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BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE

OF THE STATE OF IDAHO

In the Matter of: BLUE CROSS OF IDAHO HEALTH SERVICE, INC. Certificate of Authority No. 1900 NAIC No. 60095	Docket No. 18-2945-14 **ORDER ADOPTING REPORT OF EXAMINATION AS OF DECEMBER 31, 2012**

The State of Idaho, Department of Insurance (Department), having conducted an examination of the affairs, transactions, accounts, records, and assets of Blue Cross of Idaho Health Service, Inc. (Blue Cross), pursuant to Idaho Code § 41-219(1), hereby alleges the following facts that constitute a basis for issuance of an order, pursuant to Idaho Code § 41-227(5)(a), adopting the Report of Examination of Blue Cross of Idaho Health Service, Inc. as of December 31, 2012 (Report), as filed.

FINDINGS OF FACT

1. Blue Cross is an Idaho-domiciled insurance company licensed to transact disability insurance, including managed care, in Idaho under Certificate of Authority No. 1900.

2. The Department completed an examination of Blue Cross pursuant to Idaho Code § 41-219(1) on or about April 23, 2014. The Department's findings are set forth in the Report.

3. Pursuant to Idaho Code § 41-227(4), a copy of the Report, verified under oath by the Department's examiner-in-charge, was filed with the Department on May 5, 2014, and a copy of such verified Report was transmitted to Blue Cross on May 6, 2014. A copy of the verified Report is attached hereto as Exhibit A.

4. Pursuant to Idaho Code § 41-227(4), Blue Cross had thirty (30) days from May 6, 2014, to make a written submission or rebuttal with respect to any matters contained in the Report. No such written submission or rebuttal was received by the Department from Blue Cross.

CONCLUSIONS OF LAW

5. Idaho Code § 41-227(5)(a) provides that "[w]ithin thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the director shall fully consider and review the report, together with any written submissions or rebuttals and relevant portions of the examiner's work papers" and shall enter an order adopting the report of examination as filed or with modifications or corrections.

6. Having fully considered the Report, the Director concludes that Blue Cross meets the minimum requirements set forth in Idaho Code § 41-313.

ORDER

NOW, THEREFORE, based on the foregoing, IT IS HEREBY ORDERED that the Report is hereby ADOPTED as filed, pursuant to Idaho Code § 41-227(5)(a).

IT IS FURTHER ORDERED, pursuant to Idaho Code § 41-227(8), that the adopted Report is a public record and shall not be subject to the exemptions from disclosure provided in title 9, chapter 3, Idaho Code.

IT IS FURTHER ORDERED, pursuant to Idaho Code § 41-227(6)(a), that, within thirty (30) days of the issuance of the adopted Report, Blue Cross shall file with the Department's Deputy Chief Examiner affidavits executed by each of its directors stating under oath that they have received a copy of the adopted Report and related orders.

IT IS SO ORDERED.

DATED this 24th day of June, 2014.

STATE OF IDAHO
DEPARTMENT OF INSURANCE

William Deal

WILLIAM W. DEAL
Director

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that, on this 24th day of June, 2014, I caused a true and correct copy of the foregoing ORDER ADOPTING REPORT OF EXAMINATION AS OF DECEMBER 31, 2012 to be served upon the following by the designated means:

Blue Cross of Idaho Health Service, Inc. Attn: Zelda Geyer-Sylvia, President and CEO 3000 E. Pine Avenue Meridian, ID 83642	☐ first class mail ☒ certified mail ☐ hand delivery ☐ email
Georgia Siehl, CPA, CFE Bureau Chief / Chief Examiner Idaho Department of Insurance 700 W. State Street, 3rd Floor Boise, ID 83720-0043 georgia.siehl@doi.idaho.gov	☐ first class mail ☐ certified mail ☐ hand delivery ☒ email

Teresa Jones

Teresa Jones
Assistant to the Director

DEPARTMENT OF INSURANCE

STATE OF IDAHO

REPORT OF EXAMINATION

of

BLUE CROSS OF IDAHO HEALTH SERVICE, INC.

(NAIC Company Code 60095)

as of

December 31, 2012

EXHIBIT

A

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State of Idaho
DEPARTMENT OF INSURANCE

C. L. "BUTCH" OTTER
Governor

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WILLIAM W. DEAL
Director

Meridian, Idaho
May 5, 2014

The Honorable William W. Deal
Director of Insurance
State of Idaho
700 West State Street
Boise, Idaho 83720

Dear Director:

Pursuant to your instructions, in compliance with Section 41-219(1), Idaho Code, and in accordance with the practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC), we have conducted an examination as of December 31, 2012, of the financial condition and corporate affairs of:

Blue Cross of Idaho Health Service, Inc.
3000 East Pine Avenue
Meridian, Idaho 83642

hereinafter referred to as the "Company," at its offices in Meridian, Idaho. The following Report of Examination is respectfully submitted.

SCOPE OF EXAMINATION

This examination covered the period January 1, 2009, through December 31, 2012. The examination was conducted at the Meridian, Idaho office of the Company by examiners from the State of Idaho. The examination was conducted in accordance with Section 41-219(1), Idaho Code, the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook and* the NAIC *Accounting Practices and Procedures Manual.*

All accounts and activities of the Company were considered in accordance with the NAIC's risk-focused examination process. The NAIC *Financial Condition Examiners Handbook* requires that we plan and perform the examination to evaluate the financial condition and identify prospective risks of the Company by obtaining information about the Company including corporate governance, identifying and assessing inherent risks within the Company and evaluating 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 NAIC *Annual Statement Instructions* as governed and prescribed by Idaho law.

A Letter of Representation was signed by the Company attesting to its ownership of all assets and to the nonexistence of unrecorded liabilities or contingent liabilities.

The actuarial review of reserves, related liabilities, and other actuarial items was performed by Lewis & Ellis, Inc., consulting actuaries, for the Idaho Department of Insurance. A risk assessment review of the Company's information technology systems and controls was performed by Jennan Enterprises, LLC. There was some reliance placed on the 2012 Certified Public Accountants' statutory audit report and workpapers during the examination of the Company.

In addition to the Report of Examination, a Management Letter was issued to the Company by the Department which covered items that were not included in the Report, due to the materiality threshold, items that were related to proprietary/operational issues, as well as minor accounting and/or annual statement reporting corrections.

PRIOR EXAMINATION

The prior financial examination was conducted by the Idaho Department of Insurance covering the period January 1, 2005 through December 31, 2008.

A review was made to ascertain what action was taken by the Company with regard to comments and recommendations made by the Department in the prior examination report. Unless otherwise mentioned in the *Comments and Recommendations* section of this report, the prior report exceptions were adequately addressed by the Company.

HISTORY AND DESCRIPTION

The Company was formed as a non-profit entity on December 31, 1977. Its incorporation and formation was the result of a consolidation of Blue Cross of Idaho, Inc. and South Idaho Medical Service Bureau, Inc., who had maintained separate operations in Idaho since 1945 and 1962, respectively. The Company was formed under Title 41, Chapter 34, Idaho Code, and operated as a hospital and professional service corporation. In 1995, the Company converted to a nonprofit mutual insurer under Title 41, Chapter 28, Idaho Code.

Beginning in 1987, the Company became subject to Federal income taxes. Prior thereto it had been exempt under Section 501(c)(4), Internal Revenue Code.

Prior to the Company's mutualization, it was exempt from Idaho State premium taxes, state corporation taxes, and participation in the Life and Health Guaranty Association. State taxation in lieu of Idaho premium taxes was provided under Section 41-3427, Idaho Code, which required assessment of four cents per subscriber contract per month.

As a result of mutulization in 1995, the Company's lines of business, with the exception of its administrative service contract business, are no longer exempt from Idaho premium taxes and participation in the Life and Health Guaranty Association. In addition, the Company's Annual Statement reporting form was changed from a hospital, medical, dental and indemnity form to a Life, Accident and Health blank.

Beginning with 1994, the Company's managed care line of business, Idaho Preferred Healthcare, was no longer required to file a separate Annual Statement. Idaho Preferred Healthcare's line of business was to be reported in the Company's Annual Statement separately as to premium income, claims, administrative expenses and enrollment in the same manner as required for the other lines of business. Idaho Preferred Healthcare was reported in the Company's 1994 and 1995 Annual Statements.

The Department, by a letter dated March 12, 1996, notified the Company that, effective with the quarterly statement as of March 31, 1996, Idaho Preferred Healthcare was to begin filing separate statements. Although Idaho Preferred Healthcare did not operate as a separate legal entity, it was required to file a separate statement, since it operated under a separate certificate of authority and its business and operations were clearly distinguishable from the other types of insurance offered by the Company.

In August 1996, the name of Idaho Preferred Healthcare was changed to Blue Cross of Idaho Coordinated Care Services. As noted in the preceding paragraph, Blue Cross of Idaho Coordinated Care Services was not a corporation or legal entity, but was operated concurrently with the operations of the Company and was considered a separate and distinct division within the Company, in accordance with Section 41-3406 (4), Idaho Code.

Effective February 11, 1999, Health Ventures Corporation received its Certificate of Authority to operate as a managed care organization under Title 41, Chapter 39, Idaho Code. Prior to this, Health Ventures Corporation was incorporated as a third party administrator for the

Company's Medicare managed care line of business, which was written by Blue Cross of Idaho Coordinated Care Services. Health Ventures Corporation changed to an insurer on February 11, 1999, and effective this date became the 100 percent reinsurer of the Blue Cross of Idaho Coordinated Care Services' group managed care and Medicare Choice lines of business. Health Ventures Corporation was owned equally by the Company and St. Luke's Regional Medical Center. Health Ventures Corporation owned 50 percent of Triad Limited Liability Company while Eastern Idaho IPA, PLLC owned the remaining 50 percent.

On January 1, 2000, Blue Cross of Idaho Coordinated Care Services voluntarily surrendered its certificate of authority and ceased writing business. Consequently, Blue Cross of Idaho Coordinated Care Services' assets, liabilities, equity, and all managed care products were absorbed within the Company. The Company's Certificate of Authority was re-issued on January 3, 2000 to include managed care business.

Health Ventures Corporation executed surplus note agreements with the Company and St. Luke's Regional Medical Center on June 29, 2000. During 2000, surplus notes in the amount of $3,250,000 each were issued to the Company and to St. Luke's.

In December 2001, the Company acquired St. Luke's Regional Medical Center's interest in Health Ventures Corporation for $7,000,000 in cash in exchange for St. Luke's shares and surplus notes receivable of $3,250,000. The Board of Directors authorized the transaction on November 30, 2001. The Plan of Dissolution was submitted to the Idaho Department of Insurance and in a letter dated December 27, 2001, the Department indicated it had no objections to the acquisition. Pursuant to the Plan, Health Ventures Corporation was dissolved on February 26, 2002, and voluntarily surrendered its Certificate of Authority on February 28, 2002. Health Ventures Corporation's share of Triad Limited Liability Company was transferred to the Company. The surplus notes issued to St. Luke's were surrendered and the Company became the owner of Health Ventures' assets and liabilities.

Blue Cross of Idaho Foundation for Health, Inc. was incorporated as a non-profit entity on December 28, 2001. The Board of Directors approved the establishment of the Foundation on November 13, 2001. The purpose of the foundation is to promote health improvement initiatives to Idaho residents.

The Company changed its reporting format from the NAIC Life, Accident and Health blank to the Health blank effective January 1, 2004.

In 2007, the Company purchased 6 percent of WPMI, LLC, a joint venture with three other Blue Cross Blue Shield plans for the purpose of providing third party administrative services and health insurance products in China. In 2011, the Company increased its ownership to 8 percent. This investment is nonadmitted for statutory accounting purposes.

In 2008, the Company entered into a limited liability partnership, BlueCross BlueShield Ventures I. This entity was formed for the purpose of providing a structure to gain access to innovative companies and achieve significant strategic insights and returns in the healthcare insurance industry related to new ventures. The common stock of this investment is reported

as an admitted asset; the private equity fund portion is nonadmitted for statutory accounting purposes.

In 2010, the Company entered into a limited liability partnership, Blue Health Intelligence LLC. This entity was formed for the purpose of collecting health related data for analysis and/or purchase by outside interests. This investment is nonadmitted for statutory accounting purposes.

In 2011, the Company entered into a joint venture, BlueCross BlueShield Ventures II, for the purpose of providing a structure to gain access to innovative companies and achieve significant strategic insights and returns in the healthcare insurance industry related to new ventures. The common stock of this investment is reported as an admitted asset; the private equity fund portion is nonadmitted for statutory accounting purposes.

The Company entered into a joint venture, PEAK1 Administration, LLC, with Blue Cross and Blue Shield of Montana in 2012. PEAK1 Administration, LLC provides third party administration of account-based employee benefit plans for cafeteria and non-medical ancillary product plans. The Company owned 51 percent of this joint venture. Subsequent to the examination date, PEAK1 was sold on August 9, 2013.

The Company owned 50 percent of Idaho Benefits Administration, Inc., a joint venture with Wellpoint Health Networks. The Company contracted with Wellpoint for certain administrative services for its dental products in 2011. The Company terminated its participation in this joint venture in 2012.

In February 2012, the Company created Idaho Benefits Administration, LLC as a holding company for potential new business interests. The Company owned 100 percent of this entity at year-end 2012.

In September 2012, the Company created Network Management Initiatives (NM Initiatives, LLC), to allow the use of a non-branded network and to contract with dentists outside of Idaho. At year-end 2012, Idaho Benefits Administration, LLC owned 100 percent of NM Initiatives, LLC.

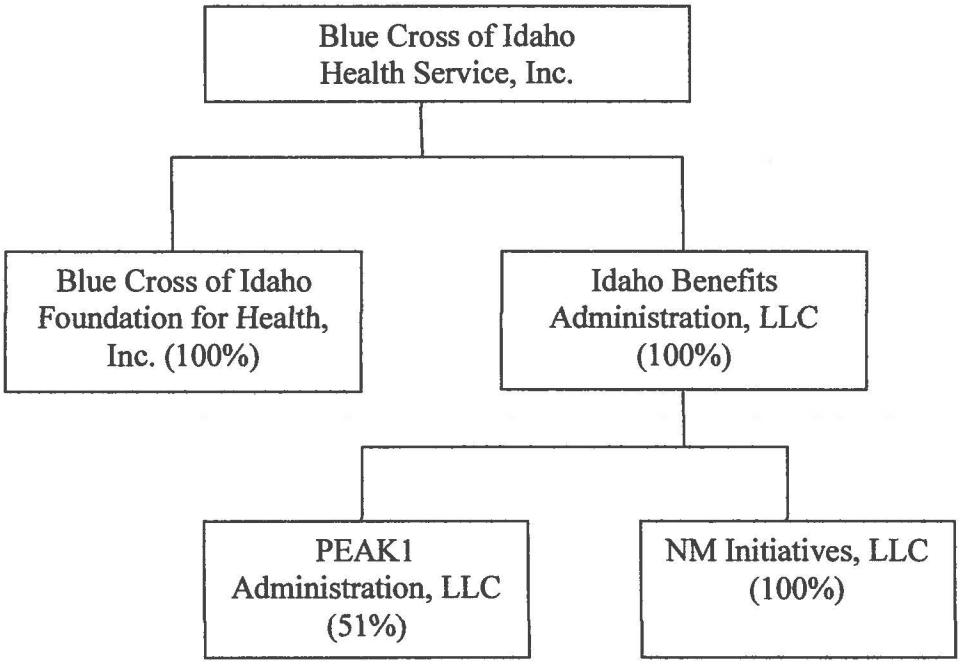
Subsequent to the examination date, the Company created Blue Cross of Idaho Care Plus, Inc. to manage Medicaid insurance business starting in 2015. See *MANAGEMENT AND CONTROL* and *SUBSEQUENT EVENTS* for additional information.

The Company is a member of the Blue Cross and Blue Shield Association. The Association serves as a national non-affiliated advisory organization for all Blue Cross and Blue Shield Plans in the United States.

MANAGEMENT AND CONTROL

Insurance Holding Company System

The Company is a member of an insurance holding company system and is the ultimate controlling person, as depicted in the following organizational chart as of December 31, 2012:



The affiliated entities are described in more detail under the caption, *HISTORY AND DESCRIPTION.*

As previously reported, Blue Cross of Idaho Care Plus, Inc. was created on February 19, 2013. The Company owns 100 percent of this entity. The Company filed the holding company registration statement with the Idaho Department of Insurance relating to the formation of this entity on March 8, 2013.

Directors

The Company is a mutual organization with each policyholder being a member of the corporation. The members annually elect Company directors to staggered three-year terms.

The affairs of the Company are managed under the direction of and supervised by the Board of Directors. The Company must have at least five directors and up to seventeen directors, including the Chief Executive Officer. The number of directors is in compliance with Section 41-2835(5), Idaho Code, which requires no less than five nor more than twenty-five members. The Board is comprised of three categories of directors which must include at least one hospital director, at least one physician director, with the majority being public directors. The President and Chief Executive Officer serves as an ex officio Director.

The following persons were the duly elected or ex officio members of the Board of Directors at December 31, 2012:

Name	Principal Occupation
Physician Directors:	
Micheal John Adcox, M.D.	St. Luke's Clinic Nephrology
Richard Kent Thurston M.D.	Chief of Staff & Emergency Department Director, Benewah Hospital
Hospital Directors:	
Sally E. Jeffcoat	President & Chief Executive Officer, Saint Alphonsus Regional Medical Center
David C. Pate, M.D., J.D.	President & Chief Executive Officer, St. Luke's Health System
Public Directors:	
Zelda Geyer-Silvia, Ex Officio	President & Chief Executive Officer, Blue Cross of Idaho Health Service, Inc.
Jack Wynn Gustavel	Chairman & Chief Executive Officer, Idaho Independent Bank
Norman Charles Hedemark	Retired
Kenlon Porter Johnson	President, Forde Johnson Oil Company, Inc.
Thomas Frederick Kealey	President, Silver Creek Holding Company
Ward Douglas Parkinson	Director & Vice President, Commercial Development, Ovonyx, Inc.
Michael James Shirley, Chair	Retired
Jo Anne Stringfield, Vice Chair	Human Resources, Finance & Accounting Advisor

Officers:

The Company's amended and restated Bylaws provide that the Board shall elect directors to serve as the Board Chair and Vice Chair. The Board Chair and Vice Chair at year-end 2012 were:

Michael James Shirley	Chair of the Board
Jo Anne Stringfield	Vice Chair of the Board

The following persons were appointed as officers of the Company as of December 31, 2012:

Zelda Geyer-Sylvia	President & Chief Executive Officer
Jack Myers	Treasurer, Executive Vice President & Chief Financial Officer
Steven J. Tobiason	Secretary, Senior Vice President and General Counsel
Bruce R. Croffy, M.D., Ph.D.	Senior Vice President & Chief Medical Officer
Dennis Warren	Vice President, Account Management
Tunde Molnar	Assistant Corporate Secretary

The rest of this page is intentionally blank.

Committees:

Pursuant to the amended and restated Bylaws, the Board may create one or more regular or special Board committees. Each committee must include at least two directors. The Committees operate under Statements of Purpose and Organization, which set forth the purpose of each committee, responsibilities, duties, eligibility, appointment, and meetings.

Directors appointed to the Board committees at year-end 2012, as well as staff advisors, are shown below:

Executive Committee	
Michael James Shirley	Chair
Jack Wynn Gustavel	
Micheal John Adcox, M.D.	
Norman Charles Hedemark	
Kenlon Porter Johnson	
Jo Anne Stringfield	
Zelda Geyer-Sylvia	Ex Officio
Audit Committee	
Kenlon Porter Johnson	Chair
Jack Wynn Gustavel	
Norman Charles Hedemark	
Thomas Frederick Kealey	
Michael James Shirley	
Jo Anne Stringfield	
Compensation and Benefits Committee	
Norman Charles Hedemark	Chair
Ward Douglas Parkinson	
Michael James Shirley	
Jo Anne Stringfield	
Zelda Geyer-Sylvia	Ex Officio
Finance Committee	
Jack Wynn Gustavel	Chair
Kenlon Porter Johnson	
Michael James Shirley	Ex Officio
Thomas Frederick Kealey	
Zelda Geyer-Sylvia	Ex Officio

Governance and Nominating Committee

Jo Anne Stringfield	Chair
Micheal John Adcox, M.D.	
Jack Wynn Gustavel	
Norman Charles Hedemark	
Ward Douglas Parkinson	
Michael James Shirley	Ex Officio
Zelda Geyer-Sylvia	Ex Officio

Independent Public Directors Committee

Michael James Shirley	Chair
Jo Anne Stringfield	
Jack Wynn Gustavel	
Norman Charles Hedemark	
Kenlon Porter Johnson	
Thomas Frederick Kealey	
Ward Douglas Parkinson	

Quality Committee

Micheal John Adcox, M.D.	Chair
Sally E. Jeffcoat	
Kenlon Porter Johnson	
Thomas Frederick Kealey	
David C. Pate, M.D., J.D.	
Richard K. Thurston, M.D.	
Zelda Geyer-Sylvia	Ex Officio

Conflict of Interest

The Company has a conflict of interest procedure in place that applies to all directors, corporate officers, managers, supervisors, administrative assistants and employees in designated sensitive areas and those who administer benefits for government programs (delegated entities).

Within thirty days from their date of hire, all new corporate officers, managers, supervisors, administrative assistants and employees in designated sensitive areas are required to complete a Conflict of Interest Statement and Questionnaire. Annually, the Board of Directors, corporate officers, directors, managers, supervisors, administrative assistants and certain employees will submit a Conflict of Interest Statement to the Company. Delegated entities are required by contract to certify to the Company that they have obtained and evaluated Conflict of Interest Statements from their employees responsible for the administration of benefits for government programs.

The Company has established processes for addressing and mitigating any conflicts of interest, which includes reviews by the Company's General Counsel and Corporate Compliance Officer or Manager. Furthermore, summaries of conflicts of interest reported by Company employees are submitted to the Board of Directors for their review.

Conflict of interest questionnaires that were completed for the period January 1, 2009, through December 31, 2012 and subsequent thereto appeared to appropriately disclose any real or potential conflicts of interest.

Contracts and Agreements

The Company had the following agreements in effect at December 31, 2012:

Agreement with State of Idaho Department of Health and Welfare
The Company entered into a contract with the State of Idaho Department of Health and Welfare to administer the State's dental insurance plan for Medicaid enrollees, otherwise known as "Idaho Smiles".

Under the contract, the Company provides insurance coverage by maintaining a statewide network of qualified and licensed dental care providers to eligible Idaho Medicaid participants. In addition, the Company is responsible for processing and paying claims for all covered dental benefits provided to eligible participants for whom the Company is paid a premium (fixed fee).

The Company is paid a fixed fee per eligible participant per month. The per participant per month fees paid to the Company must be inclusive of all services in the contract. From this fixed fee, specific dollar amounts are allocated to administrative costs and to provider costs. The administrative cost portion is fixed for the first five years of the agreement and then negotiated annually thereafter. The portion allocated to provider costs is adjusted annually by a percentage determined by Health and Welfare. The Company must increase the dental provider's reimbursements by at least this percentage adjustment.

The contract dates are from April 19, 2007 through April 18, 2012. The parties may cancel the contract at any time with or without cause upon 180 days written notice specifying the date of termination. The contract may also be terminated immediately due to causes specified therein. After the fifth year of the contract, upon mutual agreement, the parties may renew the contract at one year intervals under the same terms and conditions.

Service Agreement with BlueCross BlueShield of South Carolina
The Company entered into a service agreement with BlueCross BlueShield of South Carolina (BCBSSC) effective January 1, 2009. Under this agreement, BCBSSC agreed to provide certain services (the "Initial Implementation" and the "Production Service") to assist the Company with the processing of certain electronic transactions conducted through the Inter-Plan Teleprocessing system established by Blue Cross Blue Shield Association. This agreement shall continue for an initial two year period and shall continue on a year to year basis. Either party may terminate this agreement upon 180 days notice prior to the anniversary date.

Pharmacy Benefit Management Agreement
The Company entered into a Pharmacy Benefit Management Agreement with Express Scripts, Inc. (ESI) effective April, 1, 2010. Under this agreement, the Company agreed to use ESI as the Company's exclusive provider of certain pharmacy benefit management services. These

services included pharmacy network contracting, pharmacy claims processing, mail and specialty drug pharmacy, and formulary and rebate administration. This agreement was terminated on March 31, 2013.

Medicare Prescription Drug Services Agreement

The Company entered into a Medicare Prescription Drug Services Agreement with Express Scripts Senior Care, Inc. (ESI) effective July 1, 2010 with the implementation date on January 1, 2011. Under this agreement, the Company agreed to use ESI as the Company's exclusive provider of certain pharmacy benefit management services to members of all of its Medicare Plans. This agreement was terminated on December 31, 2012.

Administrative Services Agreement

The Company entered into an administrative services agreement with Dentaquest, LLC (Dentaquest) effective January 1, 2011. The Company has contracted with State of Idaho, Department of Health and Welfare to deliver and finance basic dental services to Medicare Advantage Special Needs Plan participants. Under this agreement, Dentaquest agreed to provide certain dental insurance services to the participants on the Company's behalf. This agreement shall continue through December 31 of each year. Each party may terminate this agreement upon 120 days advance written notice after the one year anniversary of the effective date.

Vision Care Agreement

The Company entered into a Vision Care Agreement with Vision Service Plan of Idaho, Inc. (VSP) effective January 1, 2012. In this agreement, the Company agreed to engage the services of VSP to arrange for the provision of vision care services. VSP acted as a subcontractor of the Company. This agreement commenced on January 1, 2012 for a term of 24 months and renews for an additional one-year term unless either party notifies the other in writing at least 60 days before the end of the term.

Administrative Services Agreement

The Company entered into an Administrative Services Agreement with Anthem Holding Corporation (WellPoint) effective January 1, 2012. The Company had developed and carried out a comprehensive dental program. The Company utilized the claims adjudication platform and associated services developed and maintained by WellPoint from January 1, 2012 through January 1, 2013 for claims incurred prior to January 1, 2012. This agreement was terminated on June 1, 2013.

Prescription Benefit Services Management Agreement

The Company entered into a Prescription Benefit Services Management Agreement with CaremarkPCS Health, LLC (Caremark) effective September 1, 2012 with the implementation date on April 1, 2013. Under this agreement, Caremark agreed to furnish certain drug benefit management and related services to the Company for individuals and groups that purchased coverage with such benefits. This agreement will continue through March 31, 2016; it will automatically renew for successive one year renewal terms, subject to the parties' rights of termination as provided in the agreement.

Medicare Prescription Benefit Services Agreement

The Company entered into a Medicare Prescription Benefit Services Agreement with CVS Caremark Part D Services, LLC (CVSCaremark PDS) effective September 1, 2012 with the implementation date on January 1, 2013. Under this agreement, CVSCaremark PDS agreed to furnish certain prescription drug management and related services to members of the Company's Medicare Plans. This agreement will continue through December 31, 2015 and will automatically renew for successive one year renewal terms, subject to the parties' rights of termination as provided in the agreement.

Indemnification Agreement (Directors)

The Company entered into an Indemnification Agreement with each member of the Board of Directors during the examination period. Under this agreement, the Company agreed to indemnify the director against all obligations to pay money or perform or not perform actions arising from, related to or connected with any threatened, pending or completed action, suit or proceeding and including without limitation any claim made by or in the right of the Company that involves the director.

Indemnification Agreement (Employees)

The Company entered into an Indemnification Agreement with each key employee during the examination period. Under this agreement, the Company agreed to indemnify the employee against all obligations to pay money or perform or not perform actions arising from, related to or connected with any threatened, pending or completed action, suit or preceding that involves the employee.

CORPORATE RECORDS

Articles of Incorporation and Bylaws

The Company's Articles of Incorporation were amended once during the examination period. The Board of Directors approved the Company's amended and restated Articles of Incorporation on February 12, 2010. Policyholders of the Company approved the amended and restated Articles of Incorporation at the Annual Policyholders' Meeting held on April 30, 2010. These amended and restated Articles of Incorporation were submitted to the Idaho Department of Insurance pursuant to Section 41-2805, Idaho Code. In a letter to the Company dated June 8, 2010, the Department indicated the amended and restated Articles of Incorporation were approved as of June 4, 2010, as conforming to Idaho law.

The Company's Bylaws were amended once during the examination period. The Company's Bylaws were re-written to separate Board leadership positions from corporate officer positions. Specifically, the amendments eliminated the Secretary/Treasurer of the Board position and set forth the corporate officer positions of Secretary and Treasurer. Additionally, the Bylaws were amended to conform to the Company's policies on director independence, to reinforce the Board's oversight and leadership role versus corporate management, and to simplify the Bylaws. The Board of Directors adopted the changes at their meeting of February 12, 2010. The amended and restated Bylaws were submitted to the Idaho Department of

Insurance pursuant to Section 41-2830(3), Idaho Code. In a letter to the Company dated May 13, 2010, the Department indicated the amended and restated Bylaws were accepted as filed.

Minutes of Meetings

A review of the minutes of the meetings of the Policyholders, the Board of Directors, and the various committees for the period January 1, 2009 through December 31, 2012 and subsequent thereto, indicated compliance with the Company's Articles of Incorporation and Bylaws with respect to the election of the Board of Directors and Officers, and the election or appointment of Committee members.

This review of the minutes also indicated that a quorum was present at all Board of Directors' meetings held during the examination period and that significant Company transactions were properly authorized.

Investment transactions were approved by the Finance Committee, which is charged by the Board of Directors with the duty of reviewing and considering approval of all investment transactions, in compliance with Section 41-704, Idaho Code. Furthermore, the Company maintained records of its investments in conformity with Section 41-705, Idaho Code.

The external auditors presented the audited financial statements and required communications to the Company's Audit Committee as required under IDAPA 18.01.62.021.06.

The minutes of the Board of Directors' meeting held on July 24, 2010 indicated that the Board discussed the Report of Examination as of December 31, 2008, conducted by the Idaho Department of Insurance.

FIDELITY BOND AND OTHER INSURANCE

The Company's corporate insurance coverages included a financial institutional bond, which covered losses resulting from dishonest or fraudulent acts committed by employees up to $1.75 million per single loss. The deductible was $50,000 per single loss. The financial institutional bond insurance coverage met the suggested minimum limits recommended by the NAIC *Financial Condition Examiners Handbook.*

Other insurance maintained by the Company included director and officers liability; errors and omissions liability; employment practice liability; commercial property; general liability; business automobile; umbrella excess liability; employee benefits liability, fiduciary liability, privacy liability and network risk insurance, workers compensation and employers liability coverages.

The insurance carriers providing coverages to the Company were licensed or otherwise authorized in the State of Idaho.

PENSION, STOCK OWNERSHIP AND INSURANCE PLANS

Defined Benefit Plan

The Company provides a defined benefit pension plan for employees. This plan is entirely funded by the Company and does not accept contributions from its employees. This retirement program is administered by the Blue Cross and Blue Shield Association National Employee Benefit Administration covering substantially all of its employees hired before January 1, 2007. Employees hired on or after January 1, 2007 are not eligible to participate in the defined benefit retirement program, but may receive an enhanced benefit of an additional 2.5 percent annual Company contribution to their 401(k) Plan. Benefits were based on years of service and employees' final coverage compensation. The Company's contribution to the 401(k) Plan for the enhanced benefit was approximately $430,000 for the year ended December 31, 2012. The Company accrued benefits in accordance with actuarially determined amounts. The Company contributed $4 million to the defined benefit retirement program in 2012.

The Company also reported an asset of $4,617,047 (nonadmitted) and an additional minimum liability for pensions of $7,943,597 as of December 31, 2012 in compliance with SSAP 89.

In March 2012, the NAIC adopted SSAP 92, Accounting for Postretirement Benefits Other Than Pensions and SSAP 102, Accounting for Pensions.

Retirement benefits expense in 2013 will include accruals for both vested and non-vested plan participants.

Deferred Compensation 401(k) Plan

The Company provides a 401(k) salary deferral plan that covered all employees who have attained age 18. The Company made matching contributions equal to 100 percent of the employee's deferral up to 3 percent of the employee's annual salary and 50 percent of the employee's additional deferrals up to 5 percent of the employee's annual salary. The Company's matching contributions were approximately $1,679,000 in 2012.

Postretirement Benefit Plans

The Company also provides health and life insurance benefits for retired employees and health insurance to their eligible dependents. These benefits are provided once the employee becomes eligible by satisfying plan provisions including certain age and/or service and participation requirements. Participants in the plans are required to contribute 15 percent to 100 percent of the premiums. The Company's post-retirement benefit plans, other than pension plans, were not funded. Employees retiring on or after January 1, 2012, are not eligible to participate in the Company's retiree life plan.

The Company reported a liability of $15,430,640 for postretirement benefits other than pensions as of December 31, 2012 in compliance with Statements of Statutory Accounting Principles (SSAP) 14.

The new SSAP is effective on January 1, 2013 and requires expense accruals for unvested plan participants.

The Company has elected to recognize the effect of these changes at January 1, 2013 rather than adopt a phase in period of up to 10 years. Company management estimated that expense accruals for 2013 will be increased by approximately $9,000,000 under the new guidance.

Employee Insurance Plans

The Company provides a non-contributory long term disability program for regular full-time and eligible part-time employees. The Company also provides a group health care, dental and vision plan for which the employee contributes part of the premium. Group life and accidental death and dismemberment coverages were provided for which the employee contributed part of the premium. Additional voluntary group accidental death coverage and group universal life plans were also made available to the employees at their own expense.

A flexible spending account was also made available to Company employees to pay eligible health related, dependent care expenses, or group health care expenses as qualified by Section 125 (d) of the Internal Revenue Code.

Executive Plans - Whole Life Policies

The Company had three corporate whole life par policies in effect for highly compensated key personnel. The policies were established in trust as a deferred compensation and supplemental retirement plan for employed corporate officers. The Rabbi trust was originally established in 1993 and the Company was the beneficiary and owner of the policies. The policies remain in place as of December 31, 2012. In early 2013, one of the insured passed away and the Company received a payout on that policy.

Supplemental Executive Retirement Plan

In December 1994, the Company established the non-contributory retirement program for certain Company employees. This is the Company's Defined Benefit Pension plan for executive level employees. The purpose of this program is to provide benefits for employees whose benefits would be reduced as a result of the benefit limitations of Sections 401(a) (17) and 415 of the Internal Revenue Code. The Company uses a Rabbi trust to fund the plan.

Executive Deferred Compensation Plan

This plan allows executive level employees to elect a portion of their compensation to be deferred and within the meaning of Sections 201(2), 301(a)(3), and 401(a)(1) of the Employee Retirement Income Security Act of 1974, as amended. Benefits under this plan are to be paid solely from the general assets of the Company.

Long Term Incentive Plan

This plan was set up to create a long term incentive for key executives of the Company. Over each three-year period, the participants in this plan receive a long term incentive bonus based on the performance of the Company and their incentive percentage.

Incentive Plans

Corporate incentive and division director incentive plans were set up by the Company. The objective of the plans is to improve performance and productivity and to reward the individuals that helped to accomplish the agreed upon goals. The incentive plans are based upon annual performance with the exception of the Claims and Customer Service incentive plans which are based on quarterly results. The incentives were based on a range to determine a percentage which is multiplied by the participant's salary, with the exception of the Federal Employees Program. The Federal Employees Program incentive consists of a dollar amount that is determined by the national program, which is then divided among eligible participants.

TERRITORY AND PLAN OF OPERATION

The Company is licensed only in the State of Idaho as a mutual insurer authorized to write disability insurance, including managed care. In addition to the home office located in Meridian, Idaho, the Company maintains five district offices located throughout Idaho in the cities of Coeur d'Alene, Idaho Falls, Lewiston, Pocatello, and Twin Falls. The primary functions of the district offices include marketing, policyholder service, and writing new business. Claims processing is performed in the home office.

The Company provided health care services to group and individual subscribers utilizing participating/contracting providers as a means of fulfilling their contractual obligations. In addition, the Company provided administrative services to companies that have self-funded a portion of their employees' health care claims, and the Federal Employee Health Benefit Plan to federal government employees.

During the examination period, the Company provided traditional individual major medical and Medicare supplement plans, Medicare Advantage plans, small and large group plans, Preferred Provider Organization plans, Managed Care plans and also administered Administrative Service Contracts (ASC) for self-funded plans. As previously reported under *MANAGEMENT AND CONTROL, Contracts and Agreements*, the Company began administering and paying the claims to participants of the State of Idaho Medicaid dental program, "Idaho Smiles "during the prior examination period.

The Company marketed its insurance products through commissioned producers and agencies and utilized a field force of approximately 2,927 appointed producers.

Agencies produce business pursuant to Independent Production Agreements – Agency. There is a separate Independent Production Agreement for individual agents. An Addendum to Agreement with Business Associate, which is included as part of the Independent Production Agreement, specifically pertains to privacy issues and responsibilities. The Production Agreements contain standard language, such as agency responsibilities, confidentiality, indemnification, hold harmless and compensation information. The contracts may be terminated by either party by written certified notice or personal delivery. The termination date will be effective 30 days after the date a written notice is mailed by either party.

STATUTORY AND SPECIAL DEPOSITS

As of December 31, 2012, the examination confirmed with the Idaho Department of Insurance that the Company had made provision for the following deposits to be held in trust for the protection of all its policyholders and/or creditors through said office of the Director of Insurance, State of Idaho, in compliance with Section 41-316A, Idaho Code.

Description	Par Value	Statement Value	Market Value
US Treasury Notes, 3.875 percent, Due 2/15/2013	$1,200,000	$1,199,794	$1,205,436
Totals:	$1,200,000	$1,199,794	$1,205,436

GROWTH OF THE COMPANY

The Company's growth for the years indicated, as taken from the prior examination report and its Annual Statements, is shown in the following schedule:

Year	Admitted Assets	Liabilities	Capital & Surplus	Net Income(Loss)
2008*	$443,803,959	$180,673,313	$263,130,645	$13,927,868
2009	534,275,625	178,699,068	355,576,557	49,684,694
2010	600,289,902	184,789,237	415,500,665	44,959,379
2011	653,697,237	209,870,709	443,826,528	56,618,184
2012*	718,717,103	233,048,517	485,668,586	46,688,437

Overall, the Company performed very well during the period under examination. Surplus increased from $263 million at year-end 2008 to $486 million at year-end 2012 and to $518 million as of June 30, 2013. Total revenues increased from $999.8 million at year-end 2008 to $1.260 billion at year-end 2013. Due to a combination of effective medical management of claims costs (including process improvements) and pricing, the Company had strong underwriting gains during the period under examination. Net income was fairly consistent throughout the exam period, ranging between $45 million and $57 million.

*As determined by Examination.

LOSS EXPERIENCE

The ratios of benefits and expenses to premium shown in the following schedule were derived from amounts reported in the Company's Annual Statements. Nothing unusual was noted.

Year	Premiums Earned	Claims and Claims Adjustment Expenses Incurred	Other Expenses Incurred	Total Claims, Claims Adjustment Expenses and Other Expenses Incurred	Ratio of Claims, Claims Adjustment Expenses and Other Expenses Incurred to Premiums Earned
2008*	$ 999,804,286	$914,051,087	$78,586,585	$992,637,672	99.28
2009	1,055,287,949	957,696,713	84,388,622	1,042,085,335	98.75
2010	1,146,721,106	1,043,971,873	79,998,147	1,123,970,020	98.02
2011	1,230,626,774	1,104,545,875	88,442,972	1,192,988,847	96.94
2012*	1,260,392,192	1,136,090,837	105,911,184	1,242,002,021	98.54

*As determined by Examination.

REINSURANCE

Assumed

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

Ceded

The Company had the following ceded reinsurance contracts in effect as of December 31, 2012:

Type of Contract	Reinsurer	Business Covered	Company's Retention	Coverage
Stop Loss Medical Excess of Loss	Munich Reinsurance America, Inc. (100%) Princeton, New Jersey	Stop Loss Medical business administered by the Company which provides coverage above the Company's $2 million retention per member	$2 million per member, any one policy period.	Layer 1: 100% of the ultimate net loss in excess of $2 million per member, any one policy period which is inclusive of the member's self-insured retention. Reinsurer's liability in respect of any one member shall not exceed 100% of $3 million during any one policy period.
			$5 million per member, any one policy period.	Layer 2: 100% of the ultimate net loss in excess of $5 million per member, any one policy period

				which is inclusive of the member's self-insured retention. Reinsurer's liability in respect of any one member shall not exceed 100% of $5 million during any one policy period.
			$10 million per member, any one policy period.	Layer 3: 100% of the ultimate net loss in excess of $10 million per member, any one policy period which is inclusive of the member's self-insured retention. Reinsurer's liability in respect of any one member shall be unlimited during any one policy period.
Fully Insured Medical Excess of Loss	Munich Reinsurance America, Inc. (100%) Princeton, New Jersey	Fully insured medical business which provides coverage above the Company's $2 million retention per member	$2 million per member, during the term of this contract (1/1/12 to 1/1/13)	Layer 1: 100% of the ultimate net loss in excess of $2 million per member during the term of this contract. Reinsurer's liability in respect of any one member shall not exceed 100% of $3 million during the term of this contract.
			$5 million per member, during the term of this contract.	Layer 2: 100% of the ultimate net loss in excess of $5 million per member during the term of this contract. Reinsurer's liability in respect of any one member shall not exceed 100% of $10 million during the term of this contract
			$10 million per member, during the term of this contract	Layer 3: 100% of the ultimate net loss in excess of $10 million per member during the term of this contract. Reinsurer's liability in

				respect of any one member shall be unlimited.

Munich Reinsurance America, Inc. is an authorized insurer in the State of Idaho.

The above reinsurance contracts carry adequate risk transfer in compliance with Statement of SSAP 62R.

Small Employer Health Reinsurance Program (SEHRP)
This voluntary reinsurance program was created by the Idaho Small Employer Health Insurance Availability Act, Idaho Code, Title 41, Chapter 47.

The reinsurance is available for employers who have two to 50 employees at the beginning of the plan year, the majority of whom are employed in Idaho. Under this program, an insurer can choose to reinsure either all members of an employer or a particular member within 60 days of the commencement of coverage with the insurer. The insurer may terminate reinsurance on the health benefit plan's anniversary.

The amount of claims the reinsurance covers is set annually by the SEHRP board. For the exam period, the reinsurance covered 90 percent of the re-adjudicated claim amount between $14,000 and $109,555 and 100 percent of the claims between $109,555 and $123,555 for a maximum of $100,000 paid by the reinsurance pool.

The claim amount that would be considered for reinsurance is based on what would have been paid if the insured were covered under the Small Employer Standard benefit plan, rather than the plan design that the Small Employer actually has.

Premium rates are set annually by the SEHRP board. The premium rates are higher when a single member is reinsured than when an entire small employer is reinsured.

SEHRP's board assesses Idaho carriers the following year for any shortfall between premiums and claims plus administrative expenses based on the carrier's Idaho Health Insurance premium excluding the Federal Employee Health Benefit Plan, Short Term Medical insurance, Dental and Vision coverage, Medicare Advantage, Medicare Supplement, and Excess Loss Reinsurance.

In 2012, the Company ceded $220,512 of premium and recovered $262,967 under this program.

Idaho High Risk Reinsurance Pool
The Company also participates in the Idaho Individual High Risk Reinsurance Pool. Under this Pool, the Company could submit high risk applicants to the pool if said applications were denied a preferred program, based on a health statement application, or if the premium for the preferred program was higher than the High Risk Program counterpart.

The Board of Directors of the Idaho Individual High Risk Reinsurance Pool were responsible for the design of the individual Basic, Standard, Catastrophic A and Catastrophic B high risk plans and also established the premium rates for the plans. The Company had to meet a $5,000 deductible per person per calendar year and was also responsible for 10 percent coinsurance of the next $25,000 of benefit payments during a calendar year and the pool reinsured the remainder. Lifetime policy maximums were determined by the plan selected. In 2005, Health Savings Account compatible health plans were also added to pool eligibility. The amount covered is 90 percent of claim cost between $5,000 and $30,000 and 100 percent of the claim cost over $30,000. The underlying policies have a $1,000,000 maximum coverage.

Insurer premium rates for the program are set annually by the Board. The program is also funded through an allocation of premium taxes and through grants from the Federal Government. Should the program have insufficient funds to administer and pay reinsurance claims, the shortfall would be made up by an assessment of Idaho insurers. There has never been an assessment and no assessment is anticipated in the foreseeable future. In 2012, the Company ceded $4,434,110 of premiums to this pool and recovered $8,848,009 under this program.

INSURANCE PRODUCTS AND RELATED PRACTICES

A separate limited scope market conduct examination as of December 31, 2011 was conducted concurrently with the financial examination by the Idaho Department of Insurance.

ACCOUNTS AND RECORDS

General Accounting

The Company's claims payment, processing, group administration, membership/billing administration, provider administration, customer service, medical/management, commissions, and benefits administration applications were performed on the Facets system. The Facets system runs on a series of IBM Windows Servers with a Sybase database on an IBM AIX host. Lawson software was utilized for financial and human resource applications. Lawson runs on a series of IBM Windows Servers with a Microsoft SQL database.

The general ledger and supporting accounting records were maintained on a GAAP basis and then adjusted to a Statutory basis of accounting through adjusting journal entries. The Annual Statements were compiled utilizing the SunGuard software package, the NAIC *Annual Statement Instructions* and the NAIC *Accounting Practices and Procedures Manual*.

The Company has two current practices prescribed by the Idaho Department of Insurance that differ from NAIC Statutory Accounting Principles. The prescribed practices relate to amortization periods for cost of electronic and mechanical machines set forth under Section 41-601(11), Idaho Code and Section 41-601(12), Idaho Code which permits office equipment, office furniture, and private passenger automobiles as admitted assets.

Independent Accountants

The annual independent audits of the Company during this examination period were performed by KPMG LLP, Boise, Idaho.

The financial statements in each audit report were on a statutory basis. There was some reliance on the 2012 audit report and workpapers in this examination of the Company.

Actuarial Opinion

The unpaid claim reserves and unpaid claims adjustment expenses and related actuarial items were calculated by the Company and reviewed by John Pickering, FSA, MAAA, consulting actuary with Milliman, Inc. The December 31, 2012 statement of actuarial opinion stated that the amounts carried in the balance sheet:

(A) Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

(B) Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

(C) Meet the requirements of the insurance laws and regulations of the State of Idaho;

(D) Make good and sufficient provision of all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;

(E) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statements of the preceding year-end; and

(F) Include appropriate provision of all related actuarial items that ought to be established.

The identified actuarial items in the 2012 Annual Statement were as follows:

Claims unpaid (Page 3, Line 1)	$112,258,000
Accrued medical incentive pool and bonus payments (Page 3, Line 2)	6,599,450
Unpaid claims adjustment expenses (Page 3, Line 3)	2,750,000
Aggregate health policy reserves (Page 3, Line 4)	252,708
Aggregate health claims reserves (Page 3, Line 7)	0
Retrospective experience rating assets (Page 2, Line 24)	250,000

The actuarial review of reserves, related liabilities, and other actuarial items was performed by Lewis & Ellis, Inc., consulting actuary, for the Idaho Department of Insurance.

See the *NOTES TO THE FINANCIAL STATEMENTS* section, later in this report, for further discussion regarding the Department's consulting actuary's analysis.

INFORMATION SYSTEMS REVIEW

The Company's information systems were reviewed by Information System Specialist, Jenny L. Jeffers, CISA, AES, CFE, on behalf of Jennan Enterprises, LLC. The procedures were performed in accordance with the guidelines and procedures set forth in the "Exhibit C, Evaluation of Controls in Information Technology (IT)" contained in the NAIC *Financial Condition Examiners Handbook.* In summary, the functional areas reviewed by the Information System Specialist included the following:

- Use of Information Technology.
- Information Technology Governance.
- Information Technology Infrastructure.
- Information Technology Audits, Reviews and Risk Assessments.
- Information Technology Security.
- System Development/Change Management.
- Business Continuity.
- Financially Significant Systems.

The Information System Specialist's finding was presented to the Company in the Management Letter.

SUBSEQUENT EVENTS

Subsequent to the examination date, the Company created Blue Cross of Idaho Care Plus, Inc. to manage Medicare and Medicaid insurance business starting in 2015. Blue Cross of Idaho Care Plus, Inc. holds a certificate of authority from the Idaho Department of Insurance.

Capital surplus notes were issued by Blue Cross of Idaho Care Plus, Inc. to the Company in the amount of $1,500,000. This inter-company transaction was approved by the Department.

On February 21, 2013, a Service Agreement between the Company and Blue Cross of Idaho Care Plus, Inc. was entered into and approved by the Department. The agreement addresses the terms under which the Company will provide administrative services to the subsidiary and at what reimbursement levels.

FINANCIAL STATEMENTS

The financial section of this report contains the following statements:

Balance Sheet as of December 31, 2012

Statement of Revenue and Expenses, For the Year Ending December 31, 2012

Capital and Surplus Account, For the Year Ending December 31, 2012

Reconciliation of Capital and Surplus Account, December 31, 2008, through December 31, 2012.

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Balance Sheet

As of December 31, 2012

ASSETS

	Assets	Non Admitted Assets	Net Admitted Assets
Bonds	$388,295,083	$ 0	$388,295,083
Common stocks	209,729,525	80,000	209,649,525
Real estate, properties occupied by the company	22,526,855	0	22,526,855
Cash, cash equivalents and short-term investments	4,022,618	0	4,022,618
Other invested assets	20,060,296	19,060,296	1,000,000
Investment income due and accrued	2,968,785	0	2,968,785
Uncollected premiums and agents' balances in the course of collection	6,034,719	406,527	5,628,192
Amounts receivable relating to uninsured plans	16,543,416	0	16,543,416
Current federal and foreign income tax recoverable and interest thereon	166,335	0	166,335
Net deferred tax asset	6,180,237	0	6,180,237
Electronic data processing equipment & software	9,875,404	7,036,045	2,839,359
Furniture and equipment, including health care delivery assets	1,901,108	237,513	1,663,595
Health care and other amounts receivable (Note 1)	57,084,389	2,601,544	54,482,845
Aggregate write-ins for other than invested assets:			
Non-qualified Executive Deferred Compensation	1,635,649	1,635,649	0
Prepaid Expenses and Miscellaneous Receivables	7,123,237	7,123,237	0
Cash Value Life Insurance	2,750,258	0	2,750,258
Totals	$756,897,914	$38,180,811	$718,717,103

LIABILITIES, CAPITAL AND SURPLUS

	Covered	Uncovered	Total
Claims unpaid (less $1,906,000 reinsurance ceded) (Note 1)	$112,258,000	$ 0	$112,258,000
Accrued medical incentive pool and bonus amounts (Note 1)	6,599,450		6,599,450
Unpaid claims adjustment expenses (Note 1)	2,750,000		2,750,000
Aggregate health policy reserves (Note 1)	252,708		252,708
Premiums received in advance	13,962,849		13,962,849
General expenses due or accrued	87,100,057		87,100,057
Amounts withheld or retained for the account of others	2,180,753		2,180,753
Aggregate write-ins for other liabilities:			
Mortgage Interest Rate Swap	1,103		1,103
Pension AML	7,943,597		7,943,597
Total liabilities	$233,048,517	$ 0	$233,048,517
Unassigned funds (surplus)			$485,668,586
Total capital and surplus			$485,668,586
Total Liabilities, capital and surplus			$718,717,103

CAPITAL AND SURPLUS ACCOUNT

For the Year Ending December 31, 2012

	Per Company	Examination Changes	Per Examination
Capital and surplus, December 31, 2011	$443,826,528	$ 0	$443,826,528
GAINS AND (LOSSES) IN SURPLUS			
Net income	$ 46,688,437	$ 0	$ 46,688,437
Change in net unrealized capital gains	10,503,390	0	10,503,390
Change in net deferred income tax	(8,701,208)	0	(8,701,208)
Change in nonadmitted assets	(6,560,999)	0	(6,560,999)
GAAP-STAT difference (Pension, Bond Valuation)	(87,562)	0	(87,562)
Net change in capital and surplus	$ 41,842,058	$ 0	$ 41,842,058
Capital and surplus, December 31, 2012	$485,668,586	$ 0	$485,668,586

RECONCILIATION OF CAPITAL AND SURPLUS ACCOUNT

December 31, 2008 Through December 31, 2012

	2009	2010	2011	2012
Capital and surplus, December 31, previous year	$ 263,130,645	$355,576,557	$415,500,665	$443,826,528
Net income	49,684,694	44,959,379	56,618,184	$ 46,688,437
Change in net unrealized capital gains	19,544,593	8,757,293	(9,625,412)	10,503,390
Change in net deferred income tax	(8,476,562)	(12,189,218)	(5,637,825)	(8,701,208)
Change in nonadmitted assets	33,266,197	16,823,655	(8,643,059)	(6,560,999)
Change in unauthorized reinsurance	(1,573,000)	1,573,000	0	0
GAAP-STAT difference (Pension, Bond Valuation)	0	0	(4,386,030)	(87,562)
Rounding	(10)	(1)	5	0
Net change in capital and surplus	$ 92,445,912	$ 59,924,108	$ 28,325,863	$ 41,842,058
Capital and surplus, December 31, current year	$355,576,557	$415,500,665	$443,826,528	$485,668,586

NOTES TO THE FINANCIAL STATEMENTS

Note (1) Health care and other amounts receivable	$ 54,482,845
Claims unpaid (less $1,906,000 reinsurance ceded)	112,258,000
Accrued medical incentive pool and bonus amounts	6,599,450
Unpaid claims adjustment expenses	2,750,000
Aggregate health policy reserves	252,708

Lewis & Ellis, Inc., was retained by the Department to review the above actuarial liabilities and reserves as of December 31, 2012. Regarding *Health care and other amounts receivable*, the scope was limited to reviewing only the Federal Employees Program (FEP) amount included in this line item. As of December 31, 2012 that amount was approximately $13.3 million.

Michael A. Mayberry, F.S.A., M.A.A.A., Vice President and Principal, performed the actuarial review. He relied on the testing/results of the Company's controls performed by the internal and external auditors. He also reviewed the Company's reserving assumptions and methodology as documented in its actuarial memorandum and performed a hindsight analysis of year-end 2012 incurred but not reported (IBNR) using paid claims through June 30, 2013.

Based upon Lewis & Ellis' review, it appears the Company used appropriate and typical actuarial methods in establishing its aggregate claim liabilities and reserves. Furthermore, Lewis & Ellis concluded that the Company was holding adequate liabilities at year-end 2012 for the lines of coverage and risks reviewed and that the FEP amount was appropriately computed.

SUMMARY

Summary

The results of this examination disclosed that as of December 31, 2012, the Company had admitted assets of $718,717,103, liabilities of $233,048,517, and unassigned funds of $485,668,586. Therefore, the Company's total capital and surplus exceeded the $2,000,000 minimum prescribed by Section 41-313, Idaho Code.

CONCLUSION

The undersigned acknowledges the assistance and cooperation of the Company's Directors, Officers and employees in conducting the examination.

In addition to the undersigned, Marie Sorensen, CPA, CFE, CIA, FLMI, AIE, of Risk & Regulatory Consulting, LLC, and Kelvin Ko, CFE, participated in the examination for the Idaho Department of Insurance. Michael A. Mayberry, F.S.A., M.A.A.A, Lewis & Ellis, Inc. conducted the actuarial portion of the examination. The Company's information systems were reviewed by Information System Specialist, Jenny L. Jeffers, CISA, AES, CFE, on behalf of Jennan Enterprises LLC.

Respectfully submitted,

Lois Haley, CFE
Senior Insurance Examiner
State of Idaho
Department of Insurance

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CONCLUSION

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Respectfully submitted,

Lois Haley, CFE
Senior Insurance Examiner
State of Idaho
Department of Insurance

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AFFIDAVIT OF EXAMINER

State of Idaho
County of Ada

Lois Haley, being duly sworn, deposes and says that she is a duly appointed Examiner for the Department of Insurance of the State of Idaho, that she has made an examination of the affairs and financial condition of Blue Cross of Idaho Health Service, Inc. for the period from January 1, 2009 through December 31, 2012, including subsequent events, that the information contained in the report consisting of the foregoing pages is true and correct to the best of her knowledge and belief, and that any conclusions and recommendations contained in the report are based on the facts disclosed in the examination.

Lois Haley

Lois Haley, CFE
Senior Insurance Examiner
Department of Insurance
State of Idaho

Subscribed and sworn to before me the 5th day of May, 2014 at Meridian, Idaho

Leah D Greenwood
Notary Public

My commission expires: 5/17/18