,312,664	2,064,107	43,248,557
Deferred premiums, agents' balances and installments booked but deferred and not yet due	143,372,969		143,372,969
Amounts receivable relating to uninsured plans	177,111,507	16,460,228	160,651,279
Net deferred tax asset	91,776,150	99,608	91,676,542
Guaranty funds receivable or on deposit	38,690		38,690
Electronic data processing equipment and software	21,786,381	17,143,062	4,643,319
Furniture and equipment	26,033,796	26,033,796	0
Receivables from parent, subsidiaries and affiliates	17,152,886		17,152,886
Health care and other amounts receivable	26,505,684	14,448,491	12,057,193
Aggregate write-ins for other than invested assets	314,433,224	470,042	313,963,182
	<hr/>	<hr/>	<hr/>
Total assets	<u>\$2,143,240,204</u>	<u>\$173,270,262</u>	<u>\$1,969,969,942</u>

LIABILITIES, CAPITAL AND SURPLUS

	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid		\$354,955,417	\$354,955,417
Accrued medical incentive pool and bonus amounts		\$1,311,149	1,311,149
Unpaid claim adjustment expenses		11,672,137	11,672,137
Aggregate health policy reserves		85,233,807	85,233,807
Aggregate health claim reserves		12,617,194	12,617,194
Premiums received in advance		54,704,673	54,704,673
General expenses due or accrued		20,947,432	20,947,432
Current federal income tax payable		43,994,961	43,994,961
Ceded insurance premiums payable		2,914,307	2,914,307
Amounts withheld or retained for the account of others		41,219,585	41,219,585
Remittances and items not allocated		30,727,313	30,727,313
Amounts due to parent, subsidiaries and affiliates		178,106,988	178,106,988
Payable for securities lending		80,731,159	80,731,159
Liability for amounts held under uninsured plans		84,167,141	84,167,141
Aggregate write-ins for other liabilities		323,471,707	323,471,707
Total liabilities	<u>\$0</u>	<u>\$1,326,774,970</u>	<u>\$1,326,774,970</u>
Common capital stock			\$ 1,000,000
Gross paid in and contributed surplus			258,498,945
Unassigned funds (surplus)			<u>383,696,027</u>
Total capital and surplus			<u>\$643,194,972</u>
Total liabilities, capital and surplus			<u><u>\$1,969,969,942</u></u>

STATEMENT OF REVENUE AND EXPENSES

	<u>Uncovered</u>	<u>Total</u>
Net premium income	XXX	\$4,006,686,029
Change in unearned premium reserves and reserve for rate credits	XXX	3,823,085
Aggregate write-ins for other non-health revenues	XXX	682,435
Total revenues	<u>XXX</u>	<u>\$4,011,191,549</u>
Hospital/medical benefits	\$1,830,337,336	\$1,830,457,279
Emergency room and out-of-area	118,638,424	118,638,424
Prescription drugs	702,097,170	702,097,170
Aggregate write-ins for other hospital and medical		662,228,336
Incentive pool, withhold adjustments and bonus amounts	<u>2,223,678</u>	<u>2,223,678</u>
Subtotal	\$2,653,296,608	\$3,315,644,887
Less:		
Net reinsurance recoveries	<u>(6,604,777)</u>	<u>(6,484,834)</u>
Total hospital and medical	\$2,659,901,385	\$3,322,129,721
Claims adjustment expenses	77,302,339	77,302,339
General administrative expenses	251,045,432	251,045,432
Increase in reserves for life and accident and health contracts	<u>(1,986,997)</u>	<u>(1,986,997)</u>
Total underwriting deductions	<u>\$2,986,262,159</u>	<u>\$3,648,490,495</u>
Net underwriting gain	<u>XXX</u>	<u>\$362,701,054</u>
Net investment income earned	XXX	\$28,150,045
Net realized capital gains	XXX	29,628,777
Net investment gains	<u>XXX</u>	<u>\$57,778,822</u>
Net loss from agents' or premium balances charged off	(\$5,245)	(\$5,245)
Aggregate write ins for other income or expenses		<u>710,225</u>
Net income before federal income taxes	XXX	\$421,184,856
Federal income taxes incurred	<u>XXX</u>	<u>151,672,873</u>
Net income	<u>XXX</u>	<u>\$269,511,983</u>

CASH FLOW**Cash from Operations**

Premiums collected net of reinsurance	\$4,004,017,574
Net investment income	34,813,489
Miscellaneous income	682,435
Total	<u>\$4,039,513,498</u>
Benefit and loss related payments	\$3,377,862,130
Commissions, expenses paid and aggregate write-ins for deductions	374,182,488
Federal income taxes paid	65,076,046
Total	<u>\$3,817,120,664</u>
Net cash from operations	<u>\$222,392,834</u>

Cash from Investments

Proceeds from investments sold, matured or repaid:	
Bonds	\$268,591,031
Stocks	159,191,855
Other invested assets	24,527,057
Net gains on cash and short-term investments	4
Total investment proceeds	<u>\$452,309,947</u>
Cost of investments acquired (long-term only):	
Bonds	\$310,859,298
Stocks	169,235,628
Real Estate	2,351,994
Other invested assets	125,632,747
Miscellaneous applications	44,825,904
Total investments acquired	<u>\$652,905,571</u>
Net cash from investments	<u>(\$200,595,624)</u>

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Dividends to stockholders	(\$333,200,000)
Other cash provided	180,480,696
Net cash from financing and miscellaneous sources	<u>(\$152,719,304)</u>

**RECONCILIATION OF CASH, CASH EQUIVALENTS AND
SHORT-TERM INVESTMENTS**

Net change in cash, cash equivalents and short-term investments	(\$130,922,094)
Cash, cash equivalents and short-term investments:	
Beginning of the year	180,838,245
End of the year	<u>\$49,916,151</u>

SUBSEQUENT EVENTS

1. The Corporation is subject to an annual fee under Section 9010 of the Affordable Care Act ("ACA"). The annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premium 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. SSAP No. 35R does not require an accrual for this known liability until January 1 of the payment year. The Notes to the 2013 Annual Statement disclosed that the Corporation estimated the amount of the ACA fee payable on September 30, 2014 to be \$47,741,000. Therefore, total capital and surplus at December 31, 2013, as reported in the examination report, was decreased from \$643,194,972 to \$595,453,972 on January 1, 2014. The Corporation's authorized control level risk-based capital ratio decreased from 574.1% at December 31, 2013 to 531.5% at January 1, 2014. A review of the Corporation's records indicated that it paid \$48,983,350 for its portion of the ACA fee during 2014.
2. On October 14, 2014, the Commission approved the Corporation's request to pay an extraordinary dividend on its common stock of \$335,000,000 to Anthem Southeast.
3. Effective December 2, 2014, WellPoint, Inc. changed its name to Anthem, Inc.
4. In February 2015, Anthem reported that it was the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of its information technology systems and obtained personal information related to many individuals and employees, such as names, birthdates, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Currently, Anthem is in the process of addressing the cyber attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber attack, Anthem took action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem will provide credit monitoring and identity protection services to those who have been affected by this cyber attack. While the cyber attack did not have an impact on Anthem's business, cash flows, financial condition and results of operations for the year ended December 31, 2014, Anthem has incurred expenses subsequent to the cyber attack to investigate

and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although Anthem is unable to quantify the ultimate magnitude of such expenses and any other impact to its business from this incident at this time, they may be significant. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigations, are investigating events related to the cyber attack, including how it occurred, its consequences and Anthem's responses. There is currently a separate multi-state target examination of Anthem being conducted that is focusing solely on the cyber attack. Although Anthem is cooperating in these investigations, it may be subject to fines or other obligations, which may have an adverse effect on how it operates its business and its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation on February 10, 2015 and will be heard by the Panel on May 28, 2015.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because its investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

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, other individuals from the financial examination staff of the Bureau participated in the work of the examination.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'J. E. Bunce', with a long horizontal flourish extending to the right.

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

C. Burke King
President

Anthem Blue Cross Blue Shield
2015 Staples Mill Road
Richmond, VA 23230
Phone 804.354.3516

June 16, 2015



Mr. David H. Smith
Chief Examiner
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157

Re: Anthem Health Plans of Virginia, Inc. Examination Report as of December 31, 2013

Dear Mr. Smith:

In response to your letter dated May 28, 2015 please accept this letter as acknowledgement of receipt of the examination report. The Company does not have any comments on the examination report.

Please provide Joanne Lauterbach with five copies of the examination report. Her address is as follows:

Joanne Lauterbach
Anthem Health Plans
2 Gannett Drive
South Portland, ME 04106

If you have any questions or concerns, please call me at 804-354-3516 or Joanne Lauterbach at 207-822-7794.

Very truly yours,

A handwritten signature in black ink, appearing to read "C. Burke King".

C. Burke King
President

cc: Joanne Lauterbach
Director II, Regulatory Reporting