

**REPORT
OF
EXAMINATION**

**BLUE CROSS AND BLUE SHEILD OF ALBAMA
BIRMINGHAM, ALABAMA**

as of

DECEMBER 31, 2007

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EXAMINER'S AFFIDAVIT

**STATE OF ALABAMA
COUNTY OF JEFFERSON**

Mary B. Packard, CPA, CFE, being duly sworn, states as follows:

1. I have authority to represent Alabama in the examination of Blue Cross and Blue Shield of Alabama.
2. Alabama is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.
3. I have reviewed the examination workpapers and examination report, and the examination of Blue Cross and Blue Shield of Alabama was performed in a manner consistent with the standards and procedures required by the State of Alabama.

The affiant says nothing further.

Mary B. Packard
Examiner-in-Charge

Subscribed and sworn before me by Mary Packard on this
5th day of March, 2009.

(SEAL)


(Signature of Notary Public)

**MY COMMISSION EXPIRES
FEBRUARY 6, 2010**

My commission expires _____.



BOB RILEY
GOVERNOR

STATE OF ALABAMA
Department of Insurance
201 Monroe Street, Suite 1700
Post Office Box 303351
Montgomery, Alabama 36130-3351
Telephone: (334) 269-3550
Facsimile: (334) 241-4192
Internet: www.aldoi.gov

JIM L. RIDLING
COMMISSIONER
ASSISTANT COMMISSIONER
REN WHEELER
DEPUTY COMMISSIONER
D. DAVID PARSONS
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
EDWARD S. PAULK
GENERAL COUNSEL
REYN NORMAN
RECEIVER
DENISE B. AZAR
LICENSING MANAGER
JIMMY W. GUNN

March 27, 2009

Jim L. Ridling, Commissioner
State of Alabama
Department of Insurance
201 Monroe Street, Suite 1700
Post Office Box 30351
Montgomery, AL 36130-3351

Dear Commissioner Ridling:

Pursuant to your authorization and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners (NAIC), an examination has been made of the affairs and financial condition of

**Blue Cross and Blue Shield of Alabama
Birmingham, Alabama**

at the home office located at 450 Riverchase Parkway East, Birmingham, Alabama 35244, as of December 31, 2007. The report of examination is submitted herewith.

Where the description "Company" or "BCBSAL" appears herein, without qualification, it will be understood to indicate Blue Cross and Blue Shield of Alabama.

SCOPE OF EXAMINATION

The Company was last examined for the four-year period ended December 31, 2002, by examiners representing the State of Alabama. The current examination covers the intervening period from the date of the last examination through December 31, 2007 and was conducted by examiners representing the State of Alabama. Where deemed appropriate, transactions, activities and similar items subsequent to 2007 were reviewed. The examination was conducted concurrently with the examination of the Company's insurance subsidiary, United Trust Insurance Company (UTIC) located in Birmingham, Alabama.

The examination was conducted in accordance with applicable statutory requirements of the State of Alabama for a Health Care Service Plan as provided for in ALA. CODE § 10-4-100 (1975) through § 10-4-115 (1975), and in accordance with Alabama Insurance Department regulations and bulletins in addition to the procedures and guidelines promulgated by the National Association of Insurance Commissioners (NAIC), as deemed appropriate, and in accordance with generally accepted examination standards and practices.

The examination was conducted in accordance with the NAIC *Financial Condition Examiners Handbook*. The examination was planned and performed to evaluate the financial condition of the Company as of December 31, 2007 and to identify the Company's prospective risks by obtaining information about the Company including corporate governance. In addition, the examination was planned and performed to identify and assess inherent risks within the Company and to evaluate system controls and procedures used to mitigate those risks. The examination also included 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.

An examination of BCBSAL's information systems (IS) was conducted concurrently with the financial examination. The IS examination included a review of management and organizational controls, logical and physical security controls, changes in applications controls, system and program development controls, contingency planning controls, service provider controls, operations controls, processing controls, e-commerce controls, and network and internet controls.

A market conduct examination was performed concurrently with the financial examination. The market conduct examination included a review of the Company's territory and plan of operation, advertising, agents/representatives,

claims processing, marketing and sales, policy forms and underwriting, policyholder complaints and privacy standards. See page 23 for further discussion of the market conduct examination.

The Company's annual statements for each year under examination were compared with or reconciled to the corresponding general ledger account balances.

BCBSAL maintains an Internal Audit Department. Reports generated by the Internal Audit Department were made available to the examiners and were used in the examination as deemed appropriate.

During the examination period, BCBSAL was audited annually by Ernst & Young, LLP, certified public accountants (CPA's). The CPAs' workpapers were reviewed for all years under examination and were used in the examination as deemed appropriate by the examiners.

A signed certificate of representation was obtained during the examination. In this certificate, management attested to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2007.

ORGANIZATION AND HISTORY

The Company was organized on January 15, 1935, as the Hospital Service Corporation of Alabama, under the laws of the State of Alabama and providing for the organization and regulation of nonprofit corporations for the establishment of health service plans. The Certificate of Incorporation was filed for record in the office of the Judge of Probate of Jefferson County, Alabama. An amendment to the Certificate of Incorporation, adopted at the regular annual meeting of the Board of Trustees held on February 20, 1952, changed the Company's name to Blue Cross-Blue Shield of Alabama.

To comply with the change required by Act Number 1041 enacted by the regular session of the Alabama Legislature of 1973, the Board of Directors held a meeting on October 24, 1973 and adopted several amendments to the Certificate of Incorporation and a revised set of Bylaws. The name of the Company was changed to Blue Cross and Blue Shield of Alabama, and the Board's composition was changed to reflect a majority of public directors.

To comply with the 1973 legislative changes, the objective and purpose of the Company was amended in the Certificate of Incorporation as follows:

“To establish, maintain, and operate health care service plans under which health services of all types and forms and other services and commodities incidental thereto may be furnished to such of the public who, under the rules and regulations of the Corporation, make application and are eligible therefore; and to carry on any other lawful business whatsoever which may seem to the Corporation capable of being carried on in connection with the above, or calculated directly or indirectly to promote the interests of the Corporation or to enhance the value of its properties or the conduct of its business affairs.”

No amendments to the Company’s Certificate of Incorporation or Bylaws were made during the examination period.

Blue Cross and Blue Shield of Alabama is a non-stock not-for-profit corporation organized under ALA. CODE §10-4-100 (1975), which provides that:

“Any non-stock corporations organized not for profit for the purpose of establishing, maintaining, and operating a health care service plan under which health services are furnished to such of the public who became subscribers to such plan pursuant to contracts are authorized and shall be governed by the provisions of this article.”

At December 31, 2007, the Company had four wholly-owned subsidiaries. Two of these entities each wholly-owned a subsidiary. All six of the entities were domiciled in Alabama.

MANAGEMENT AND CONTROL

Board of Directors

The enabling statutes generally, and the Bylaws specifically, provide that the management and control of the business, property and affairs of the Company shall be vested in the Board of Directors, which shall have all of the powers of the Company. Article I, Section 2 of the Bylaws provided that:

The Board of Directors shall be composed of 27 persons, consisting of the following:

- Fourteen public directors, who shall reflect the social, economic and geographic characteristics of the population served by the Corporation;
- The Chief Executive Officer of the Corporation, who shall be a member of the Board during and by virtue of occupancy of the chief executive office and the Corporation, or, when the office of the Chief Executive Officer is vacant, the President of the Corporation who shall be a member of the Board and by virtue of occupancy of the office of President while the office of the Chief Executive Officer remains vacant;
- Six directors, who shall be representatives of health care facilities participating as members of the Corporation in accordance with Section 10-4-102 of the Alabama Code of 1975; and,
- Six directors, who shall be members of the medical profession in the state of Alabama.

No director (except the Chairman of the Board, the Chief Executive Officer and the President), who has served for two consecutive three-year terms, is eligible for re-election until he or she has not served on the Board for one year.

The composition of the Board of Directors, described above, complies with ALA. CODE § 10-4-103 (1975), which states in part:

“The board shall be composed of not less than 15 nor more than 27 directors...Providers of health care and their representatives may also serve on the board, but in no event may constitute a majority thereof. Persons who derive income from the delivery or administration of health care or services shall not be eligible to serve as public directors.”

Board members elected and serving at December 31, 2007 were as follows:

Directors/Residence

Principle Occupation

Terry Wayne Andrus
Opelika, Alabama

President
East Alabama Medical Center

James Malcolm Aycock Decatur, Alabama	President Cook's Pest Control
Donald Maurice Ball Montgomery, Alabama	Retired President and Chief Executive Officer Jackson Hospital and Clinic, Inc.
Raymond James Browne, M.D. Birmingham, Alabama	Physician Mayfair Internal Medicine
Clarence Neal Canup, M.D. Anniston, Alabama	Physician, Anniston Family Practice Medical Director, Northeast Alabama Regional Medical Center
Robert Curtis Chapman Cropwell, Alabama	Retired President and Chief Executive Officer Eastern Health System, Inc.
Edward Franklin Crowell Hope Hull, Alabama	Senior Vice President VT Miltope Corporation
Thomas Fuller Dyas, Jr. Auburn, Alabama	Partner Dyas Leasehold, LLC
Allen Paul Fletcher Anniston, Alabama	President and Chief Executive Officer Northeast Alabama Regional Medical Center
Cathy Anderson-Giles Mobile, Alabama	President and Chief Executive Officer Equity Technologies Corporation
Stanley Keith Hammack Mobile, Alabama	Vice President University of South Alabama Health Systems
Kenneth Earl Hubbard Birmingham, Alabama	Chairman and Chief Executive Officer Western Supermarkets
Brian Neal Kindred Tuscaloosa, Alabama	President and Chief Executive Officer DCH Health System
Charles Waldron Lancaster Gadsden, Alabama	President Lancaster Management
Honorable Helen Shores Lee Birmingham, Alabama	Circuit Judge Jefferson County Circuit Court

William Charles Mayer, III Birmingham, Alabama	Retired Senior Executive Vice President and General Banking Group Head - Regions Bank Partner - Oaktasasi Partners
James Phillip Merrell Tuscaloosa, Alabama	President Ross-Merrell Associates
Manly Eugene Moor, Jr. Birmingham, Alabama	Retired AmSouth Bank
Clarence Charles Nailen, Jr. Dothan, Alabama	President BBG Specialty Foods
Joel Candler Pittard, M.D. Opelika, Alabama	Physician Lee Obstetrics and Gynecology, PA
Gary Phillip Pope Birmingham, Alabama	Chief Executive Officer Blue Cross and Blue Shield of Alabama
Jon Emory Sanford, M.D. Fayette, Alabama	Physician Family Practice
John David Savage Muscle Shoals, Alabama	Retired Vice President Rolls, Inc.
James Michael Segrest Huntsville, Alabama	President and Chief Executive Officer The Spencer Companies, Inc.
William Jackson Stevens Birmingham, Alabama	President and Chief Executive Officer Motion Industries, Inc.
Burt Fowler Taylor, M.D. Mobile, Alabama	Physician The Orthopedic Group, P.C.
Pamela Duncan Varner, M.D. Birmingham, Alabama	Physician University of Alabama at Birmingham

Committees

Executive Committee

Article I, Section 14 of the Bylaws provided that the Company shall have an Executive Committee of the Board of Directors with authority to act as follows:

“During intervals between meetings of the Board of Directors, the Executive Committee shall have, subject to the control and direction of the Board, the authority to exercise any and all of the powers and to perform any and all duties of the Board of Directors as may lawfully be exercised and performed by such Committee.”

The following directors were serving on the Executive Committee as of December 31, 2007:

Manly Eugene Moor, Jr., Chairman
Donald Maurice Ball
Raymond James Browne, M.D.
Kenneth Earl Hubbard
William Charles Mayer, III
Gary Phillip Pope
William Jackson Stevens

Hospital Advisory Committee

Article I, Section 13 of the Bylaws provided that the Board of Directors shall establish a Hospital Advisory Committee consisting of five hospital representatives who are not members of the Board and are knowledgeable in providing health services. “The Advisory Committee shall from time to time, as requested by the Board of Directors or any committee thereof, consult and advise with the Board of Directors or any committee or member thereof concerning matters as to which consultation or advice is requested by such Board or committee.”

The following persons were serving on the Hospital Advisory Committee as of December 31, 2007:

Jeffery Maurice Brannon
Clark Patrick Christianson
Garry Lee Gause
Gary Ray Gore
Linda Upton Jordan

Other Committees

Article I, Section 15 of the Company’s Bylaws provided that, “The Board of Directors or the Chairman of the Board may appoint such committees from the

members of the Board as may be deemed necessary or advisable and may prescribe their respective powers authorities and duties.”

These other committees were in addition to the Executive Committee and the Hospital Advisory Committee, both of which were required by the Company's Bylaws.

The following committees had been established and existed as of December 31, 2007:

Salary Review Committee

William Jackson Stevens, Chairman
Allen Paul Fletcher
Manly Eugene Moor, Jr.
John David Savage
Burt Fowler Taylor, M.D.

Nominating Committee

Robert Curtis Chapman, Chairman
Clarence Neal Canup, M.D.
Thomas Fuller Dyas, Jr.
Manly Eugene Moor, Jr., ex officio
James Michael Segrest

Audit Committee

James Malcolm Aycock, Chairman
Donald Maurice Ball
Charles Waldron Lancaster
Helen Shores Lee
Manly Eugene Moor, Jr.
Clarence Charles Nailen, Jr.
Pamela Duncan Varner, M.D.

Medical Review Committee

Raymond James Browne, M.D.
Clarence Neal Canup, M.D.
Joel Candler Pittard, M.D.
Jon Emory Sanford, M.D.
Burt Fowler Taylor, M.D.
Pamela Duncan Varner, M.D.

Facility Standards and Membership Committee

Clarence Neal Canup, M.D., Chairman
Terry Wayne Andrus
Edward Franklin Crowell
Cathy Anderson-Giles
Bryan Neal Kindred
Charles Waldron Lancaster
James Phillip Merrell
Manly Eugene Moor, Jr., ex officio

Officers

<u>Position</u>	<u>Name</u>
Chairman of the Board	Manly Eugene Moor, Jr.
President	Gary Phillip Pope
Treasurer	Terry Dee Kellogg
Secretary	Arthur Grey Till, Jr.*
Senior Vice President	Joseph Benjamin Bolen, III*
Senior Vice President	James Martin Brown, Jr.
Vice President	Tony Hayes Carter
Vice President	Jerry William Chambers
Vice President	Edward Owen Harris
Vice President	Walter Thomas Hudgins, Jr.*
Vice President	Jeffery Alan Ingram
Senior Vice President	Richard Colin King
Senior Vice President	Timothy Lee Kirkpatrick
Senior Vice President/Chief Financial Officer	Sherrie Dumas LeMier
Assistant Vice President	Carol Downer Mackin
Vice President	Terry Joseph McCartney
Vice President	Douglas Edward McIntyre

Vice President
Vice President
Vice President
Senior Vice President
Vice President
Senior Vice President
Vice President
Vice President
Vice President
Vice President

William Allen Moon
Robert Reynolds Orr, Jr.
Michael Leonard Patterson
Patrick Earl Ryce, M.D.
Vickie Ledbetter Saxon
Timothy Terrell Sexton
Leigh Logan Stevens
Janet Perry Stewart
Cynthia Mizell Vice
Timothy Vines

* These three officers retired in 2008.

Code of Business Conduct and Compliance Program

The Company requires that conflict of interest statements be completed annually by all directors, officers and exempt status employees. In addition, the Company requires every new employee, whether they are exempt, non-exempt, full-time, part-time or contracted, to attend a Code of Business Conduct and Compliance Program.

The Code of Business and Compliance Program provides employees with a formal statement of the Company's standards and rules of ethical business. According to management, this program is usually conducted on the second day of employment. At the end of the program, the employee is required to sign a statement of understanding, which is maintained in the employee's personnel file.

A review was conducted of all conflict of interest statements filed by the Board of Directors and the Officers for the years covered by the examination. No items of disclosure, which seemed to have the potential of a material or adverse impact on the operations of the Company, were noted.

CORPORATE RECORDS

The Certificate of Incorporation and Bylaws and any amendments thereto, were inspected during the course of the examination and appeared to provide for the operation of the Company in accordance with usual corporate practices and applicable statutes and regulations.

HOLDING COMPANY AND AFFILIATE MATTERS

Holding Company

The Company is not subject to the Alabama Insurance Holding Company System Regulatory Act as defined in ALA. CODE § 27-29-1 (1975); however, its subsidiary, United Trust Insurance Company (UTIC) is registered with the Alabama Department of Insurance as registrant of an Insurance Holding Company System. UTIC is a wholly-owned subsidiary of Alabama Industries Financial Corporation (AIFC). AIFC is a wholly-owned subsidiary of the Company. See page 19 for the Company's organizational chart, which presents affiliated corporate relationships. Appropriate filings required under the Holding Company Act were made from time to time on behalf of the Company by UTIC as registrant.

Franchise Affiliation

The Company is affiliated with and is a franchisee of the Blue Cross and Blue Shield Association (Association), which is located in Chicago, Illinois. The Company pays annual dues to the Association in order to continue the right to use the Blue Cross and Blue Shield names and trademarks and to benefit from the services provided by the Association. Association dues charged to each Plan are based on a formula, which uses a graduated scale computed on a combination of total subscription (premium) revenue and subscription revenue per contract.

There are 39 "Blue Cross" and/or "Blue Shield" Plans affiliated by virtue of Association franchises in the United States and Puerto Rico. Approximately 20 Plans are statewide or U.S. possession organizations with the remaining plans covering only a specific county, territory or area. A few of the plans do not provide both Blue Cross and Blue Shield coverage within the same plan. Generally, the term "Blue Cross" refers to coverage provided for hospital inpatient and outpatient while "Blue Shield" refers to coverage provided for physicians, including major medical, dental and eye care. The Company's franchise covers the state of Alabama and includes both "Blue Cross" and "Blue Shield" coverage.

The Association provided various services to BCBSAL, which include the following:

1. Congressional Legislative Liaison
2. National Marketing
3. Research and development of new products

4. Competition studies
5. Studies of national trends
6. Training workshops for new staff in standardized areas such as:
 - a. Hospital Auditing
 - b. Underwriting
 - c. Accounting
 - d. Other functions common to all plans
7. Operation and availability of Blue Card and Inter-Plan Teleprocessing System - a system network used for inter-plan accounting for provider services provided by one Plan to another Plan's card holder (or subscriber), when the card holder is outside his/hers Plan's territory
8. National Contractor for Medicare Part A and Federal Employee Programs, through which BCBSAL participates.

BCBSAL is required under the franchise agreement to meet governance, financial and operational requirements and standards imposed by the Association. The Company is also required to produce and provide various reports to the Association.

Generally, services provided to a Plan's subscriber while in another Plan's territory are handled through the Inter-Plan Teleprocessing System, as discussed above in 7. There are complexities when dealing with certain national accounts, such as when a Plan enacts under a "Control Plan - Par Plan" arrangement.

The "Control Plan - Par Plan" operates in a manner whereby the Control Plan holds the master contract with a company (employer). The Control Plan is responsible for all administrative functions for their customers (employers) including maintaining benefits, eligibility, identification card production, customer service and all claims processing. The Participating Plans assist the Control Plan by hosting the Control Plan's membership in the Par Plan service area. The Par Plan is responsible for collecting, keying, pricing and electronically transmitting claims incurred in their service area to the Control Plan for processing. After claims have been processed by the Control Plan, the Par Plan transmits payments to their providers. All accounting for claim processing, claim expense and risk associated therewith flows through the Control Plan's financial statements. An administrative expense allowance is paid to the Participating Plan.

The BlueCard Program allows members without BlueCard PPO (Preferred Provider Organization), as defined in the following paragraph, to access other Plans' traditional providers. The discounts, the hold harmless clauses and claims filing clauses that other Plans have negotiated with their providers apply when

services are provided to subscribers while outside of the local Plan's service area. Groups automatically fall under this program if they do not have BlueCard PPO.

BlueCard PPO is a nationwide PPO program sponsored by the Blue Cross and Blue Shield Association and is symbolized by the "PPO in a suitcase" logo on the identification card. Nearly all of the Blue Cross and Blue Shield Plans have a PPO network that participates in this program. This program is frequently used to consistently administer PPO benefits for groups that do not qualify as National Accounts, but have employees outside of the local Plan's service area.

Management and Service Agreements

The Company provided various services to the following affiliated companies at December 31, 2007:

Cahaba Government Benefit Administrators (CGBA)

Effective April 1, 2006, BCBSAL entered into an administrative services agreement with CGBA. Under this agreement, CGBA will manage the Medicare Part B contract and Part A subcontract, while BCBSAL will provide the following services for CGBA:

- Provide facilities, personnel and experience in bidding on and negotiating Medicare Administrator Contractor (MAC) contracts and other Medicare Work;
- Prepare and forward billing and fee collection;
- Provide consultative functions with respect to bidding on MAC contracts and other Medicare work; and
- Provide human resources, system support, purchasing, LAN administration, telecommunication services, and graphic services.

BCBSAL will bill CGBA monthly for all costs incurred during the previous month. This agreement is automatically renewable for successive like terms of one-year unless written notice is given by either party to the contrary 180 days before the end of any one year term. On May 18, 2006, the agreement was amended to document the support services and direct costs that would be paid by BCBSAL on behalf of CGBA.

Cahaba Safeguard Administrators, LLC (CSA)

On June 1, 2002, BCBSAL entered into an administrative services agreement with CSA. The agreement provides that CSA will contract with the Company to provide facilities and administrative/staff support services that will enable CSA to provide Medicare Integrity Program services. CSA agreed to reimburse BCBSAL for the costs of providing such services on a non-profit basis. The term of this agreement is one year. It will automatically renew for successive like terms of one year unless written notice to the contrary is given by either party to the other not less than 180 days before the end of any one year term.

The agreement was amended and effective on July 5, 2002 to include the following additional responsibilities of BCBSAL:

- To prepare and forward billing to and collect from CSA the fees prescribed for the provision of CSA services;
- To perform consulting functions requested by CSA associated with bidding on task orders from Centers for Medicare and Medicaid Services for Medicare Integrity Services;
- To provide all necessary support services, including but not limited to: LAN administration, human resources services, internal audit services, telecommunication services, graphics services and legal services necessary for the business operation of CSA;
- To supply office equipment, personal computers, furniture, and other real and personal property as needed via a personal property lease; and
- To provide such other administrative and professional services as may reasonably be necessary for conduct of CSA business operations.

On April 1, 2005, a second amendment was issued to modify the cost rates for services provided under the agreement.

The Caring Foundation (TCF)

Effective January 1, 1991, BCBSAL entered into an administrative services agreement with TCF. The agreement provides that BCBSAL is to provide TCF with accounting, data processing, legal services and other managerial, administrative and professional services as may be reasonably necessary for the conduct of TCF's business. TCF agrees to reimburse BCBSAL for its cost of

providing such services on a non-profit basis. TCF is a charitable corporate foundation formed to "ensure that the Company will have adequate funds into the future available for handling civic obligations." The term of this agreement is one year. The agreement automatically renews unless written notification is made by either party 180 days before the end of the term. On January 1, 2005, the agreement was amended to document that TCF would no longer reimburse BCBSAL for an administrative charge as such costs were considered donations from BCBSAL. Additionally, TCF would assist BCBSAL in carrying out its responsibilities under this agreement.

United Trust Insurance Company (UTIC)

Effective January 1, 1990, BCBSAL entered into an administrative services agreement with UTIC. The agreement provides that the Company will furnish administrative services to UTIC including facilities, personnel, accounting, legal and auditing services. According to the agreement, a set monthly fee is to be paid to the Company for the services provided. The amount may be adjusted by giving UTIC 30 days advance notice. The charge is to be based on BCBSAL's cost to provide such services on a non-profit basis. The agreement was amended on December 7, 1999 to document the increase in the monthly administrative fee. On December 27, 2005, a second amendment was issued to add the provision that BCBSAL would maintain all master policies and other documentation as well as market and sell the Company's products.

Preferred Care Services, Inc. (PCS)

Effective June 1, 1989, BCBSAL entered into an administrative services agreement with PCS. The agreement provides that PCS wishes to contract with the Company to provide administrative and managerial services, personnel, facilities and experience and expertise in marketing their services. The agreement is for successive like terms of one year unless either party gives the other written notice 180 days before the end of the one year term.

The agreement was amended effective January 1, 1998 to include the following:

- The Company is to reimburse PCS for administrative services provided by the agreement; and
- PCS shall enter into contractual agreements with pharmacies and other health care entities in order to provide clinical pharmacy management for

the Company's participants. A mutually agreed upon fee will be paid to PCS by the Company.

Alabama Child Caring Foundation (ACCF)

Effective March 1, 1988, BCBSAL entered into an administrative services agreement with ACCF. The agreement states that BCBSAL will provide at no cost the following services:

- Administer the benefits provided by ACCF, subject to all of the terms and conditions of the benefit plan and to the terms and conditions of the agreement;
- Furnish application forms and material necessary and appropriate for the enrollment of subscribers and provide ACCF such assistance as reasonably necessary to the enrollment process;
- Issue identification cards to each subscriber enrolled and certified as eligible by ACCF to evidence the subscriber's entitlement to benefits under the plan; and
- Provide ACCF with claim cost projections, analyses, and other actuarial and statistical data as may be reasonably requested by ACCF in its management of the plan. The agreement was amended on March 1995 to add:
 - Claims administrator shall also provide all managerial and other overhead functions and services, including all necessary and appropriate accounting, equipment, utilities, supplies, legal compensation and benefits, payroll and similar services at no cost to ACCF.

Income Tax Allocation Agreements

The Company has tax sharing agreements with Cahaba Government Benefit Administrators (CGBA), Cahaba Safeguard Administrators (CSA), Alabama Industries Financial Corporation (AIFC), and Preferred Care Services (PCS) for the purpose of allocating income taxes with respect to the consolidated federal income tax return. The agreements provide that in the event that there is a net operating loss for any calendar year for any subsidiary, BCBSAL agrees to pay an amount equal to the applicable federal tax rate of that net operating loss. Likewise, if there is a net operating gain for any calendar year, each subsidiary agrees to pay

BCBSAL an amount equal to the applicable federal tax rate of that net operating gain. The agreements renew automatically for successive like terms of one year unless written notice to the contrary is given by either party to the other not less than 30 days before the end of any one-year term. The agreements with AIFC and PCS were amended on January 1, 2005 to add the provision that within 90 days following the filing of the BCBSAL federal consolidated tax return, inter-company balances are to be settled.

Organizational Chart

The following chart presents the corporate affiliations of the Company as of December 31, 2007. See page 19 for organizational chart.

DIVIDENDS TO STOCKHOLDERS OR POLICYHOLDERS

The Company is not a stock or a mutual corporation; therefore, no dividends were paid by the Company. See page 3 for discussion of the Company incorporation, under the caption "ORGANIZATION AND HISTORY."

FIDELITY BOND AND OTHER INSURANCE

The Company was a named insured with BCS Insurance Company for an aggregate amount, which met the suggested minimum requirements of the NAIC *Financial Condition Examiners Handbook*. In addition to this bond, the Company also had insurance coverage for the following:

- Auto Coverage provided by St. Paul Insurance Company
- Blanket Coverage provided by St. Paul Insurance Company which includes:
 - Acts of Terrorism
 - Building and Personal Property
 - Machinery and Equipment
 - Flood or Surface Water
 - Earthquake or Volcanic Eruption
 - Miscellaneous Property
 - Documents and Data located at Iron Mountain Storage
 - Valuable Paper
 - Leased Computers
 - Equipment Breakdown
- Umbrella Excess Liability provided by St. Paul Insurance Company
- Directors and Officers Liability provided by BCS Insurance Company
- Managed Care Errors and Omissions provided by BCS Insurance Company
- Electronic Crime and Fidelity provided by BCS Insurance Company
- Employee Benefit Liability provided by St. Paul Insurance Company
- Excess Errors and Omissions Liability provided by St. Paul Insurance Company
- Fiduciary Liability provided by St. Paul Insurance Company (Note: As of January 1, 2008, this policy is provided by Chubb Group Insurance Companies.)
- General Liability provided by St. Paul Insurance Company
- Network Security Coverage provided by Darwin Select Insurance Company

- Non-owned Aircraft Coverage provided by W. Brown Associates Insurance Services
- Nurses Liability Coverage provided by Gulf Insurance Company

EMPLOYEE AND AGENT WELFARE

The Company offered the following benefit plans for its employees and agents at December 31, 2007.

Vacation Leave	Group Travel Accident Insurance
Sick Leave	Voluntary Travel Accident Plan
Paid Holidays	Tuition Reimbursement
Paid Jury Duty	Life, Accident and Disability Insurance
Personal Leave	401k Deferred Compensation
Funeral Leave	Retirement Plan
Military Pay Differential	On-Premises Health Assistance
Health Insurance	On-Site Sick Care for Children
Dental Insurance	Associate Assistance Program
Service Incentive Award	Overtime Meal Allowance
GainSharing Program (for exempt)	Performance Based Pay (non-exempt)
Supplemental Benefit Plan	Off-Site Child Development Center
Air Med	Dependent Care Assistance Plan
Premium Only Provision	Long Term Care Insurance
Medical Leave in the 1 st Year	FMLA Leave
Extended Leave	

The Violent Crime Control and Law Enforcement act of 1994, US Code, Title 18, Section 1033 (e)(1)(A), in part, prohibits individuals who have been convicted of specified criminal activity from engaging in the business of insurance without written consent from the [sic Alabama] Commissioner of Insurance. The Company, as part of its hiring procedures, requires potential employees and contractors to disclose and explain any criminal convictions and criminal background checks are performed on all new hires. The Company also requires all employees to sign a conflict of interest statement yearly stating that they have not been convicted of a felony since becoming an associate of the Company. The Company performs criminal reinvestigations on all associates at least once every five years and compares that information to associates' conflict of interest statements.

SPECIAL DEPOSITS

The Company maintained the following deposits with the respective statutory authorities at December 31, 2007, as required or permitted by law.

States and Territories	Book Value	Fair Value
Alabama	\$ 30,000	\$ 30,000
TOTAL	\$ 30,000	\$ 30,000

FINANCIAL CONDITION/GROWTH OF THE COMPANY

	Admitted Assets	Liabilities	Capital & Surplus	Premiums Earned
2007*	\$ 1,917,173,084	\$ 1,172,719,108	\$ 744,453,976	\$ 3,495,234,465
2006	1,781,603,269	1,087,016,348	694,586,920	3,341,983,684
2005	1,610,846,857	1,023,693,331	587,153,526	3,059,456,231
2004	1,509,855,569	955,505,300	554,350,269	2,797,283,868
2003	1,378,626,876	864,009,534	514,617,342	2,537,225,027
2002*	1,267,480,836	815,217,243	452,263,593	2,352,730,396

*Per Examination

SCHEDULE T – PREMIUMS AND OTHER CONSIDERATIONS

States	Accident & Health Premiums	Medicare Title XVIII	Federal Employees Health Benefit Program Premiums	Total
Alabama	\$ 2,883,187,857	\$ 64,235,261	\$ 551,391,234	\$ 3,498,814,352
Reporting entity contributions for Employee Benefit Plans	362,147			362,147
TOTAL	\$ 2,883,550,004	\$ 64,235,261	\$ 551,391,234	\$ 3,499,176,499

MARKET CONDUCT ACTIVITIES

Territory

As of December 31, 2007, the Company was licensed to transact business in the state of Alabama. The Company is licensed as Hospital, Medical and Dental Service or Indemnity. The Company's lines of business include Comprehensive (Hospital and Medical), Title XVIII Medicare and Medicare Supplement, Long-Term Care and Other Health (Federal Employees Health Benefits Plan). A perpetual Certificate of Authority was issued to the Company with an effective date of June 1, 1991, which shall remain in effect until suspended, cancelled or revoked. The Company is solely licensed to conduct health insurance business in the state of Alabama.

Plan of Operation

The Company is a non-stock, not-for-profit company, which maintains and operates health care plans under which services are offered to the public. Individuals who participate in a plan are referred to as "subscribers." The Company marketed both insured health plans and contracts to administer self-insured health plans via salaried sales representatives employed by the Company. The Company's Board of Directors establishes an annual market goal. The goal is then communicated to the various district managers and ultimately to the marketing representatives.

Various policies and plans offered by the Company include the following: Rural Health Program (an ALFA franchise group), Individual Health Care policies and Group contracts including underwritten plans and cost plus (self insured) plans.

The Company maintains a home office, four district offices and seven satellite offices. Most services and functions are handled at the home office located on Riverchase Parkway East in Birmingham, Alabama. The district offices are located in the cities of Birmingham, Huntsville, Montgomery and Mobile with the satellite offices being in Andalusia, Dothan, Florence, Foley, Gadsden, Opelika and Tuscaloosa.

Marketing and Sales

The Company's advertising and marketing strategy focused on television commercials. Media advertising is primarily through television and advertisements in newspapers throughout Alabama. The Company utilized various means to

market its products through ads produced by the Company and those provided by the Blue Cross and Blue Shield Association, as well as media spots and materials developed through the Company's advertising agency.

The Company markets and acquires business (group health and dental insurance products) by utilizing Marketing & Service Representatives that are employees of BCBSAL. These products are marketed to employers in the state that have two to 999 employees. For groups/employers with 1,000 or more employees, these groups are managed by Account Executive and an Account Executive Coordinator who are also employees of BCBSAL. These groups are serviced from the home office and the district offices in Montgomery, Mobile, Huntsville and Birmingham.

BCBSAL also offers Individual Health Products and Long-Term Care. There are three individual plans which are Individual Blue, Individual Blue HSA Qualified and Blue Link. Medicare-eligible individuals are offered CPlus, Blue Advantage and Blue RX products. These products are sold and serviced by Marketing Representatives and Benefit Service Representatives who are employees of the Company.

Advertising

The Company did not file its Long-Term Care (LTC) advertisements for review and approval with the ALDOI Rates & Forms Division in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.21 (2001), which states,

“(1) Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the Commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.”

For the period under review, ten of the LTC advertisements were not filed with the ALDOI.

Agents/Representatives

The Company utilized captive (in house) agents to market and to solicit its business. All marketing associates of the Company are enrolled in an intense training course where they receive in-depth training on the multiple products that BCBSAL offers; federal government regulations surrounding HIPAA, ERISA and COBRA; as well as the Company's organizational structure. The representative training is designed to familiarize the representative with support processes such as enrollment, claims processing, billing and customer service. The sales force is kept current through continuing education classes, NewsFlash and Undercurrent articles, Webinars and on-site training.

An inspection of the Company's records determined that the agents representing the Company were duly licensed by the Company. At December 31, 2007, the Company had 230 employees with producer's license, including 144 agents. A reconciliation of the Company's agents listing was made to the Alabama Department of Insurance (ALDOI) Licensing Division's listing. There were 31 employees with an active agent's license that were not appointed by the Company. These employees were required to be licensed because they assisted agents with making benefit recommendations and providing consultative functions. Additionally, the Centers for Medicare and Medicaid Services (CMS) require anyone who enrolls or advises to be licensed. CMS 422 CFR Parts 422.2272 (c) and 423.2272 (c) states, "we propose that plans must appoint and use only State licensed representatives to conduct direct marketing activities in accordance with applicable State appointment laws." However, ALA. CODE § 27-7-1 (18) 1975 requires, "A service representative shall otherwise qualify and be licensed as a service representative under this chapter...The service representative must be appointed for each insurer or association of insurer represented for each class of insurance handled by the insurer or insurers in this state." The Company is also required to file Licensing Division Form AL-1-TSR (1/2008) with the ALDOI, for all employees with a producer license that assist agents in a service representative capacity.

Claims Processing

Health Claims

The total claims paid for all lines of business reconciled to the claims paid shown in the annual statement for that year. A sample of paid Merit, Small Group and Federal Employee Program (FEP) claims for 2007 were reviewed. The documentation was reviewed with regards to compliance with policy provision,

adequacy of documentation and accuracy of actuarial lags. One variance was noted which was determined to be immaterial.

Long-Term Care (LTC) Claims

A sample of LTC paid claims for the examination period was reviewed to determine that claim payments were payable to the correct payees with the correct address, that benefit amounts were correct and that there were no misrepresentations of relevant facts or policy provisions relating to coverages at issue. It was determined that the LTC claims were appropriately paid according to the policy provisions.

Policy Forms and Underwriting

The Company properly utilized the rates filed and approved by the Alabama Department of Insurance for the examination period under review. The Company performed periodic filings with the Alabama Department of Insurance and did not implement the rates calculated until the proper approval was received. During the review of the rate filings, the Company had premium and dental rate increases for the Small Group category of business for 2003, 2004, 2005 and 2007. There were no increases in 2006. The rate increases were developed to comply with ALA. ADMIN. CODE 482-1-116 (2001) which purpose is to enhance the availability of health insurance coverage to small employers.

Long-Term Care

Three Long-Term Care (LTC) policy forms disclosed that the number of days for notifying policyholder's of a premium increase was 30 days, which was in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.28 at that time. However, on July 1, 2006, the Regulation was amended requiring companies to notify policyholders within 45 days of a premium increase which states, "(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least [forty five (45) days] prior to the implementation of the premium rate schedule increase by the insurer...."

Per the Company, these forms will be revised with the correct number of days for notifying policyholders of a premium increase and will be submitted to the ALDOI Rates & Forms Division for approval. The Company should revise all LTC policies issued after July 1, 2006 to comply with the Regulation.

Group LTC Replacement Underwriting Procedures

The Company's Group LTC Underwriting Replacement procedures were reviewed to determine compliance with ALA. ADMIN. CODE 482-1-091 in its entirety.

ALA. ADMIN. CODE 482-1-091-.06 (4)(c) and (5) (2006) states,

“... that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason... shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.”

“If a group long-term care policy is replaced... the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered... and premiums charged to persons under the new group policy: (a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (b) Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.”

Per the Company's LTC Marketing and Operations, the Company has only had a few group replacement situations and none during the period under examination. The Company used its standard group underwriting guidelines for those situations, but the guidelines did not relate to the replacement situations. The Company should develop and implement underwriting guidelines for Group LTC Replacements that are in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.06 (2006) stated above.

ALA. ADMIN. CODE 482-1-091-.12 (3) (2006) states,

“Solicitation Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.”

A sample of replacement policies issued during the examination period was reviewed to determine if the files included the required disclosure form. Only two of the files sampled had the form. The Company's LTC Marketing & Operations Department intends to immediately establish and implement procedures to educate the sales force on this requirement, as well as protocols for the Company's administrative departments to ensure this Notice is supplied both to the customer and within the application file prior to or upon issuance of the Individual replacement policy.

Compliance with the Requirements of Mental Health Parity Act

ALA. CODE § 27-54-4(b) (1) (2000) states, "The group health benefit plan shall offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses."

The Mental Health Parity Act (MHPA) allows for two exemptions: (1) a small employer who employed an average of between 2 and 50 employees and (2) a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least 1%.

The Company did not maintain evidence that employers of 51+ were offered mental health benefits not less than other medical benefits of the plan or that the employer either accepted or rejected the offer. Therefore, it could not be determined if the Company complied with ALA. CODE § 27-54-4(b) (1) (2000).

Policyholder Complaints

During the examination period, there were 1,137 complaints documented in the Company's complaint logs for Corporate Compliance, HIPAA, Customer Feedback and the Alabama Department of Insurance (ALDOI). The Company appropriately maintained the following information in its grievance register: general description of the reason for the grievance; the date the grievance was received; the date of resolution and the name of the covered person for whom the grievance was filed.

A review of the ALDOI register determined that there was not a large number of complaints or any trending of complaints which related to reimbursement rates being too low or to non-payment of claims. In addition, there were 33 complaints

which the responses were beyond the ten days as required by ALA. ADMIN. CODE 482-1-118-.06 (1999) which states, "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the commissioner..." The Company provided documentation of the late complaints which included detailed explanations for the dates that additional time was requested and when the final response was provided to the ALDOI. The information was deemed to be appropriate.

Evidence of Grievance Procedures

The Company's Group Summary Plan Description (SPD) and Individual Benefit Booklet were reviewed for its grievance procedures. The Company had appropriate written procedures and processes for handling expedited appeal and informed subscribers of their rights and due process for how expedited appeals are handled in the Group Summary Plan Description and Individual Benefit Booklet.

Privacy Standards

The Company was not required to comply with the NAIC Privacy Model Regulation, ALA. ADMIN. CODE 482-1-122 (2001), since it was incorporated under ALA. CODE § 10-4-103 (1975). However, the Company is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) where Privacy standards were established beginning April 14, 2003.

The Company complied with the requirements of HIPAA as follows:

- A Corporate Operating Policy has been implemented to guard against unauthorized collection, use or disclosure of member's protected health information;
- The Company does not share its members' or subscribers' personal health or financial information with any nonaffiliated third parties;
- HIPAA training is provided to new associates within two weeks of their employment;
- Existing employees receive updated HIPAA training every three years;
- Employees access to members' and subscribers' health information is based upon their job title;
- Strict disciplinary measures have been implemented for violations of health information policies up to and including termination of employment; and

- Business Associates (Health Care providers) are informed of their obligation to comply with any applicable state and federal statutory and regulatory requirements governing the collection, use or disclosure of protected health information.

The Company's Privacy Notice to members and subscribers disclosed the types of information collected, the way the information is used and the manner of collections. The notice also specifically states the member's rights and that the Company does not disclose any information to any nonaffiliated third parties unless permitted to do so by law. The Company's Privacy Policy does not allow for an opt out provision. There is not an opt out provision due to the following:

- (1) the Company does not disclose any nonpublic personal financial information to nonaffiliated third parties;
- (2) the Company does not disclose any nonpublic personal health information to nonaffiliated third parties; and
- (3) the Company is not required to comply with the NAIC Privacy Model Regulation, ALA. ADMIN. CODE 482-1-122 (2001), because of its incorporation under ALA. CODE § 10-4-103 (1975).

The Company only allows disclosure of medical information for the following purposes: Health Care Provider's Treatment Purposes, Payment, Health Care Operations, Health Services to Business Associates and to Plan Sponsor, and as required by law. The Company does not allow disclosure of personal health and medical information for any other purposes unless written authorization is received from the member or subscriber.

REINSURANCE

Assumed Reinsurance

The Company did not assume any reinsurance during the examination period.

Ceded Reinsurance

The Company ceded reinsurance under two agreements in effect at December 31, 2007. These agreements were reviewed with regard to type, limits, and pertinent safeguards. The following was noted during the review of these agreements:

Munich American Reassurance Company (MARC) effective December 1, 2001

The Company ceded its Long-Term Care policies on an automatic coinsurance basis. For claims on policies that have been paid less than or equal to the equivalent value of 1,825 days of claims payments (Pre-Five Year Claims), MARC will reinsure 50% of the risk up to the Company's Maximum Daily Benefit Amount of \$300. For claims on policies that have been paid in the equivalent value of more than 1,825 days of claims payments (Post-Five Year Claims), MARC will reinsure 80% of the risk up to the Company's Maximum Daily Benefit. As reflected in the Company's 2007 Schedule S, the Company had ceded premiums of \$2,775,214 and reserve credits taken of \$467,545.

HM Life Insurance Company (HM Life) effective December 31, 2006

The Blue Cross and Blue Shield Association (Association) gave all Blue plans the option to participate or not in the Federal Employees Program Blue Vision Plan (FEP BlueVision). If the plan chose not to participate, another Blue Plan would service the area. The Company chose to participate and was given the option to underwrite the business themselves or to reinsure the business. The Company reinsures 100% of the FEP BlueVision business issued in the Company's service area with HM Life. The Company is responsible for the sales and marketing of FEP BlueVision and the Association helped coordinate this reinsurance agreement. The Company receives \$0.21 per member per month as ceding commission to cover administrative services. As reflected in the Company's 2007 Schedule S, the Company had ceded premiums of \$1,166,820 and reserve credits taken of \$60,738.

The Company did not establish standards of acceptability of its reinsurers as was recommended in the prior examination. The Company also did not establish procedures to monitor the financial strength of its reinsurers.

ACCOUNTS AND RECORDS

Information Systems and Other Security Areas

The Company's claim, premium, expense and cash processing is conducted using an IBM Mainframe. This computer utilizes 13 general purpose processors in conjunction with three z application assist processors (zAAP) and three z integrated information processors (zIIP) along with 80 gigabytes of volatile memory to process a maximum of 8.759 billion instructions per second.

Another IBM Mainframe is utilized by the Company for testing. The testing computer uses seven general purpose processors, in conjunction with two zIIPs and two zAAPs along with 64 gigabytes of volatile memory to process a maximum of 5.268 billion instructions per second.

The Company began using Epicor as its new commercial general ledger application, which derives data from mainframe processing. Other financial applications including Concur, SQL Financials, Camra and PeopleSoft were also utilized by the Company.

During the examination period, the Company outsourced the conversion of imaged claims into data files to Affiliated Computer Services, Commercial Data Processing and SourceCorp. The services provided represented approximately 8% of all claims data files.

In the previous Report of Examination, there were employees with multiple active identification cards. A recommendation was made for each employee to have only one active identification card. The Company's management stated that they had made a business decision to allow multiple identification cards for select executives.

Capital Benchmark Requirement and Health Risk Based Capital

The Company was required by a circuit court suit to maintain a certain capital benchmark level for six years from 1998 to 2004. At the expiration of that court order, the Company requested the use of the Health Risk Based Capital (HRBC) as a different methodology, which was approved on October 26, 2004 by the Alabama Department of Insurance (ALDOI). An amendment to the contract was done in 2008 changing the HRBC ratio from a target level of 850% to a range of 425% to 850%, which was also approved by the ALDOI. Per the Company's 2007 Annual Statement- Five-Year Historical Data, the Company's HRBC levels for 2004 through 2007 were:

2004- 673.05%
2005- 664.28%
2006- 746.72%
2007- 773.94%

The Company's HRBC ratios were within the required range during the examination period; however, the Blue Cross and Blue Shield Association (Association) required the Company to maintain a HRBC ratio of 800% or maintain a Subscriber Protection Account to hold in custody amounts to make up the difference between the Company's HRBC and the required 800%. Because the Company's HRBC ratio was less than 800%, the Company set up a Subscriber Protection Account to meet the Association's requirements.

Actuarial Opinions

The Company's opining actuary for the examination period was Gary L. Brace, FSA, MAAA, who is associated with the consulting actuarial firm of Milliman, Inc., Consultants and Actuaries.

The actuarial opinion was not complete in that it did not contain all of the language required by the NAIC *Annual Statement Instructions*. Specifically the language that was omitted was, "Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion."

FINANCIAL STATEMENTS

The Financial Statements included in this report were prepared on the basis of the Company's records, and the valuations and determinations made during the examination for the year 2007. Amounts shown in the comparative statements for the years 2003, 2004, 2005, 2006 and 2007 were compiled from Company copies of filed Annual Statements. The statements are presented in the following order:

Statement of Assets	35
Statement of Liabilities, Surplus and Other Funds	36
Statement of Operations.....	37
Capital and Surplus Account.....	38

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

Blue Cross and Blue Shield of Alabama
Statement of Assets
For the Year Ended December 31, 2007

	<u>Assets</u>	<u>Nonadmitted</u> <u>Assets</u>	<u>Net Admitted</u> <u>Assets</u>
Bonds - Note 1	\$ 867,827,335	\$ -	\$ 867,827,335
Stocks: Preferred stocks	4,238,784	-	4,238,784
Stocks: Common stocks	278,718,949	-	278,718,949
Real estate: Properties occupied by the Company	108,250,436	843,960	107,406,476
Cash, cash equivalents and short-term investments	218,238,968	-	218,238,968
Other invested assets	3,000,000	-	3,000,000
Subtotal, cash and invested assets	\$ 1,480,274,472	\$ 843,960	\$ 1,479,430,512
Investment income due and accrued	9,771,259	-	9,771,259
Premium considerations:			
Uncollected premiums and agents' balances in the course of collection	209,347,023	1,612,465	207,734,558
Amounts receivable relating to uninsured plans	157,019,176	527,439	156,491,737
Net deferred tax asset	360,321,087	349,707,143	10,613,944
Electronic data processing equipment and software	117,856,769	111,795,149	6,061,620
Furniture and equipment, including health care delivery assets	8,973,038	8,973,038	-
Receivable from parent, subsidiaries and affiliates	5,479,336	-	5,479,336
Health care and other amounts receivable	72,189,342	34,524,379	37,664,963
Other assets nonadmitted	45,699,980	45,699,980	-
Premium tax recoverable	3,669,974	-	3,669,974
Accrued premium tax	255,181	-	255,181
TOTAL	<u>\$ 2,470,856,637</u>	<u>\$ 553,683,553</u>	<u>\$ 1,917,173,084</u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

**Blue Cross and Blue Shield of Alabama
Statement of Liabilities, Capital and Surplus
For the Year Ended December 31, 2007**

<u>LIABILITIES</u>	<u>2007</u>
Claims unpaid	\$ 327,365,333
Unpaid claims adjustment expenses	11,279,492
Aggregate health policy reserves	330,427,610
Premiums received in advance	58,492,091
General expenses due or accrued	285,631,674
Current federal and foreign income tax payable and interest thereon	23,847,820
Amounts withheld or retained for the account of others - Note 2	33,597,908
Amounts due to parent, subsidiaries and affiliates	4,401,418
Liability for amounts held under uninsured plans	92,962,706
Deferred gain in unassigned funds	<u>4,713,056</u>
TOTAL LIABILITIES	\$ 1,172,719,108
<u>CAPITAL AND SURPLUS</u>	
Unassigned funds (surplus) - Note 3	<u>744,453,976</u>
TOTAL LIABILITIES, CAPITAL AND SURPLUS	<u>\$ 1,917,173,084</u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

Blue Cross and Blue Shield of Alabama
Statement of Revenue and Expenses
For the Years Ended December 31, 2007, 2006, 2005, 2004 and 2003

	2007	2006	2005	2004	2003
Net premium income	\$ 3,495,234,465	\$ 3,341,983,684	\$ 3,059,456,231	\$ 2,797,283,868	\$ 2,537,225,027
Change in unearned premium reserves	<u>11,506,011</u>	<u>(15,678,996)</u>	<u>6,083,872</u>	<u>(21,998,234)</u>	<u>(33,174,877)</u>
Total revenues	<u>\$ 3,506,740,476</u>	<u>\$ 3,326,304,688</u>	<u>\$ 3,065,540,103</u>	<u>\$ 2,775,285,634</u>	<u>\$ 2,504,050,150</u>
Hospital and Medical:					
Hospital/medical benefits	\$ 2,031,325,650	\$ 1,898,241,000	\$ 1,786,810,440	\$ 1,682,665,996	\$ 1,500,668,616
Other professional services	571,077,182	553,035,681	546,392,542	496,581,398	433,626,755
Emergency room and out-of-area	220,009,700	200,360,995	177,968,354	147,641,223	122,617,545
Prescription drugs	<u>402,756,922</u>	<u>359,600,381</u>	<u>319,919,009</u>	<u>287,919,593</u>	<u>244,549,192</u>
Subtotal	<u>\$ 3,225,169,454</u>	<u>\$ 3,011,238,057</u>	<u>\$ 2,831,090,345</u>	<u>\$ 2,614,808,210</u>	<u>\$ 2,301,462,108</u>
Less:					
Net reinsurance recoveries	\$ 1,070,159	\$ 132,346	\$ 11,976	\$ 138,182	\$ -
Total hospital and medical	3,224,099,295	3,011,105,711	2,831,078,369	2,614,670,028	2,301,462,108
Claim adjustment expenses	71,452,694	72,596,002	56,790,584	39,445,026	51,692,692
General administrative expenses	<u>191,596,923</u>	<u>138,537,274</u>	<u>158,078,523</u>	<u>125,548,491</u>	<u>103,018,514</u>
Total underwriting deductions	\$ 3,487,148,912	\$ 3,222,238,987	\$ 3,045,947,476	\$ 2,779,663,545	\$ 2,456,173,314
Net underwriting gain or (loss)	19,591,564	104,065,701	19,592,627	(4,377,911)	47,876,836
Net investment income earned	62,029,290	52,576,809	40,829,558	37,200,885	34,001,979
Net realized capital gains (losses)	9,246,275	3,318,145	5,893,197	4,734,909	(2,302,702)
Net investment gains (losses)	71,275,565	55,894,954	46,722,755	41,935,794	31,699,277
Net income or (loss) after capital gains tax and before other federal income taxes	90,867,129	159,960,655	66,315,382	37,557,883	79,576,113
Federal income taxes incurred	<u>\$ 19,216,276</u>	<u>\$ 45,902,322</u>	<u>\$ 17,404,206</u>	<u>\$ 8,675,343</u>	<u>\$ 15,561,910</u>
Net income (loss)	<u>\$ 71,650,853</u>	<u>\$ 114,058,333</u>	<u>\$ 48,911,176</u>	<u>\$ 28,882,540</u>	<u>\$ 64,014,203</u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

Blue Cross and Blue Shield of Alabama
Statement of Revenue and Expenses (continued)
For the Years Ended December 31, 2007, 2006, 2005, 2004 and 2003

	2007	2006	2005	2004	2003
<u>Capital and Surplus Account</u>					
Capital and surplus prior reporting period	\$ 694,586,920	\$ 587,153,526	\$ 554,350,269	\$ 514,617,342	\$ 452,263,593
Net income	71,650,853	114,058,333	48,911,176	28,882,540	64,014,203
Change in net unrealized capital gains (losses)	(14,068,521)	13,241,168	(1,204,648)	7,682,173	26,448,385
Change in net deferred income tax	45,561,690	36,186,286	17,235,645	10,081,377	16,556,303
Change in nonadmitted assets	(56,218,279)	(43,362,473)	(31,266,355)	(22,347,246)	(36,104,386)
Change in additional minimum liability of defined benefit plans	2,616,203	(3,470,882)	(872,561)	15,434,083	(15,434,083)
Change in intangible asset for defined benefit plans	(2,090,436)	(2,090,436)	-	-	6,873,327
Deferred gain in unassigned funds	2,415,546	(7,125,602)	-	-	-
Net change in capital & surplus	<u>\$ 49,867,056</u>	<u>\$ 107,436,394</u>	<u>\$ 32,803,257</u>	<u>\$ 39,732,927</u>	<u>\$ 62,353,749</u>
Capital and surplus end of reporting period	<u>\$ 744,453,976</u>	<u>\$ 694,589,920</u>	<u>\$ 587,153,526</u>	<u>\$ 554,350,269</u>	<u>\$ 514,617,342</u>

**THE NOTES TO THE FINANCIAL STATEMENTS ARE AN
INTEGRAL PART THEREOF.**

NOTES TO FINANCIAL STATEMENTS

Note 1 – Bonds

\$867,827,335

The above captioned amount is the same as reported by the Company in the 2007 Annual Statement.

The previous examination noted that the Company did not file SUB 1 filings in accordance with Part 8, Section 2 (a) of the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* which requires the SUB 1 form to be filed with the NAIC Securities Valuation Office (SVO) within 30 days of acquisition or formation of a new SCA investment. The Company formed Cahaba Government Benefit Administrators, LLC on April 1, 2006 and did not file the SUB 1 filing until September 5, 2007.

The previous examination also noted that the Company did not file SUB 2 filings in accordance with Part 8, Section 2 (c) of the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* which requires the SUB 2 form to be filed with the NAIC SVO by June of each year after the filing of the SUB 1 form for the SCA. The Company did not file the year-end 2007 SUB 2 filings until October 28, 2008.

The previous examination report recommended that the Company file all necessary forms with the SVO in a timely manner as required by the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* Part 5, page 12, section 4 (a) (ii). Since the SUB 1 and SUB 2 forms were not filed within a timely manner, the Company did not comply with this recommendation.

Note 2- Amounts withheld or retained for the account of others

\$33,597,908

The captioned amount is the same as reported by the Company in its 2007 Annual Statement.

According to ALA. CODE § 35-12-72 (2004), “Presumption of abandonment (a) Property is presumed abandoned if it is unclaimed by the apparent owner during the time set forth below for the particular property: ... (18) All other property, three years after the owner’s right to demand the property or after the obligation to pay or distribute the property arises, whichever first occurs.” Also regarding the unclaimed property report to be filed with the Alabama State Treasurer, according to ALA. CODE §35-12-76 (2004) (c) “The report shall be filed before November 1 of each year and cover the 12 months next preceding July 1 of that year.”

After a review of 244 stale-dated checks over three years past due at July 1, 2007, the examiner determined that there were eight checks totaling \$858 that should have been escheated to the Alabama Treasurer in accordance with the aforementioned statutes. These checks were subsequently remitted to the Alabama State Treasurer in December 2008.

There were an additional 10,185 stale-dated checks totaling \$772,142 that were also over three years past due at July 1, 2007. Due to the noncompliance issues already noted after the review of the 244 stale-dated checks, the examiner opted to not review the remaining 10,185 stale-dated checks during the course of the examination; however, the Company will need to review these stale-dated checks and determine which checks are related to Alabama and escheat them to the Alabama Treasurer in accordance with ALA. CODE §35-12-76 (c) (2004). For those stale-dated checks not related to Alabama, the Company should determine the appropriate action for each related state.

Note 3 – Unassigned Funds (surplus)

\$744,453,976

Unassigned funds (surplus), as determined by this examination, was the same as reported by the Company in its 2007 Annual Statement.

SUBSEQUENT EVENTS

A review of events subsequent to the December 31, 2007 examination date was done. The following was noted during this review:

Three officers announced their retirement effective in 2008. They were Grey Till, Vice President and General Counsel; Joseph Bolen, Senior Vice President of Health Care Networks; and, Tommy Hudgins, Vice President of District Sales. Upon Mr. Till's retirement, Carol D. "Koko" Mackin assumed the responsibilities of Corporate Secretary. Scott McGlaun was hired as the Company's Chief Information Officer effective October 1, 2008.

As was approved by the Board, the Company is building a new primary data center facility with site preparation scheduled to begin early March 2009 with a projected completion date of late Summer or Fall 2010.

With regard to Hospital Tiered Network and the Company's first step toward value-based reimbursements with the purpose of further aligning healthcare cost

and quality, effective October 1, 2008, the Company will not cover or reimburse hospitals for specific medical errors relating to preventable events by the hospitals.

The Company's Bylaws were amended and were approved by the Board on March 26, 2008. The amendments were as follows:

Article I Section 3. Selection and Terms of Office- If the Company has a Vice Chairman of the Board, this person shall be excluded from the requirement that after serving two consecutive three year terms, no director shall be eligible for re-election until he shall have been off the Board for one year. Also, the Chairman and the Vice Chairman of the Board, once elected to office, may serve no more than the remainder of his or her then current term, and two consecutive three-year terms thereafter.

Section 9. Notice of Meetings- The means of notifying the Board members of regular meetings shall be by telephone, electronic mail, facsimile, U.S. mail, overnight courier or telegram. Special meetings can be given by the Chief Executive Officer (President was removed).

Section 14. Executive Committee- The requirement for the number of 7 Executive Committee members was removed and the Vice Chairman of the Board was added for a required member when so elected. The Board may prescribe additional powers, authorities and duties of the Executive Committee.

Section 15- Other Committees- A requirement was added regarding the committee members of all standing committees, with the exception of the Medical Review Committee, shall be comprised of a majority of public directors.

Article II Section 1. Officers- The officers of the Corporation shall be ... a Vice Chairman of the Board (when so elected from time to time from the membership of the Board)... . Neither the offices of Chairman and Chief Executive Officer nor the offices of Vice Chairman and the Chief Executive Officer may be held concurrently by the same person.

Section 2. Chairman of the Board- The requirement that the Chairman shall submit annually to the Board of Directors a report covering the affairs of the Corporation was removed.

Section 3. Vice Chairman of the Board (was added in its entirety)- The Vice Chairman of the Board (when so elected from time to time from the membership of the Board), in the absence, disability or disqualification of the Chairman of the Board, shall assume all of the duties of the Chairman of the Board, provided that

such duties shall at all times be subject to the control of the Board. In addition, the Vice Chairman shall perform such duties as are from time to time delegated to such office by the Board or by the Chairman of the Board.

Article III Section 4. Fees- was completely removed.

The Board also approved on March 26, 2008 the following: the Board of Directors' Governance Policy and Guidelines, the Audit Committee Charter, the Compensation Committee Charter, the Executive Committee Charter, the Facility Standards Committee Charter, the Medical Review Charter, and the Nominating Committee Charter. The purpose of the Board of Directors' Governance Policy and Guidelines establishes the Board's policy and guidelines for the eligibility and selection criteria for Board members and members of certain committees of the Board; the policies and procedures for the periodic evaluation of Board functions and processes; the periodic training of Board members; the procedures for conduct of Board and Committee meetings, both regular and executive; the eligibility and appointment of Committee members; Board member conflicts of interest and management succession planning. The Board may modify or amend these Guidelines and the authority and responsibilities of the Board.

CONTINGENT LIABILITIES AND PENDING LITIGATION

The examination for contingent liabilities and pending litigation included a review of the Company's Annual Statement disclosures, minutes of the corporate governing bodies, pending claims, and the usual examination of the accounts for unrecorded items. No unreported contingent liabilities were noted and all litigation pending against the Company, at December 31, 2007, appeared to be within the ordinary course of its business.

The Company's Chief Executive Officers and its Chief Financial Officer executed a letter of representation, attesting to the non-existence of unreported liabilities and contingencies as of December 31, 2007.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted during the current examination with regard to the Company's compliance with the recommendations made in the previous examination report. This review indicated that the Company had satisfactorily

complied with those recommendations, with the exception of certain items, which are commented on and reaffirmed below:

Ceded Reinsurance - It was noted in this examination, as it was in the prior examination, that the Company did not establish standards of acceptability for its reinsurers. The Company also did not have procedures to monitor the financial strength of its reinsurers. Recommendations are included in this examination report at page 45.

Accounts and Records – In the previous examination there were employees with multiple active identification cards, and a recommendation was made for each employee to have only one active identification card. During this examination, management stated that they had made a business decision to allow multiple identification cards for select executives. See page 45 for the recommendation included in the examination report.

Bonds – As discussed on page 39, the Company again did not comply with filing the necessary forms with the SVO in a timely manner as required by the *Purposes and Procedures Manual of the NAIC Securities Valuation Office*. See page 45 for recommendations made in this report.

IMPORTANT POINTS, COMMENTS AND RECOMMENDATIONS

Advertising – Page 24

It is recommended that the Company file its Long-Term Care advertisements with the ALDOI Rates & Forms Division for review and approval in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.21 (2001) which states, “(1) Every insurer, health care service plan or other entity...shall provide a copy of any long-term care insurance advertisement intended for use in this state...to the Commissioner of Insurance...for review or approval.... In addition, all advertisements shall be retained...for at least three (3) years from the date the advertisement was first used.”

Agent Reconciliation – Page 25

It is recommended that the Company appoint employees that have a producer license and are acting in a capacity of assisting producers with benefit recommendations and providing consulting functions as a “Service Representative” in accordance with the requirements of ALA. CODE § 27-7-1 (18)

(1975) which states, “A service representative shall otherwise qualify and be licensed as a service representative under this chapter...The service representative must be appointed for each insurer or association of insurer represented for each class of insurance handled by the insurer or insurers in this state.”

It is further recommended that the Company file a Licensing Division Form AL-1-TSR (1/2008) with the ALDOI and appoint each of the employees that have producer licenses and are assisting the agents in a “Service Representative” capacity.

Policy Forms and Underwriting – Page 26

It is recommended that the Company submit the revised LTC policies to the ALDOI Rates & Forms Division which comply with ALA. ADMIN. CODE 482-1-091-.28 (2006) which states, “(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least [forty five (45) days] prior to the implementation of the premium rate schedule increase by the insurer...”

It is recommended that the Company revise all LTC policies issued after July 1, 2006 in order to comply with the aforementioned Regulation.

It is recommended that the Company establish and implement written underwriting guidelines for Group Long-Term replacement policies that are in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.06 (2006) which states, “(4)(c)... that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason... shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.” “(5) If a group long-term care policy is replaced...the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered...and premiums charged to persons under the new group policy: (a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (b) Shall not vary or otherwise depend on the individual’s health or disability status, claim experience, or use of long-term care services.”

It is recommended that the Company maintain evidence of “Notice to Applicant Regarding Replacement of Accident & Sickness or Long-Term Care Insurance” in all LTC replacement files in accordance with the requirements of ALA. ADMIN. CODE 482-1-091-.12 (2006).

It is recommended that the Company maintain evidence that large group employers were offered Mental Health Benefits at issue or renewal and if the employer accepted or rejected the offer in order to examine the Company's compliance with ALA. CODE § 27-54-4 (2000).

It is recommended that the Company contact all current clients and make the offer, and then on a go-forward basis, the Company will make the offer to all entities, whether new issues or renewals.

Ceded Reinsurance – Page 43

It is again recommended that the Company establish standards of acceptability for reinsurers to whom it cedes business.

It is further recommended that the Company establish procedures to monitor the financial strength of its reinsurers.

Account and Records – Page 31

It is again recommended that there only be one active identification card for each employee.

It is recommended that the opining actuary include the required language "Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion." This requirement is found in the NAIC *Annual Statement Instructions for Health* for the 2007 reporting year on Pages 9 and 10.

Bonds – Page 39

It is again recommended that the Company file a SUB 1 form with the NAIC SVO within 30 days of acquisition or formation of a new SCA investment, as required by the *Purposes and Procedures Manual of the NAIC Securities Valuation Office*.

It is again recommended that the Company file a SUB 2 form with the NAIC SVO by June of each year after the filing of the SUB 1 form for the SCA, as required by the *Purposes and Procedures Manual of the NAIC Securities Valuation Office*.

It is again recommended that the Company file all necessary forms with the SVO in a timely manner as required by the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* Part 5, page 12, section 4 (a) (ii).

Amounts withheld or retained for the account of others - Page 39

It is recommended that the Company file all Alabama stale-dated checks over three years past due with the Alabama State Treasurer on November 1 of each year and cover the 12 months next preceding July 1 of that year in accordance with ALA. CODE § 35-12-72 (a) and (18) and ALA. CODE §35-12-76 (c) which states, “The report shall be filed before November 1 of each year and cover the 12 months next preceding July 1 of that year.”

It is recommended that the Company review the 10,185 stale-dated checks totaling \$772,142 that were over three years past due at July 1, 2007 and determine which checks are related to Alabama and escheat them to the Alabama Treasurer in accordance with the aforementioned ALA. CODE §35-12-76 (c) (2004) which states “The report shall be filed before November 1 of each year and cover the 12 months next preceding July 1 of that year.”

It is recommended that the Company determine the appropriate action for those stale-dated checks not related to Alabama.

CONCLUSION

Acknowledgement is hereby made of the courteous cooperation extended by the Officers and Associates of Blue Cross and Blue Shield of Alabama during the course of this examination.

The customary insurance examination procedures, as recommended by the National Association of Insurance Commissioners, have been followed to the extent deemed appropriate in connection with the verification and valuation of assets and determination of liabilities set forth in this report.

In addition to the undersigned, Rhonda Ball, Toni Bean, AFE, Juliette Glenn, MCM, Charles Turner and Lori Wright, AFE, examiners for the State of Alabama Department of Insurance; and Harland A. Dyer, FSA, MAAA, actuarial examiner, participated in this examination of Blue Cross and Blue Shield of Alabama.

Respectfully submitted,



Mary B. Packard, CPA, CFE
Examiner-in-charge
State of Alabama
Department of Insurance