Highmark Reserve/Surplus Application and Supplemental Documents

Highmark Inc.

Response to Notice 2004-01

Regarding Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations

April 15, 2004

Candy Gallaher/CorpAffairs/CORP/Highmark
04/14/2004 07:41 PM

To ra-in-healthplan@state.pa.us
cc rrohrbaugh@state.pa.us, stjohnson@state.pa.us, Gary Truitt/EXEC/CORP/Highmark@HighmarkNotes
bcc
Subject Highmark Inc. April 15, 2004 Surplus Document

Highmark hereby provides its response to Notice 2004-01. We are not seeking to maintain as confidential or proprietary any section of the attached document. However, if the Department should seek additional detail regarding any of the information in the document that would entail release of information which we consider confidential or proprietary, we would reserve the right to designate it as such.

Tomorrow we will have four copies of the document hand-carried to the attention of Sandy Ykema.

We look forward to the Department's review and comments.

Sincerely,
Candy

Highmark April 15 2004 Surplus Document.pdf

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Highmark Inc. Statement

In Response to the Insurance Department Notice 2004-01 on Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations

Highmark Inc. ("Highmark") is a not-for-profit health insurer doing business as Highmark Blue Shield throughout Pennsylvania and as Highmark Blue Cross Blue Shield in the 29-counties of western Pennsylvania. In addition to its primary health insurance business, Highmark's Government Business operations areas process Medicare Part A and Part B claims as both a Medicare Intermediary and Medicare Carrier.

Highmark's key health subsidiaries, Keystone Health Plan West, Inc. and HealthGuard of Lancaster, Inc., offer quality managed care coverage. Keystone Health Plan West administers SecurityBlue, a Medicare Advantage HMO, and Highmark administers FreedomBlue, a Medicare Advantage PPO. Another jointly owned subsidiary, Gateway Health Plan, Inc. administers a HealthChoices contract, the Commonwealth's managed care coverage for medical assistance recipients.

Other Highmark subsidiaries and affiliates provide a range of insurance services which complement the benefits offered to Highmark's health customers, and respond to customers' demands for full-service insurance programs.

Highmark Inc. makes this submission to the Pennsylvania Insurance Department ("Department") in response to Notice 2004-01, published by the Department in the *Pennsylvania Bulletin* on January 17, 2004, 34 Pa. Bull. 458 ("Notice"), as modified by representations of the Department at a hearing in *Capital Blue Cross v. Koken*, No. 172 M.D. 2004, in the Commonwealth Court of Pennsylvania and as interpreted by the Opinion and Order of the Honorable Dan Pellegrini in that case.

Highmark reserves all of its rights, positions and arguments with respect to the procedural and substantive validity of the Notice. Highmark's voluntary submission of information in response to the Notice should not be construed as a waiver by Highmark of any of these positions or as Highmark's abandonment of its original jurisdiction proceeding pending in the Commonwealth Court. (See Appendix I for details regarding Highmark's position.) In addition, the references to RBC and RBC ranges or levels contained in this submission do not in any way waive Highmark's position with regard to the impropriety and lack of applicability of RBC to regulation of surplus levels.

The Notice requests information regarding the reserves and surplus level of Highmark and its insurance subsidiaries and affiliates. Highmark notes that each year it, and all of its subsidiary and affiliated insurance companies, report these reserves and surplus numbers in required Annual Statement filings due each March.

As discussed in detail in this document, Highmark believes it must maintain certain levels of surplus to satisfy the marketplace expectations of its customers and meet its substantial financial obligations. Only by remaining viable and financially stable, can Highmark fulfill its corporate mission – providing access to affordable and quality health care, enabling individuals to live longer, healthier lives.

Highmark believes it is important to view its corporate mission in a broad context, reflecting the changing and varied health care needs of different segments of the population the company serves. Highmark is committed to the customers and subscribers it serves. Highmark also remains committed to the charitable activities that support the needs of the medically and economically disadvantaged in our communities. Addressing the needs of all these groups has been – and will continue to be – an integral part of Highmark's corporate mission. Over the past seven years Highmark has provided over $516 million in charitable endeavors. To harm or diminish the ability of Highmark to continue its operations and remain a strong and viable company would be to harm the many people served by its insurance programs, services and community initiatives.

Highmark's corporate mission today and in the future encompasses a range of economic, social, demographic and technological forces that are straining all participants in the health care system – employers, consumers, unions, hospitals, physicians, health and human services organizations, public officials and regulators. Highmark's long-standing role in the community – balancing the sometimes-conflicting interests of all these stakeholders – is becoming even more critical. This dynamic perspective of Highmark's mission – and its unique role as the largest non-profit health insurer in the Commonwealth – is an important consideration in the review of the information that Highmark is submitting relating to appropriate reserve and surplus levels.

Highmark Inc. Response to:
Notice 2004-01
Regarding Reserve and Surplus Levels of Hospital Plan and Professional Health Services Plan Corporations

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Section I.

(a) Report of Company and Subsidiaries Reserves and Surplus Levels at Year End 2003

Highmark's Report of Company and Subsidiaries Reserves and Surplus Levels at Year End 2003

The notice published by the Insurance Department ("Department") requests a report of company and subsidiary reserves and surplus levels at year-end 2003. Highmark notes that each year it, and all of its subsidiary and affiliate insurance companies, reports these reserves and surplus numbers in the required Annual Statements due each March.

Reserves are the estimated liability for medical services rendered but not yet paid. Reserves include the costs of both services rendered and administrative expense to process the claims. Insurers are required to reserve appropriately for this liability. Surplus is statutory net worth. It is a statement of the company's excess of assets over liabilities, and is a measure of financial strength. It is not a lump sum of cash.

PricewaterhouseCoopers LLP performed an independent review of the claim reserves of Highmark and its subsidiaries and affiliates. This review concluded that Highmark's and each of its subsidiaries' and affiliates' recorded claim reserves fell within a reasonable range of results.

Some of Highmark's subsidiaries include licensed operations in other states, particularly United Concordia Companies, Inc., the dental insurance company, Davis Vision of Michigan, Inc, the vision insurance company, and Highmark Life and Casualty Group. The companies listed on the attached report are:

- Highmark Inc
- Keystone Health Plan West, Inc.
- Gateway Health Plan, Inc.
- HealthGuard of Lancaster Inc.
- Davis Vision of Michigan, Inc.
- Inter-County (2 companies)
- Highmark Life & Casualty Group (4 companies)
- United Concordia Companies, Inc. (16 companies)

I. Company and Subsidiaries Report

	December 31, 2003	
	Loss and Loss Adjustment Expense Reserves	Total capital and surplus
Highmark Inc.	451,774,393	2,194,710,174
Gateway Health Plan, Inc.(a)	67,032,600	68,268,697
HealthGuard of Lancaster, Inc.	24,274,220	12,209,228
HCI, Inc. (b)	441,847	2,180,853
Highmark Casualty Insurance Company	36,426,838	44,314,455
Highmark Life Insurance Company	176,499,844	90,648,736
Highmark Life Insurance Company of New York	13,000,498	8,956,030
Davis Vision of Michigan, Inc.	463,953	2,515,270
Inter-County Health Plan, Inc. (a)	3,472,227	2,127,469
Inter-County Hospitalization Plan, Inc. (a)	6,135,273	5,017,920
Keystone Health Plan West, Inc.	197,583,486	213,135,565
United Concordia Companies, Inc.	21,292,505	96,292,016
United Concordia Dental Corporation of Alabama	246,041	453,793
United Concordia Dental Plans, Inc.	1,252,268	1,598,939
United Concordia Dental Plans of Arizona, Inc.	9,460	91,213
United Concordia Dental Plans of California, Inc.	2,393,794	1,918,735
United Concordia Dental Plans of Delaware, Inc.	45,527	485,598
United Concordia Dental Plans of Florida, Inc.	7,686	359,207
United Concordia Dental Plans of Illinois, Inc.	4,494	148,910
United Concordia Dental Plans of Kentucky, Inc.	63,264	503,617
United Concordia Dental Plans of the Midwest, Inc.	732,561	2,549,269
United Concordia Dental Plans of Pennsylvania, Inc.	1,296,316	2,029,238
United Concordia Dental Plans of Texas, Inc.	31,336	550,036
United Concordia Insurance Company	5,716,852	31,169,895
United Concordia Insurance Company of New York	586,850	2,140,152
United Concordia Life and Health Insurance Company	23,091,891	76,643,300
JustDental of Delmarva, Inc.	-	199,696

Legend:

a Gateway Health Plan, Inc., Inter-County Health Plan, Inc. and Inter-county Hospitalization Plan, Inc. are 50% owned affiliates. Amounts represent 50% of the respective totals.

b Statutory annual statements are not required by the state of domicile for HCI, Inc. Financial information presented is based on the GAAP audit report.

Section II.

(b) Highmark's Target RBC Ratio Range for Management of Risks and Operations

- **Mechanism For Identifying Surplus Levels Beyond Range**

Highmark's Target RBC Ratio Range for Management of Risks and Operations

Introduction

The Department previously published Notice 2004-01 ("Notice") in the Pennsylvania Bulletin, which was subsequently modified by representations of the Department in court proceeding before the Commonwealth Court. The Department is now asking each of Pennsylvania's four Blue plans to submit: (1) a suggested maximum surplus range within which to operate, using RBC or another methodology, (2) a plan to expend funds for charitable purposes, and (3) a proposed business plan explaining how surplus maintained in excess of the suggested maximum range should be fairly and equitably distributed.

Highmark's response is guided by a key principle acknowledged by the Department: each of Pennsylvania's Blue plans "face a large variety of financial, economic and operating risks, all of which require the maintenance of surplus to assure continued viability of these plans." Viability is a particularly relevant criterion to help ensure that Highmark can continue to meet its corporate mission into the future and to determine an appropriate operating surplus range for the company. Continued viability must be the touchstone by which surplus is measured.

Highmark is a not-for-profit health plan that is a health insurer and, for many in the Commonwealth, the health insurer of last resort. Because of Highmark's unique role, any plan to evaluate surplus requirements must take into consideration not only the best interests of the individual and group subscribers that Highmark serves but also the community it serves. This requires Highmark to remain more than solvent. It requires a viable and stable company that can meet its financial obligations under a range of often unpredictable scenarios. It also requires a company that has the financial capacity to add new products as local, state and national markets evolve, and to make necessary and prudent business and infrastructure investments.

The Department appears to suggest in the Notice that an RBC ratio is an authorized and appropriate measure or standard for determining an appropriate level of surplus. However, RBC does not quantify levels of surplus necessary for such things as the growth of business, capital investments needed for new product development and implementation, and technology acquisitions. In short, an RBC ratio is not an appropriate vehicle for measurement of maximum surplus levels.

Although Highmark has challenged, and continues to challenge, the propriety of using an RBC ratio as a measure or standard for surplus, because the Department has asked for an assessment of surplus in RBC terms in the Notice, Highmark presents its proposed operating range as a percentage of RBC and discusses why this range is greater than one suggested in the Notice.

Highmark addresses considerations of viability, the importance of maintaining its Blue license, and the reasons why Highmark or any other insurance company must hold adequate surplus. Finally, the company presents a means to determine whether the company's surplus exceeds the capital needs of the company at a given point in time.

Highmark's Proposed Risk-Based Capital Operating Range

In response to the Notice, Highmark proposes an operating surplus equivalent to the range of 650% to 950% of Authorized Control Level RBC. It is Highmark's intent to maintain its RBC ratio within this range under normal operating conditions. Highmark opposes the setting of a specific maximum RBC ratio.

If Highmark's RBC ratio should exceed 950%, Highmark would undertake a review to determine whether its surplus is greater than the capital needs of the Plan at that time. In the event the evaluation determines that the company's surplus is greater than a level necessary to meet its current or future capital needs, subject to the approval of Highmark's Board of Directors, as well as the boards of any affected subsidiaries, Highmark would submit a business plan in accordance with the standards and principles outlined in Section IV of this document.

Any plan to regulate health insurers' surplus levels must take into consideration the best interests of policyholders. Highmark believes that well-reasoned analyses of the economic, financial, operational and marketplace considerations affecting Highmark demonstrate the appropriateness of a surplus target operating range of 650% to 950% of RBC under normal operating conditions.

Determining an Appropriate Operating Surplus Range

To ensure the continued viability of this insurance enterprise, and thus Highmark's ability to meet its corporate commitments, Highmark must operate within a surplus range that assures the company will have a high probability of viable operations on an ongoing basis. An appropriate target surplus should consist of three components:

- A base component of surplus to meet the Blue Cross Blue Shield Association ("BCBSA") Early Warning Threshold requirement, which is 375% of Authorized Control Level RBC;
- The operating component of surplus maintained to assure continued viability of normal operations, such as funds to cover underwriting risk, unanticipated significant claims (to be prepared for the unexpected, and able to pay claims as needed), capital investments, and to meet corporate and public commitments; and
- The contingencies component of surplus maintained to be prepared for unforeseen and extraordinary events or developments, such as significant market or regulatory requirements or changes.

A detailed analysis is also necessary because of the complexity of the health insurance business and the inherent limitations of the RBC ratio as a suitable measure for determining an appropriate surplus range. The RBC methodology, as developed by the National Association of Insurance Commissioners and subsequently adopted by the Commonwealth, does not address the issue of what surplus level a given company should maintain to remain viable. RBC is a solvency-monitoring tool, not an indicator of financial viability or robustness.

An appropriate target surplus range may vary widely from one company to the next and for a given company depends in large part on that company's risk profile and strategic plan. To determine an appropriate target surplus for Highmark, the actuarial consulting firm Milliman USA was engaged. Milliman USA conducted a detailed review of Highmark's financial condition, risk profile, operating history, and strategic plan. Highmark's target surplus operating range of 650% to 950% of RBC is based on and supported by Milliman USA's analysis.

Solvency and Blue Trademark Considerations

A reasonable starting point for addressing this issue is the BCBSA's monitoring thresholds. BCBSA has identified an RBC ratio of 375% of Authorized Control Level RBC to constitute an "Early Warning Level", at which point monitoring is considered by that organization. If a Blue Plan's RBC ratio drops below 375%, the Plan is subject to formal monitoring. A drop in RBC ratio to below 200% could result in immediate termination of the right to use the Blue Cross and Blue Shield brand names.

Clearly, the BCBSA regards 375% as a dangerously low level of surplus. Since Highmark's group customers and individual subscribers depend on access to coverage by arrangement throughout the Blue Plan system, revocation of the Blue trademarks and removal from the Blue system would cause immediate and immeasurable harm to Highmark's customers and would be a devastating blow to the corporation.

In view of the BCBSA's categorization of an RBC ratio of 375% as an "Early Warning Level," Highmark believes this level should be viewed as the starting point for determining an appropriate range. From a pure financial solvency perspective, Highmark views this level as the bare minimum below which Highmark should not fall. The 375% RBC ratio, however, does not adequately reflect the substantial financial pressures and risks Highmark faces that can unexpectedly shrink its surplus and undermine the Plan's efforts to remain viable by developing and growing its business. It constitutes the floor, but does not represent a prudent level for continued viability. A prudent level is one that provides a high probability that Highmark will never fall below 375%, and further, maintains necessary operating surplus levels on an ongoing basis.

In addition to the trademark considerations above, as an independent licensee of BCBSA, Highmark must either participate in a state guaranty fund, establish an alternative method which assures payment of claims liabilities and continuation of coverage in the event of an insolvency, or have 800% or greater of the Authorized Control Level RBC. Through

this standard, BCBSA addresses the concern that a plan with an RBC ratio below 800% presents an unacceptable risk of default on its obligations to customers which must be protected by a state guaranty association or some other means. Since its RBC ratio dropped below 800% in 2002, Highmark established, in consultation with the Department, a Custodial Trust Account to assure that sufficient funds are available to discharge obligations to subscribers, and has entered into reciprocal agreements with other Pennsylvania Blue Plans for continuation of coverage in the event of an insolvency.

A Surplus Operating Range of 650% to 950% of RBC is Appropriate for Continued Viability

Highmark's target surplus operating range between 650% and 950% of RBC is needed for several reasons:

- To meet Highmark's corporate and public commitments;
- To be able to weather the potentially adverse effects of health insurance underwriting cycles and remain safely above the minimum state and BCBSA surplus requirements;
- To support necessary investments in technology and infrastructure improvements;
- To maintain financial flexibility to grow business through internal expansion or acquisitions, to have sufficient capital to grow as needed to maintain operational excellence, and to meet marketplace challenges and growth opportunities as they arise;
- To meet customers' needs and expectations notwithstanding unusual occurrences of severe financial magnitude, such as public health outbreaks, class action lawsuits, or events that involve losses of potentially very high severity and unknown frequency such as the terrorist attacks of September 11, 2001; and
- To comply with unfunded government mandates.

Meeting Highmark's Corporate Mission

Highmark's corporate mission – to provide access to affordable, quality health care coverage enabling individuals to live longer, healthier lives – applies to all of the services Highmark provides. While a not-for-profit company, Highmark must also operate in a business fashion in a competitive market. Highmark provides insurance to large employers, small groups, and individuals, and charges premiums for that service. Highmark's financial health and solvency is important to assure it can continue to be a strong, viable company, able to meet all of those commitments.

Highmark also has a public commitment to work to provide access to coverage to the greatest number of Pennsylvanians. For example, Highmark contributes to programs and products that help reduce the number of uninsured in the Commonwealth by providing access to health insurance for everyone in the community, regardless of medical condition, age or gender. In 2003, Highmark contributed $66.3 million in rate subsidies to its individual and senior products to help make them more affordable to Pennsylvanians.

Highmark also contributes to health insurance programs for Pennsylvanians who are economically disadvantaged. In 2003, Highmark contributed $15.3 million to the adultBasic, Children's Health Insurance Program (CHIP) and Caring Programs in the form of direct contributions, administration and underwriting subsidies. Highmark currently covers over 43,000 children in CHIP and over 21,000 adults in adultBasic. Since the inception of CHIP and adultBasic, Highmark has covered over 300,000 individuals in these programs.

Highmark also supports community organizations and strategic, community-based health programs that help improve the health and well being of people in the communities served by Highmark. In 2003, Highmark contributed $14.5 million in direct community contributions. This funding supported strategic community initiatives such as those to combat childhood obesity and minority health disparities, and to promote health prevention and education activities.

Highmark plans for these commitments, and budgets for them; they are an essential part of Highmark's mission. Monies are allocated for these programs, as discussed in Section III of this document. By maintaining an appropriate surplus range, Highmark is better able to meet these commitments year after year and make a difference in the lives of many Pennsylvanians.

Surviving Adverse Underwriting Cycles

Highmark must maintain a robust operating range to ensure it is able to pay claims and expenses during periods of variation in claims costs and investment income, when claims costs rise and investment income drops. The most destabilizing impact on a company's surplus level can occur during the down period of the phenomenon commonly known as the health insurance underwriting cycle.

Health insurance is a cyclical business. Just like the general economy, Highmark's financial results move like a pendulum. Highmark must keep its surplus in an optimal range during the years of favorable operating results to weather the erosion of surplus during the years of unfavorable operating results. These cycles are not unique to Highmark and have been seen throughout the health insurance industry; comparable Blue Cross and Blue Shield plans have experienced this same phenomenon.

For example, since 1980, Highmark has experienced three major cycles of operating losses. On average, Highmark's operating losses during these cycles represented about 15 percent of company insured premium.

The impact of operating losses on the company's surplus level can be offset, to some extent, by contributions from investment activities. Moving forward, however, the potential for investment income to help offset operating losses is expected to be less certain as a vehicle to withstand the impact on surplus of a downturn in the underwriting cycle. When applying an anticipated downturn in the underwriting cycle of similar magnitude as previous downturn cycles to Highmark's current operations, it is apparent

that a resultant decrease in surplus could result in a concurrent decrease in RBC of 350 to 650 percentage points. Thus the proposed target operating range of 650% to 950% of RBC would be needed to permit Highmark to withstand an underwriting downturn similar to historic cycles, and enable the company to continue operating in a viable fashion.

Supporting Investments in Technology

A large company, such as Highmark, with over 4.1 million subscribers in its core health business, over 8,700 employees in its core health business in Pennsylvania, and over 13,000 nationwide, has significant technological needs. Everything from claim processing systems to employees' desktop computers requires substantial and ongoing capital investment. During the past five years, the company has spent approximately $230 million on information technology and computer systems that support essential health insurance functions.

Looking forward, it is likely even more investments will be necessary just to stay current in technologies, and to meet its customers' and providers' expectations. The technology and information systems supporting these and other development activities require substantial capital outlays - investments that will continue in the future.

Technology is needed to provide hospitals and physicians with more information so they can practice more cost-effective medicine. Enhanced provider electronic connectivity is expected. For instance, Highmark provides primary care physicians with data at the practice level to help them spot medical trends and identify opportunities to improve overall approaches to care.

New technologies will support virtually all aspects of Highmark's business: pricing and underwriting, market research, consumer directed healthcare programs, new products such as HSAs, web-enabled exchange of information with customers and providers, integrated care management and disease management programs, in addition to the well-recognized claims processing and customer service functions. A reasonable operating range must take into account the capital needs associated with these technology-related requirements.

Maintaining Financial Flexibility to Meet Marketplace Challenges and Opportunities

A reasonable operating surplus range is also needed to assure that Highmark can maintain the financial flexibility needed to address new or emerging market challenges or opportunities. For example, customers are now seeking access to HSAs (health savings accounts that take account of tax advantages). And recent guidance from the Treasury Department indicates that Highmark and other insurers will have to integrate services and systems in new ways to offer these programs. Use of surplus funds is the principle way to assure Highmark can continue to meet this challenge, customers' expectations, and the new market opportunities without turning to current customers to finance this future expectation.

Highmark and other not-for-profit companies face inherent disadvantages in accessing capital for acquisitions and the development of new products to remain viable. Highmark cannot turn to the stock market to raise capital. The company's primary sources of raising capital are investment income and operating gains. Because Highmark's options for raising capital are far more limited than publicly held companies, Highmark must rely heavily on its surplus for the financial flexibility to respond to marketplace opportunities and challenges as they arise.

Some of Highmark's wholly owned, for-profit subsidiaries, obtained through acquisitions, are important components in helping Highmark remain financially flexible and meet marketplace challenges and opportunities. These investments are also examples of the company's prudent use of surplus to pursue market opportunities. The subsidiaries, providing dental, vision and life and casualty coverage in Pennsylvania and elsewhere, serve as investment vehicles to generate revenues that support Highmark's core health business and help the company meet its substantial financial obligations. They also have a tangible impact on the economy of the state, by employing thousands of people in central and western Pennsylvania and paying millions of dollars in state and local taxes in the Commonwealth.

Weathering the Impact of Unexpected Developments

Unexpected developments can have a profound effect on Highmark's surplus level and its continued viability. The loss of a large national customer with thousands of subscribers can directly influence the company's operating performance and, ultimately, its surplus level. So, too, can an unanticipated catastrophic event. A public health crisis, such as the hepatitis outbreak that occurred in Western Pennsylvania in late 2003, illustrates the potential for unexpected medical outbreaks. A more significant outbreak, or one on a larger scale, could quickly drain surplus.

The events of September 11, 2001 are a vivid reminder of the need for insurance companies to operate within a reasonable surplus range. The financial risks associated with terrorism, class-action lawsuits, and public health outbreaks have the potential to involve losses of very high severity, reinforcing the need for health insurers to retain significant surplus to support all of the risks they assume.

Complying with unfunded government mandates

Federal and state legislation can create new capital obligations for health insurers without providing any funding to meet those obligations. For example, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) included many specific provisions to deal with the growing public concern about the privacy and security of electronically transmitted data. Highmark has spent tens of millions of dollars to upgrade its computer systems and data transmissions to comply with HIPAA and other federal legislation. Of the $230 million referenced earlier, $44 million applied just to meeting HIPAA requirements.

Determining if Surplus Exceeds Operating Needs

Highmark proposes a reasoned and forward-looking approach to determine whether a surplus level greater than 950% of RBC also exceeds the needs of the company at a given time. A surplus level greater than 950% of RBC should be treated as a first indicator, or a flag. If an RBC ratio exceeded the target operating range, this would trigger additional analysis by the company to determine whether further action is warranted.

This analysis would include key considerations, and take into account the company's longer-term capital planning needs. The board of directors is responsible for assuring the company is properly planning for and able to meet its commitments and must review the company's surplus in that context. Thus, the review would include a look at the following, among other things:

- RBC ratio status – a change in RBC ratio from prior period, change in any major components of RBC from prior period, projected RBC ratio for future periods;
- Other standard measures – surplus as a percentage of premium, surplus measured as number of months of claims and administrative expenses, average surplus per subscriber;
- Business measures - change in premium and enrollment from prior period, actual and projected claim trends, actual and projected investment returns, emerging changes in underwriting cycles;
- Planned capital expenditures or requirements, pending mergers, acquisitions, and divestitures; and,
- Corporate and public mission activities - actual and projected community contributions, and current and projected charitable contributions.

Since the RBC ratio is just that, a ratio, use of RBC at all requires consideration of anticipated changes that affect the numerator (surplus) and the denominator (Authorized Control Level, RBC), either separately, or simultaneously.

There are many potential future events that can affect surplus, RBC, or both, but which are not reflected in the current RBC ratio. For example, three years ago the federal Medicare+Choice program was facing severe financial pressures, resulting in flat or declining enrollment in Medicare HMOs. Few public policy health experts could have anticipated the broad changes that will now occur as a result of the Medicare Modernization Act. Now Highmark is considering significant capital requirements to be able to continue offering Medicare Advantage plans to seniors. These requirements will have a direct impact on surplus and RBC, with the potential to reduce substantially Highmark's RBC ratio in the absence of any mitigating actions.

Likewise, advances in computer technology and the significant volumes and increasing complexity of data associated with measuring health care utilization and quality pose key challenges. While it is true that health insurance entities need much greater computer infrastructure (both in software and hardware) than many other businesses, Highmark

expects additional specific capital requirements over the next three to eight years. The expected obsolescence of certain major operational systems designed and built in the 1980's, is likely to lead to a multi-year development effort requiring hundreds of millions of dollars. Due to the magnitude of such a project, most of it would be expected to be financed by drawing upon surplus funds, rather than using funds generated by normal business operations. These expenditures would also have the potential to substantially reduce Highmark's RBC ratio.

Conclusion

Highmark believes that a comprehensive review of multiple financial measures and business considerations must be undertaken to determine an appropriate capital operating range. This analysis must recognize that RBC ratios are highly variable ratios, affected by the type of risk inherent in the company's book of business, as well as the amount of surplus on hand at any given moment. Highmark believes its proposed surplus operating range approach provides for the required flexibility to permit the company to manage its business, meet its commitments, satisfy its customers' expectations, and keep pace with marketplace challenges and opportunities moving forward.

Section III.

(c) Statement of Charitable Activities and Projected Expenditures

Highmark's Charitable Expenditures

In 2002 and 2003, And Planned Expenditures in 2004 - 2006

Introduction

Highmark's corporate mission – to provide access to affordable, quality health care coverage enabling individuals to live longer, healthier lives – can be viewed in a variety of ways. Highmark has traditionally interpreted its corporate mission quite broadly, meaning that Highmark constantly looks for new ways to meet the changing health care needs of the communities it serves. Its partnership with the state and federal government to develop the health coverage tax credit program to help many unemployed workers in Pennsylvania (especially in the steel industry) and its efforts to help address the public health crisis of childhood obesity underscore the importance of viewing Highmark's corporate mission through a wide lens – one which recognizes that there are countless ways to help people live longer, healthier lives.

Although Highmark believes it is important to address new health care issues as they arise, Highmark remains committed to core charitable activities that have been part of the company's heritage. Throughout the decades, Highmark has developed programs to protect populations that were considered high-risk or uninsurable – seniors, the unemployed, workers who earned too little to afford private health insurance and children in lower-income families. It is sometimes overlooked – perhaps because the Blue Plans in Pennsylvania have been doing it for so long – that Highmark offers coverage to everyone, regardless of medical condition, age or gender. No other commercial health insurer in the state can make that claim. At the same time, Highmark has provided subsidies to help make its insurance programs that cover lower-income families and uninsured children more affordable.

Some of Highmark's business practices further support the company's charitable activities by helping Pennsylvanians achieve greater access to health care coverage:

- Highmark offers continuous open enrollment in its guarantee issue direct pay products;
- Highmark's group programs include limited pre-existing condition waiting periods with conversion privileges;
- Highmark makes available the Special Care program to low-income Pennsylvanians;
- Highmark continues to make coverage available to all small employers. In 2003, Highmark underwrote in excess of $900 million in small group business; and
- Highmark, along with the other Blue plans in the state, serves as the HIPAA State Alternative Mechanism for individuals, assuring access to health insurance without a pre-existing condition waiting period to those leaving group health coverage.

The company's allocated expenditures are reported on the attached reports, which summarize Highmark's 2002 and 2003 actual contributions as well as those anticipated for 2004 through 2006. In 2003, Highmark provided $96 million in support of charitable activities. More than $81 million was provided to help hold down the cost and expand access to health care coverage for lower-income families, older adults and uninsured children. Specifically, Highmark contributed **$66.3** million in rate subsidies to direct pay and senior products. Highmark also contributed **$15.3** million to the adultBasic, the Children's Health Insurance Program (CHIP) and the Caring Programs in the form of direct contributions, administration and underwriting subsidies. Highmark serves over 43,000 children in CHIP, over 21,000 adults in adultBasic, and has served over 300,000 individuals in aggregate since these programs began.

In 2003, Highmark also contributed **$14.5** million to 1,017 community organizations, in the form of cash grants, sponsorships and in-kind gifts, to improve the health and well being of people in the communities served by Highmark. More than two-thirds of the awards that were distributed went to organizations serving human services, health and educational needs, including programs to address childhood obesity and inactivity, minority health disparities, health prevention and education activities through HealthPLACE and the Center for Grieving Children. These awards align closely with Highmark's overall corporate mission.

Highmark employees are deeply involved in the communities the company serves through their volunteerism (22,172 hours in 2003) and management representation on non-profit Board of Directors (172 individuals in 2003). Highmark will continue to support such employee commitments to programs and communities.

The following pages provide details regarding Highmark's charitable contributions and activities in 2002 and 2003, and projected expenditures in 2004 through 2006.

Highmark Funds Expended for Charitable Purposes ($ in Millions)	**2002 Final**
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$0.8
CHIP and Caring Program Administrative Expense Contributions	$8.4
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$36.4
Community Contributions	$13.0
TOTAL	**$60.8**

Highmark Funds Expended for Charitable Purposes ($ in Millions)	2003 Final
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$0.8
CHIP, Caring Program and adultBasic Administrative Expense Contributions	$9.3
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$39.1
Community Contributions	$14.5
Medicare Choice Rate Subsidy	$25.0
CHIP and adultBasic Claim Losses	$5.2
TOTAL	**$96.1**

Projection of Highmark Funds Allocated for Charitable Purposes ($ in Millions)	2004 Projection*
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$1.0
CHIP, Caring Program and adultBasic Administrative Expense Contributions	$8.3
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$40.7
Community Contributions	$15.7
adultBasic Claim Losses	$10.0
Underwriting Losses on Direct Pay Business (Reflects on investment income adjustment)	$16.0
TOTAL	**$93.9**

Projection of Highmark Funds Allocated for Charitable Purposes ($ in Millions)	2005 Projection*
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$1.0
CHIP, Caring Program and adultBasic Administrative Expense Contributions	$9.0
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$46.8
Community Contributions	$16.0
TOTAL	**$75.0**

Projection of Highmark Funds Allocated for Charitable Purposes ($ in Millions)	2006 Projection*
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$1.0
CHIP, Caring Program and adultBasic Administrative Expense Contributions	$9.2
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$50.4
Community Contributions	$17.0
TOTAL	**$79.8**

*** Projection Assumptions summarized below:**

Direct Contributions to Caring Program for Children -The projections assume that Highmark will give $800,000 to the Highmark Caring Foundation and $200,000 to the Independence Blue Cross and Highmark Blue Shield Caring Foundation. These projections are based on historical contribution levels.

BlueCHIP, Caring Program and adultBasic Administrative Expense Contributions -The projections are based on historical contribution levels but adjusted downward slightly for 2004 based on knowledge that the adultBasic enrollment will not be increasing at the same rate as it has historically.

Special Care Rate Subsidy -The projection is based on historical levels.

Group Conversion/Subsidy - The projection is based on Highmark's forecasts of the group business Highmark anticipates underwriting in these future periods.

Community Contributions - The projections are based on Highmark's budget forecasts.

adultBasic Claim Losses - The projections for underwriting losses in 2004 are based on the fact that it is anticipated that the Insurance Department will grant a rate increase that is significantly less than Highmark has requested and is required for rate adequacy. The 2005 and 2006 projections are based on receiving adequate rates.

Underwriting Losses on Direct Pay Business - The projections for underwriting losses in 2004 are based on the fact that Highmark's 2004 rate filings have not been approved for its direct-pay business. For 2005 and 2006, it is anticipated that Highmark will receive adequate rates.

Description of Contributions and Programs

Direct Contributions to Caring Program for Children

Highmark Inc. matches dollar for dollar any community contributions made to the Caring Foundation. These funds support the Caring Program for Children, a broad umbrella of programs that help low-income families secure access to health care for their children. Promoting healthy lifestyles among children has been a centerpiece of the Caring Program's activities. For example, the Program has built awareness of the importance of receiving flu shots through birthday card reminders and immunization record cards, and encouraged healthy behaviors such as washing hands and wearing safety helmets.

Additionally, Highmark provides support to The Caring Place, a Center for Grieving Children, Adolescents and Their Families, in the Pittsburgh, Erie and Harrisburg areas. The Caring Place provides peer support for children and families who have suffered the death of a parent or other loved one, through caring, encouragement and support from trained professionals and volunteers in a nurturing environment. The services are offered at no cost.

In 2002, The Caring Place served 1,024 families and in 2003, served 975 families. The Caring Place in Central Pennsylvania opened its doors in 2003. Since its inception, The Caring Place has helped more than 8,000 family subscribers. The Caring Place provides ongoing education, training and consultation to counselors, teachers, therapists and other professionals who serve children.

Highmark, in conjunction with Independence Blue Cross (IBC), also matches dollar for dollar any community contributions raised by the Independence Blue Cross and the Highmark Blue Shield Caring Foundation in the Southeastern region of the state. No funds are matched in the other regions of the state, as these Caring Foundations do not conduct community fundraising activities.

Highmark expects that it will support the Caring Place in the future as demand for its services continues to increase.

CHIP, Caring Program, and adultBasic Administrative Expense Contributions

Highmark and its partner, the Caring Foundation, has been a contractor for both the Children's Health Insurance Program (CHIP) and adultBasic programs since their inception. In this capacity, they provide a wide range of administrative services to support these state-financed programs, including community outreach, enrollment, income verification, claims processing and customer service. The administrative costs incurred by Highmark and the Caring Foundation have historically exceeded the state's payments to CHIP and adultBasic contractors to administer these programs. Highmark has absorbed the un-reimbursed administrative costs.

Community outreach is an integral part of the company's administrative activities in support of CHIP and adultBasic. The outreach activities are designed to identify children and adults who may be eligible for CHIP or adultBasic, and to guide them to the appropriate public program (CHIP, adultBasic or medical Assistance) so they receive necessary health care services. Highmark and the Caring Foundation provide staff and resources in conducting grass-roots outreach to find and enroll eligible uninsured individuals. In 2002, outreach staff conducted 84 events that touched over 40,000 individuals. In 2003, outreach staff conducted 102 events that touched over 87,000 individuals.

Special Care Rate Subsidy

The Blue Plans in Pennsylvania developed the Special Care program in 1992 to help make health care coverage more available, accessible and affordable for low-income Pennsylvanians whose incomes are at or below 185% of the federal poverty level. Statewide, 56,559 individuals are enrolled in the Special Care program – making it one of the largest and most successful private sector initiatives to address the issue of the uninsured in the nation.

Highmark Inc. subsidizes the Special Care rates in its programs throughout the State in two ways: through a $2.2 million Special Care rate subsidy and through the direct pay rate subsidy derived from the group conversion subsidy, which is described below.

Group Conversion/ Subsidy

Highmark Inc. subsidizes the rates charged to direct pay programs with premium income collected from rates charged to group customers, with the direct intent of subsidizing the rates of conversion and guarantee issue enrollment. These direct pay rate subsidies are reflected in all rate filings presented and approved through the Pennsylvania Insurance Department. These subsidies help to make health care coverage more affordable to individuals who may otherwise be uninsured. In 2003, Highmark served over 500,000 individuals through all of its direct pay programs. Highmark will continue to offer guarantee issue direct pay coverage to all Pennsylvanians in 2004-2006.

Medicare Advantage (Previously Medicare + Choice) Rate Subsidy

In 2003, Highmark applied a $25 million rate subsidy to its Medicare + Choice HMO product (now Medicare Advantage). This subsidy helped mitigate rate increases to senior citizens at a time when federal reimbursement levels were inadequate in some areas.

CHIP and adultBasic Claim Losses

Highmark has a long history of commitment to children's health insurance programs beginning with the Caring Program for Children in 1985. Highmark, with its partner the Caring Foundation, is the only insurer providing CHIP coverage in 49 counties in

Western and Central Pennsylvania, and has continued in the program since its inception in 1993 despite administrative and claim losses.

Highmark is proud of its partnership role with the Commonwealth in the nationally recognized public/private CHIP program in Pennsylvania. Highmark, with its partner the Caring Foundation, is also the only insurer to administer the adultBasic program in the Western region of the state.

Experience with these programs has demonstrated that the individuals enrolling in these programs come into the programs with significant unmet medical needs as a result of being uninsured. This unmet need drives up the rates required for the program in order to cover claim costs.

Community Contributions: Improving Health and Well Being

Highmark's efforts to improve the community's health encompass a number of approaches, including education, training, health prevention programs, injury prevention, provision for life essentials and support for economic and community development. Working in partnerships with community-based health and human services organizations, Highmark provides support for programs that have been shown to benefit the health and well being of the community. Highmark considers its support of community-based health resources to be a key part of the company's charitable activities.

Addressing Childhood Obesity

Childhood obesity is an emerging problem with long-term implications for the health care system and the health of our communities. The number of overweight children has increased dramatically, along with chronic health conditions normally seen only in adults. The problem primarily results from unhealthy lifestyle habits involving poor nutrition and lack of exercise. Highmark has launched a number of programs to address obesity and inactivity.

In partnership with the Pittsburgh Public Schools, Highmark has helped to develop a new curriculum for teaching fitness and physical education classes. Children participating in an initial pilot program showed significant improvement in their diet, as reflected by 19%, 15%, and 18% decreases in the consumption of high sodium, high-sugar, and high-fat foods, respectively. The schools also increased the amount of class time devoted to physical activity. In the 2002-2003 school year, the program was instituted throughout Pittsburgh's 58 elementary schools, affecting nearly 22,000 children.

The KidShape® program adopted by Highmark also has potential to produce similar results, such as weight loss and increased physical activity. Through nutrition, education, group support, and physical activity, the pediatric weight management program for overweight children emphasizes lifestyle change. Highmark is working through hospitals, schools and community service organizations to deliver the program.

Highmark also has provided grants for two other initiatives. Working with the Children's Health Fund, Highmark is participating in activities to increase awareness and education regarding childhood obesity and health risks that includes a local forum for community leaders and national experts, physician training, and a forum convening state legislators and community leaders to discuss a state-wide strategy.

The company also launched the "Challenge for Healthier Schools" in Western Pennsylvania – a $125,000 grant program for schools to create ways to improve nutrition and physical activity among students. In Central Pennsylvania, Highmark hosted a childhood obesity forum, bringing together many segments of the community to discuss childhood obesity and coordinate their efforts. Highmark will continue its commitment to this key initiative in 2004.

Protecting Seniors Against Influenza

Highmark has established partnerships with community-based organizations in Central and Western Pennsylvania to help ensure that seniors at high risk received flu shots. For example, in 2002, Highmark contributed $500,000 to a multi-dimensional flu immunization. Highmark partnered with 50 organizations that coordinated community flu-shot clinics and targeted homebound seniors. The partnerships were supported by a Highmark-orchestrated advertising campaign to help build awareness of the importance of receiving flu shots – especially to persons over the age of 50 with chronic illness or weakened immune systems. As a result of this campaign, 106,927 flu shots were provided to senior citizens.

Reversing Heart Disease

Highmark makes contributions to support the Dr. Dean Ornish Program for Reversing Heart Disease. This program provides an alternative treatment option for patients facing invasive procedures such as bypass surgery and angioplasty. It combines a low-fat vegetarian eating style, moderate aerobic exercise, stress management techniques and group support to improve blood flow to the heart and decrease cholesterol, blood pressure and chest pain. To date, over 2,500 individuals have benefited from this program. A recent study showed that participants in the program had fewer cardiac events and associated heart procedures.

Promoting Healthy Lifestyles in the Community

Highmark has a well-established tradition of developing and delivering health promotion and health education services to the community through its HealthPLACE sites and the HealthPLACE on the MOVE mobile unit both in Western and Central Pennsylvania. In 2003, over 202,600 units of service were offered to the community including 57,192 screenings, 6,225 Health Awareness classes and 25,880 Lifestyle Improvement classes offered through HealthPLACE.

Highmark's health promotion activities are designed to move toward a health care system that is oriented toward prevention and that focuses on wellness. One example of this approach is the H.O.P.E. (Highmark Osteoporosis Prevention & Education) program, aimed at helping reduce the risks and problems posed by this disease to thousands of seniors. This program focuses on protection and prevention for those at risk, bone-strengthening exercise, diet and medication counseling, and group support for those who have been diagnosed. Participants in the program have increased their strength and flexibility and reduced risk for falls. Many also experienced lower blood pressure, decreased pain, and a better sense of well-being. In the future, Highmark will continue to develop programs in the community, such as H.O.P.E., that will improve the quality of life for Pennsylvanians.

Community Contributions: Direct Charitable Giving

Highmark has long upheld a tradition of community support through corporate giving. The company is committed to helping sustain organizations that touch the lives of tens of thousands of people living in Highmark's 49-county service region.

Support for health and human services comprise more than two-thirds of the company's contributions. Highmark contributes to programs that support health and wellness promotions and education, disease prevention and intervention for all age segments, with an emphasis on health issues affecting youth and senior citizens.

While the majority of the funding goes to health and human services, Highmark also supports programs to strengthen communities, educational institutions and arts and culture. In 2003, Highmark gave direct contributions to 1,017 non-profit organizations with the average contribution amount being $7,250.

The following examples highlight the support Highmark provides for health and human services programs in the community:

- A grant to the American Lung Association of Central Pennsylvania to provide Asthma Care Packages to help educate families about asthma and help them effectively manage the disease with their newly diagnosed child;
- A grant to Nuestra Clinical in Central Pennsylvania for a pilot Hepatitis C Screening/Intervention program;
- A grant to the Laurel Foundation to provide defibrillators at various schools and community sites in Western Pennsylvania;
- Sponsorship of the Sisters Take Charge of Your Health Conference in Central Pennsylvania to inspire women of color to take charge of their health;
- A grant to Family Links to provide needed mental health services in Western Pennsylvania area schools;
- Grants to nursing schools in Western Pennsylvania to provide scholarships to students pursuing nursing careers to assist in addressing the nursing shortage in Pennsylvania;

- A grant to St. Joseph Medical Center in Central Pennsylvania to fund an educator/interpreter/outreach position to work with Latino patients and their families to reduce language barriers and enhance their health and wellness;
- A grant to the Eastern Area Adult Services organization to set up Health Check Kiosks at local malls in Western Pennsylvania;
- Organized and funded the "Walk for a Healthier Community in Western Pennsylvania," designed to support non-profit, human service organizations; and
- Grants to numerous organizations such as the United Way, the American Red Cross, the American Heart Association and the American Diabetes Association, just to mention a few.

Highmark's Additional Contributions in Support of Employee Volunteerism and Non-Profit Board Participation

In addition to the contributions outlined previously, Highmark strongly encourages its employees to be active in the community. Highmark has staff which regularly advise employees of volunteer opportunities with local, non-profit organizations, and encourages and supports employee participation. Highmark annually recognizes key employee volunteers through a volunteer luncheon and volunteer of the year ceremony.

In 2002, Highmark employees volunteered over 23,158 hours of their time, which equated in dollars to a contribution of about $383,033*. In 2003, Highmark employees volunteered over 22,172 hours of their time, which equated in dollars to a contribution of $366,725*.

Additionally, Highmark encourages all management level individuals to be involved in non-profit community organizations through Board of Director participation.

Based on a survey conducted in 2003, 172 management individuals actively served on the Board of Directors of non-profit community organizations.

***Value of volunteer time was $16.54/hour. Source: Independent Sector 2002.**

Section IV.

(d) Outline of Future Business Plan Methods and Principles

Business Plan's Methods and Principles

Method

Any attempt to use an RBC ratio to initiate a process of review of Highmark's surplus must distinguish between the normal course of business and other extraordinary business, economic, societal, governmental, or competitive issues that create an environment different from those in which Highmark normally operates. When unusual or uncommon circumstances exist, and depending on where Highmark is in the underwriting cycle, it may be necessary to provide for additional contingencies when considering the necessary capital for the continued viability of the entire insurance enterprise.

If RBC is used by the Department to measure surplus, Highmark believes that in the normal course of business an operating range of 650% to 950% of Authorized Control Level RBC is prudent for management of the inherent and potential risks in its book of business and insurance programs. An RBC ratio exceeding that range would serve as a monitoring flag, which would trigger a review of key environmental elements, in order to determine whether, and what level of, non-essential surplus existed.

Through a "Surplus Report" to be submitted to the Department, Highmark would evaluate and report on surplus relative to key environmental elements that must be considered, in order to determine whether a position of non-essential surplus existed.

Key environmental elements reviewed would include but not be limited to:

- RBC ratio status – a change in RBC ratio from prior period, change in any major components of RBC from prior period, projected RBC ratio for future periods;
- Other standard measures – surplus as a percentage of premium, surplus measured as number of months of claims and administrative expenses, average surplus per subscriber;
- Business measures - change in premium and enrollment from prior period, actual and projected claim trends, actual and projected investment returns, emerging changes in underwriting cycles;
- Planned capital expenditures or requirements, pending mergers, acquisitions, and divestitures; and,
- Corporate and public commitments - actual and projected community contributions, and current and projected charitable contributions.

Highmark must remain a strong and viable company, able to meet its obligations and commitments to customers, subscribers, providers, subsidiaries and partners. The analysis of surplus will have to assure that the corporate entity can meet its current and future commitments. It will also take into consideration the fact that Highmark already plans and allocates budgetary activity for its public commitments, as noted in Section III. Thus, any surplus beyond those commitments is surplus to serve the company's customers, and provide for their insurance protection.

The Business Plan to distribute surplus beyond the company's operating needs in a fair and equitable fashion would return designated surplus through the means of a rate credit to all then current customers. Highmark's customers include low-income direct pay program enrollees, small business owners and employees, as well as large accounts. Highmark's obligation to distribute any designated surplus to benefit the Commonwealth's citizens begins and ends with its customers and subscribers.

The method whereby this would occur is proposed through the following surplus adjustment fund:

Surplus Adjustment Fund (SAF)

If, in reviewing its surplus, Highmark were to conclude that it maintained surplus beyond its current and projected needs, the amount of funds designated as excess, as of the valuation date of the end of the prior year, would be set forth as a liability. This liability, to be referred to as a surplus adjustment fund (hereinafter referred to as "SAF"), would be established in the accounting period when such excess surplus amount is identified. Highmark would seek approval from the Department that this would constitute a permitted practice, which would allow for a direct charge to statutory surplus of Highmark or any affected subsidiary for the establishment of the SAF.

The SAF, which would be similar in treatment to a rate stabilization fund, would be utilized to return the excess surplus over a defined period of time, at a defined rate of adjustment to customer premium rates or fees. This adjustment factor would be in the form of a rate credit expressed as a percent of developed premium or premium and premium equivalents, as appropriate, subject to approval by the Department.

The SAF rate credit would be applicable to policies or agreements offered through Highmark's core health insurance business as Highmark Blue Cross Blue Shield and Highmark Blue Shield, and through Highmark's core managed health insurance subsidiaries, Keystone Health Plan West and HealthGuard of Lancaster, Inc (HealthGuard). Depending on the amount of such excess funds, the period of time over which the rate credit would apply would range from a 3-to-5 year period. The funds would be returned to Highmark's group and non-group customers through a SAF rate credit, not to exceed 1%, and no less an amount than 0.1%.

This moderate credit would return the designated funds back to the customers who helped create them, and would be low enough so as not to destabilize rates. By including non-group customers and both KHPW and HealthGuard, the SAF would benefit the broadest numbers of subscribers, as well as the many senior citizens of the Commonwealth enrolled in Medicare Advantage programs.

The distribution of such designated funds would occur through the use of the SAF rate credit. It would apply both to new business clients and to renewals of existing clients.

Application of the SAF rate credit would begin for New Business clients with client notification dates on the first day of the month that is on or after 60 days following

submission of the Business Plan to the Department. For Renewal clients, application would begin for client notification dates two months later, consistent with the implementation methodology for all other rating changes that affect both New Business and Renewal clients.

This adjustment would continue for a full twelve months of client notification dates, i.e., so that each New Business and Renewal client receives a rate credit within the 12-month period following the commencement date with respect to each. This cycle of customer rate adjustment activity will be referred to as a Distribution Cycle.

In the case of non-group programs the SAF rate credit would be included as a component of retention within rates submitted for approval.

The determination of the continued existence of any non-essential surplus would be re-evaluated every year, subsequent to the filing of the Annual Statement blanks to the Department and would reflect the inclusion of the existing SAF fund balance in its determination.

Should the subsequent years reflect no excess surplus, then the SAF would become zero and the SAF rate credit would cease with the conclusion of the Distribution Cycle. Should the subsequent years reflect any non-essential amount of surplus funds, then a new SAF balance would be established, and a new SAF rate credit determined. This would create another Distribution Cycle, using the new SAF rate credit in rate/fee developments, under the same terms as noted above. This process would be repeated until it is determined that excess surplus no longer exists. Once it is determined that no excess surplus exists, the distributions of designated funds would be fully discharged.

Principles

Operations below the 950% RBC threshold level would automatically provide a safe harbor for both the company and the Department with regard to the review of rates. Below that point the Department would review and approve rates under the normative standards of review, without requiring reductions due to the Plan's surplus levels.

Highmark would utilize statutory financial statements in determining surplus and excess surplus numbers.

The company is responsible for conducting its review and analysis of surplus levels, in the event the operating range exceeds 950% RBC, and providing that analysis in a Surplus Report to its Board of Directors, and then the Insurance Department.

Highmark would submit a Business Plan for distribution of designated surplus only after a determination of non-essential surplus status had been established through the review process undertaken by the company, and a Business Plan approved by Highmark's Board of Directors and the board of any affected subsidiary.

The distribution of any designated surplus should be in a form permitting it to be monitored as needed by the Department.

Appendix I

Highmark's Position Regarding the Notice

Highmark Inc. makes this submission to the Pennsylvania Insurance Department ("Department") in response to Notice 2004-01, published by the Department in the *Pennsylvania Bulletin* on January 17, 2004, 34 Pa. Bull. 458 ("Notice"), as modified by representations of the Department at hearing in *Capital Blue Cross v. Koken*, No. 172 M.D. 2004, in the Commonwealth Court of Pennsylvania and as interpreted by the Opinion and Order of the Honorable Dan Pellegrini in that case.

In that Opinion and Order, the Court concluded that the Notice "fundamentally required two things . . . (1) "*suggested*" maximum RBC and . . . [the] rationale for arriving at that number and (2) a plan to distribute the amounts over and above . . . [the] suggested maximum RBC in the event that . . . [a Blue Plan] . . . in fact has surpluses above its suggested maximum RBC." The Court specifically noted that "testimony at the hearing indicated that the guidelines in the Notice . . . were merely guidelines, and . . . [a Blue Plan] . . . in fact was not precluded from submitting a suggested RBC that fell outside those guidelines . . . or to adopt another methodology in deriving what it believed was to be excess capital." The Department has also noted in correspondence dated April 7, 2004 that the Department is considering clarification of the content of the Notice by including additional statements to the effect that . . . the Blues are not prohibited from positing a different ratio range or standard and offering a rationale in support thereof.

While Highmark does not challenge the broad and exclusive authority of the Department to regulate various operations of insurers, including Highmark and other Blue Plans in Pennsylvania, to the extent the Department seeks to utilize standards, including but not limited to risk-based capital or RBC, for purposes for which the General Assembly has not granted regulatory authority to the Department or to the extent that the Department applies standards, including RBC, for purposes for which the Department has no statutory authority, Highmark preserves and maintains its positions and objections to such actions by the Department.

In this regard, the General Assembly of the Commonwealth of Pennsylvania has defined by statute the regulatory authority of the Department. The General Assembly has vested within the Department broad and exclusive authority to regulate various operations of insurers, including Highmark and other "Blue" Plans in Pennsylvania:

- Both HPCA at 40 Pa. C.S. §§ 6124(a), 6329(a), and the Accident and Health Filing Reform Act, 40 P.S. §§ 3801-3815 ("Reform Act"), provide a comprehensive scheme for the review and approval of various actions by "Blue" plans, including the setting of rates for insurance products.

- The Commissioner is afforded exclusive authority to approve or disapprove rates both before and after they become effective. 40 P.S.

§§ 3803-3808. Moreover, insurers found to be in violation of the Reform Act are subject to statutory penalties. *Id.* § 3813.

- The General Assembly has also conferred upon the Department the exclusive authority to regulate and monitor the financial affairs of nonprofit health plan corporations including the "Blues."

- Every "Blue" plan is required to file with the Department an annual report, "showing its condition at the end of the preceding calendar year. Such statement shall be in such form, and shall contain such matters, as the department shall prescribe." 40 Pa. C.S. § 6125(a); *see id.* § 6331(a) (containing similar language).

- At least once every three years, each plan must submit to an examination by the Department. Moreover, the Department "may, at any time, without making such examination, call on any such corporation for a written report, authenticated by at least two of its principal officers, *concerning the financial affairs and status of the corporation*." *Id.* § 6331(b) (emphasis added); *see id.* § 6125(b) (containing similar language).

- In addition, the investments of "Blue" plans are subject to the regulatory authority of the Department. *Id.* § 6123; *see id.* § 6330 (containing similar language).

- Through Article V of The Insurance Department Act of 1921, P.L. 789, *as amended*, 40 P.S. §§ 221.1-221.63 ("Article V"), the Department also has broad and exclusive statutory authority over insurers, including Highmark, where the financial status of the company may threaten insureds, creditors, and the public in general.

While these various statutes define the broad extent of the Department's regulatory authority over Highmark and other "Blue" Plans, they also define the limitations of that authority. These statutes, in this sense, define the exclusive methods and procedures through which the Department regulates the financial condition of insurers like Highmark. The General Assembly has provided this comprehensive framework for monitoring and regulating, and that framework does not include the Notice or the procedures contained in the Notice as to which this submission is being made.

In this regard, in making this submission, Highmark does not concede the propriety of the "novel procedure," as the Commonwealth Court described the Notice in its March 23, 2004 Opinion and Order. Highmark has commenced an original jurisdiction proceeding in the Pennsylvania Commonwealth Court -- *Highmark Inc. v. Commonwealth of Pa., Ins. Dep't*, 47 M.D. 2004 -- that challenges both procedural and substantive validity of the Notice. Although Highmark does not challenge the Department's authority to regulate Highmark's surplus levels as part of its statutory authority under Pennsylvania's existing insurance laws and the procedures contained in those laws, Highmark maintains that the comprehensive framework established by the General Assembly for monitoring

and regulating Highmark and other Pennsylvania "Blue" Plans does not include the Notice or the procedures the Notice purports to implement. In its Petition for Review to the Commonwealth Court and otherwise, Highmark maintains that the Notice is defective for at least the following reasons:

- The Notice is void because it purports to regulate the surplus of Highmark in a manner not provided for as authorized in the governing statutory schemes enacted by the General Assembly.
- The Notice is void because there is no provision in HPCA, the Reform Act, Article V, Article V-B, or in any other applicable statute, that vests authority within the Department: (1) to establish, by "notice" or otherwise, a surplus "range" using RBC as a measure; (2) to compel "Blue" plans to submit applications for approval of a "maximum RBC ratio" within that range; and (3) to approve or disapprove such an application in the absence of any express authority conferred or standards established by the General Assembly.
- The Notice is void because it amounts to a *de facto* regulation, which the Department failed to promulgate in accordance with Article II of the Commonwealth Documents Law, 45 P.S. §§ 1201-1208, and the Regulatory Review Act, 71 P.S. §§ 745.1-.15.
- The Notice is unfairly and impermissibly discriminatory against "Blue" plans, including Highmark.
- The Notice violates Article V-B by requiring Highmark to submit confidential information for public scrutiny.
- The Notice violates due process rights of Highmark.

Highmark reserves all of its rights, positions and arguments with respect to the procedural and substantive validity of the Notice. Highmark's voluntary submission of information in response to the Notice should not be construed as a waiver by Highmark of any of these positions or as Highmark's abandonment of its original jurisdiction proceeding pending in the Commonwealth Court. In addition, the references to RBC and RBC ranges or levels contained in this submission do not in any way waive Highmark's position with regard to the impropriety and lack of applicability of RBC to regulation of surplus levels.

Highmark Inc. and Subsidiaries

Agreed-Upon Procedures Reports
December 31, 2003

Highmark Inc. and Subsidiaries
Index
December 31, 2003

I. Highmark Inc.

II. Keystone Health Plan West

III. Highmark Life & Casualty Group

IV. United Concordia Companies, Inc.

V. HealthGuard of Lancaster, Inc.

VI. Davis Vision of Michigan, Inc.

VII. Gateway Health Plan, Inc.

VIII. Inter-County

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Philadelphia PA 19103-7042
Telephone (267) 330 3000
Facsimile (267) 330 3300

Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below, which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and the results, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	219,711,010
Less: Unapplied cash		(61,847,527)
Non-admitted receivables		(7,457,002)
Allowance for doubtful accounts		(9,137,607)
Miscellaneous debits / (credits)		(70,610,256)
Accident and health premiums due and unpaid	$	70,658,618

The gross accounts receivable balance represents amounts due to the Corporation as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Corporation for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debits/(credits) includes a credit balance totaling $(69,637,821), which represents amounts billed in advance of the coverage period that are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

The remaining miscellaneous amount relates primarily to ceded premiums payable by the Corporation under a reinsurance agreement to a related party totaling $960,350.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct #	Account Description		Balance
130302	A/R Subscription Fees-TIGAR-Med/Surg	$	83,140,406
130303	A/R Subscription Fees-TIGAR-Dental		841,676
130304	A/R Subscription Fees-TIGAR-Vision		2,970,546
130306	Subscription Income Receivable - Unassigned TIGAR		3,912,537
130308	Non-Syndicate Res for Refund		163,594
130309	A/R Prospective HighBAR		48,564,979
130310	Non-Syndicate Receivable		3,636,490
130316	A/R Direct Pay Subscription Fees		438,672
130317	A/R Prospective Legacy		62,094,156
130324	A/R - BlueCHIP		7,111
130325	A/R - Risk Billed to Groups		130,382
130328	A/R CHIP Adult Basic Participants		368,170
130391	A/R Freedom Blue PPO		(63,875)
130416	A/R CMS		94,661
132002	Plan 865 Par A/R - HMARK as CNTL		71
132007	Plan 865 Par A/R - ext CNTL Plan		13,575
132010	NASCO Control Plan Receivable		46,142
132016	A/R CFA Host BlueCard NPOS		12,566,103
132017	A/R CFA Host BlueCard POS		390,421
132018	A/R CFA Host Custom		109,252
230012	Syndicate Applied Advances		73,907
230021	Cntl Plan Rec Equal		212,034
		$	219,711,010

General ledger accounts 130302, 130303, 130304, 130308 and 130310 included both risk and non-risk activity. The Company reclassified the non-risk activity in these accounts to line 14 in the Annual Statement. The above amounts include only the risk activity in each account based on calculations performed by the Corporation. The detailed aging reports contain both risk and non-risk receivables. As such, the reclassifications will represent reconciling items between the general ledger and the detail. We have agreed the reclassifications by the Corporation to supporting schedules, noting no exceptions.

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging reports, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	General Ledger Balance	Aging Balance	Difference
130302	A/R Subscription Fees-TIGAR-Med/Surg	$ 83,140,406		
130303	A/R Subscription Fees-TIGAR-Dental	841,676		
130304	A/R Subscription Fees-TIGAR-Vision	2,970,546		
		86,952,628	98,003,023	(11,050,395)
130306	Subscription Income Receivable - Unassigned TIGAR	3,912,537	3,854,587	57,950
130308	Non-Syndicate Reserve for Refund	163,594	N/A	N/A
130309	A/R Prospective HighBAR	48,564,979	48,549,116	15,863
130310	Non-Syndicate Receivable	3,636,490	4,507,310	(870,820)
130316	A/R Direct Pay Subscription Fees	438,672	673,832	(235,160)
130317	A/R Prospective Legacy	62,094,156	61,208,459	885,697
130324	A/R - BlueCHIP	7,111	7,111	-
130325	A/R - Risk Billed to Groups	130,382	130,382	-
130328	A/R CHIP Adult Basic Participants	368,170	588,846	(220,676)
130391	A/R Freedom Blue PPO	(63,875)	(63,698)	(177)
130416	A/R CMS	94,661	45,909	48,752
132002	Plan 865 Par A/R - Highmark as Control	71	84,202	(84,131)
132007	Plan 865 Par A/R - External Control Plan	13,575	13,575	-
132010	NASCO Control Plan Receivable	46,142	46,142	-
132016	A/R CFA Host BlueCard NPOS	12,566,103	12,566,103	-
132017	A/R CFA Host BlueCard POS	390,421	390,421	-
132018	A/R CFA Host Custom	109,252	109,252	-
230012	Syndicate Applied Advances	73,907	73,907	-
230021	Control Plan Receivable - Equalization	212,034	212,034	-
		$ 219,711,010	$ 231,000,513	

Account 130308 is not supported by an aging. The Corporation has provided a reconciliation of the general ledger balance to the supporting detail which is discussed in step 5 below.

Results: Aging reports were obtained for accounts 130302, 130303, 130304, 130306, 130309, 130310, 130316, 130317, 130324, 130325, 130328, 130391, 130416, 132002, 132007, 132010, 132016, 132017, 132018, 230012 and 230021. We compared the account balance, per the general ledger, to the aging report(s), noting the following exceptions:

Accounts 130302, 130303 and 130304
The Corporation provided a reconciliation between the general ledger balance and the aging report, which included reconciling items totaling $11,050,395. The Corporation explained that the two reconciling items related to the following: 1) $(12,275,521) related to non-risk accounts receivable included in the aging report that were reclassified to line 14 in the Annual Statement; 2) $1,000,000 related to a manual entry recorded to estimate accounts receivable in November and December 2003 for certain groups due to a billing system issue. The Corporation provided an analysis to support this estimate. The remaining reconciling item of $225,126 is less than $500,000.

Account 130306
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130309
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130310
The Corporation provided a reconciliation between the general ledger balance and the aging report, which included a reconciling item of $870,820. The Corporation provided support for the reconciling item, which represents non-risk accounts receivable included in the aging report that were reclassified to line 14 in the Annual Statement.

Account 130316
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130317
The Corporation provided a reconciliation between the general ledger balance and the aging report, which included reconciling items totaling $885,697. The Corporation provided support for a reconciling item totaling $1,176,212, which represents manual adjustments related to the difference between amounts paid and billed (called over/short) on the Legacy Membership System. The remaining reconciling item of $(290,515) is less than $500,000.

Account 130328
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130391
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130416
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000. However, the Corporation provided support for the difference of $48,752, which represents an estimated receivable for retrospective adjustments due from the Centers for Medicare & Medicaid Services (CMS) for which an aging was not available (see step 5 for procedures performed related to this amount).

Account 132002
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

		Aging Category					
Acct. #	Account Description	Open Future	0-30	31-60	61-90	90+	Total
	TIGAR - Group	40,061,825	34,519,424	18,108,641	2,285,057	3,028,076	98,003,023
130306	TIGAR - Individual	2,544,479	432,056	187,082	97,220	593,750	3,854,587
130309	HighBAR	17,965,890	20,226,893	4,352,580	1,764,749	4,239,004	48,549,116
130310	Non-Syndicate	-	144,238	-	3,461,137	901,935	4,507,310
130316	Legacy - Individual	-	651,948	21,884	-	-	673,832
130317	Legacy - Group	-	46,471,268	8,541,275	4,593,546	1,602,370	61,208,459
130324	BlueCHIP	3,670	3,441	-	-	-	7,111
130325	A/R Risk Billed to Groups	-	120,514	(17,034)	27,621	(719)	130,382
130328	CHIP / Adult Basic	562,647	15,108	2,742	2,399	5,950	588,846
130391	Freedom Blue	(143,345)	78,009	1,098	270	270	(63,698)
130416	A/R CMS	-	5,200	-	-	40,709	45,909
132002	Plan 865 - Highmark Control	-	84,202	-	-	-	84,202
132007	Plan 865 - External Control	-	9,027	1,043	3,052	453	13,575
132010	NASCO Control Plan	-	1,287	170	-	44,685	46,142
132016	A/R CFA Host BlueCard NPOS	-	12,549,524	(256)	(4,558)	21,393	12,566,103
132017	A/R CFA Host BlueCard POS	-	390,331	-	-	90	390,421
132018	A/R CFA Host Custom	-	109,252	-	-	-	109,252
230012	Syndicate Applied Advances	-	4,284	608	243	68,772	73,907
230021	Control Plan	-	163,748	-	3,773	44,513	212,034
	Total	60,995,166	115,979,754	31,199,833	12,234,509	10,591,251	231,000,513

The TIGAR - Group aging report includes accounts 130302, 130303 and 130304 and non-risk accounts receivable balances totaling $12,275,521 that have been reclassified from the accident and health premiums due and unpaid line to line 14, amounts receivable relating to uninsured plans in the Annual Statement. The Corporation provided support for the non-risk reclassification. No exceptions were noted.

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Corporation. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Corporation as to why the accounts receivable balance is not supported by an aging report.

Results:

Account 130308
The Corporation provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

The Corporation explained that this account represents estimated receivables under retrospectively rated contracts based on the loss experience to date under the contracts. The Corporation has explained there is no aging due to the fact that the account balance is an estimate and amounts are not due until the contract year is settled.

Account 130416
The Corporation explained that a portion of the balance in account 130416 totaling $48,752 is not supported by a detailed aging report. The Corporation provided a reconciliation between the general ledger balance and the detailed schedule supporting the portion not supported by an aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

The Corporation explained that this amount represents an estimated receivable due from CMS for retroactive adjustments. As the estimate relates to retroactive adjustments, no aging is available.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: The Corporation provided a detailed listing of credit balances included in each gross accounts receivable balance. The total credit balances, per the detail listing, related to each gross accounts receivable balance are shown below.

Acct. #	Account Description	Balance	Credit Balances
130302	A/R Subscription Fees-TIGAR-Med/Surg	$ 83,140,406	
130303	A/R Subscription Fees-TIGAR-Dental	841,676	
130304	A/R Subscription Fees-TIGAR-Vision	2,970,546	
		$ 86,952,628	$ (82,819)
130306	Subscription Income Receivable - Unassigned TIGAR	3,912,537	(25,046)
130308	Non-Syndicate Res for Refund	163,594	-
130309	A/R Prospective HighBAR	48,564,979	(2,463,310)
130310	Non-Syndicate Receivable	3,636,490	(169)
130316	A/R Direct Pay Subscription Fees	438,672	-
130317	A/R Prospective Legacy	62,094,156	-
130324	A/R - BlueCHIP	7,111	-
130325	A/R - Risk Billed to Groups	130,382	(272,376)
130328	A/R CHIP Adult Basic Participants	368,170	(220,677)
130391	A/R Freedom Blue PPO	(63,875)	(143,345)
130416	A/R CMS	94,661	-
132002	Plan 865 Par A/R - HMARK as CNTL	71	(990)
132007	Plan 865 Par A/R - ext CNTL Plan	13,575	-
132010	NASCO Control Plan Receivable	46,142	-
132016	A/R CFA Host BlueCard NPOS	12,566,103	(15,000)
132017	A/R CFA Host BlueCard POS	390,421	-
132018	A/R CFA Host Custom	109,252	-
230012	Syndicate Applied Advances	73,907	-
230021	Cntl Plan Rec Equal	212,034	(2,238)
		$ 219,711,010	$ (3,225,970)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Account Description	Balance
130001	Cash-In-Transit - Harrisburg	$ 170,717
130002	Cash-In-Transit - Philadelphia	(930,074)
130003	Cash-In-Transit - Wilkes-Barre	1,658,230
130004	Direct Billed Cash	(22,045,385)
130312	Unappl BC Syndicate Cash	(255,594)
130393	Unapplied Cash Freedom Blue	(42,331)
130704	Direct Pay Unapplied Cash	(499,117)
130705	Unapplied Cash - Adult Basic	(53,561)
130708	Unapplied Cash Non-Synd	(5,692,768)
130712	Unapplied Cash - HighBAR	(6,108,201)
230102	NCRP Cash Unapplied	(28,049,443)
		$ (61,847,527)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Account Description	Balance	Unapplied Cash	
130302	A/R Subscription Fees-TIGAR-Med/Surg	$ 83,140,406		
130303	A/R Subscription Fees-TIGAR-Dental	841,676		
130304	A/R Subscription Fees-TIGAR-Vision	2,970,546		
		$ 86,952,628	$ (21,402,106)	(a)
130306	Subscription Income Receivable - Unassigned TIGAR	3,912,537	-	
130308	Non-Syndicate Res for Refund	163,594	-	
130309	A/R Prospective HighBAR	48,564,979	(6,108,201)	
130310	Non-Syndicate Receivable	3,636,490	-	
130316	A/R Direct Pay Subscription Fees	438,672	(499,117)	
130317	A/R Prospective Legacy	62,094,156	(33,742,211)	(b)
130324	A/R - BlueCHIP	7,111	-	
130325	A/R - Risk Billed to Groups	130,382	-	
130328	A/R CHIP Adult Basic Participants	368,170	(53,561)	
130391	A/R Freedom Blue PPO	(63,875)	(42,331)	
130416	A/R CMS	94,661	-	
132002	Plan 865 Par A/R - HMARK as CNTL	71	-	
132007	Plan 865 Par A/R - ext CNTL Plan	13,575	-	
132010	NASCO Control Plan Receivable	46,142	-	
132016	A/R CFA Host BlueCard NPOS	12,566,103	-	
132017	A/R CFA Host BlueCard POS	390,421	-	
132018	A/R CFA Host Custom	109,252	-	
230012	Syndicate Applied Advances	73,907	-	
230021	Cntl Plan Rec Equal	212,034	-	
		$ 219,711,010	$ (61,847,527)	

(a) Consists of accounts 130001-130004, 130312

(b) Consists of accounts 130708 and 230102.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	Balance	Balance per Detailed Support	Difference
130001	Cash-In-Transit - Harrisburg	$ 170,717	$ 187,006	(16,289)
130002	Cash-In-Transit - Philadelphia	(930,074)	(984,391)	54,317
130003	Cash-In-Transit - Wilkes-Barre	1,658,230	1,776,489	(118,259)
130004	Direct Billed Cash	(22,045,385)	(22,045,385)	-
130312	Unappl BC Syndicate Cash	(255,594)	(383,890)	128,296
130393	Unapplied Cash Freedom Blue	(42,331)	(42,741)	410
130704	Direct Pay Unapplied Cash	(499,117)	(499,117)	-
130705	Unapplied Cash - Adult Basic	(53,561)	(53,561)	-
130708	Unapplied Cash Non-Synd	(5,692,768)	(5,732,205)	39,437
130712	Unapplied Cash - HighBAR	(6,108,201)	(6,103,830)	(4,371)
230102	NCRP Cash Unapplied	(28,049,443)	(28,069,456)	20,013
		$ (61,847,527)	$ (61,951,081)	

Results:

Account 130001
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130002
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130003
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

The Corporation explained that the above three accounts (130001,130002 and 130003) include both risk and non-risk business. As a result, the Corporation reclassified $122,922 of non-risk business to line 14 of the Annual Statement. We obtained supporting schedules from the Corporation supporting the reclassification.

Account 130312
The Corporation provided a reconciliation between the general ledger balance and the aging report, which included a reconciling item of $128,296. The Corporation provided support for the reconciling item, which represents non-risk unapplied cash that was reclassified to line 14 in the Annual Statement.

Account 130393
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130708
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130712
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 230102
The Corporation provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

> ***Results:*** The Corporation provided a detailed listing of debit balances included in each unapplied cash account. The total debit balances, per the detailed listing, related to each unapplied cash account are shown below.

Acct. #	Account Description	Balance	Debit Balances
130001	Cash-In-Transit - Harrisburg	$ 170,717	$ 187,006
130002	Cash-In-Transit - Philadelphia	(930,074)	3,241,320
130003	Cash-In-Transit - Wilkes-Barre	1,658,230	1,658,230
130004	Direct Billed Cash	(22,045,385)	-
130312	Unappl BC Syndicate Cash	(255,594)	146,010
130393	Unapplied Cash Freedom Blue	(42,331)	410
130704	Direct Pay Unapplied Cash	(499,117)	-
130705	Unapplied Cash - Adult Basic	(53,561)	-
130708	Unapplied Cash Non-Synd	(5,692,768)	-
130712	Unapplied Cash - HighBAR	(6,108,201)	-
230102	NCRP Cash Unapplied	(28,049,443)	-
		$ (61,847,527)	$ 5,232,976

The Corporation explained that the balance in the Cash-In-Transit accounts (130001-130003) represents amounts due from (to) the Blue Cross plans (agent plans) with which Highmark does business. Balances can be in a receivable or payable position based on amounts received from the agent plans each month. On a monthly basis, the agent plans send Highmark an advance payment for amounts actually collected from customers. This amount is adjusted each month based on detail supplied by the agent plan, which can result in a receivable or payable position.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above. In addition, identify any customer accounts receivable balances less than 90 days old that have been non-admitted as a result of the customer having an outstanding balance over 90 days old that is not considered to be di minimis.

	TIGAR Group	TIGAR Individual	HighBAR	Non-Syndicate	CHIP / Adult Basic	CMS
Over 90 day balance per aging report	$ 3,028,076	$ 593,750	$ 4,239,004	$ 901,935	$ 5,950	$ 40,709
Non-admitted receivable balance per Annual Statement	(3,961,489)	-	(2,585,513)	(726,738)	(5,950)	-
Non-admitted balance (over)/under 90+ day balance	(933,413)	593,750	1,653,491	175,197	-	40,709
Bad debt reserve	(2,001,000)	-	(2,470,000)	-	-	-
Non-admitted/bad debt reserve (over)/under 90+ day balance	(2,934,413)	593,750	(816,509)	175,197	-	40,709
Receivables less than 90 days old requiring non-admission	3,300,931	-	3,864,884	-	-	-
Deficiency/(excess)	$ 366,518	$ 593,750	$ 3,048,375	$ 175,197	$ -	$ 40,709

	Freedom Blue	Legacy	National	Host CFA	Total
Over 90 day balance per aging report	$ 270	$ 1,602,370	$ 157,704	$ 21,483	$ 10,591,251
Non-admitted receivable balance per Annual Statement	-	-	(158,423)	(18,889)	(7,457,002)
Non-admitted balance (over)/under 90+ day balance	270	1,602,370	(719)	2,594	3,134,249
Bad debt reserve	-	(3,351,124)	(1,315,483)	-	(9,137,607)
Non-admitted/bad debt reserve (over)/under 90+ day balance	270	(1,748,754)	(1,316,202)	2,594	(6,003,358)
Receivables less than 90 days old requiring non-admission	-	-	-	-	7,165,815
Deficiency/(excess)	$ 270	$ (1,748,754)	$ (1,316,202)	$ 2,594	$ 1,162,457

The National column includes accounts 130325, 132002, 132007, 132010, 230012 and 230021.

The Host CFA column includes accounts 132016-132018.

Results: The Corporation explained that its process for recording non-admitted receivables is to evaluate the receivable and determine the amount that should be non-admitted in accordance with SSAP 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and* Brokers, which includes accounts receivable balances over 90 days old as well as those accounts receivable balances less than 90 days old for which there is a related customer balance greater than 90 days old. The Corporation then compares the amount that should be non-admitted to the bad debt reserve that has been established and records a non-admitted asset for the incremental difference. As a result of the Corporation's methodology for assessing non-admitted receivables, the non-admitted receivable balance included in the Corporation's Annual Statement represents the sum of the over 90 day accounts receivable balance PLUS accounts receivable balances less than 90 days old that have been non-admitted as noted above LESS the reversal of any bad debt reserve recorded against the gross accounts receivable balance in column 1. As a result of the Corporation's methodology for recording its net admitted accounts receivable balances, we noted the following:

TIGAR - Group
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $366,518. The Corporation explained that the deficiency represents 1) an amount totaling $269,916 related to non-risk business that is included in the over 90 day balance per the aging report and was reclassified and non-admitted in line 14 of the Annual Statement for which the Corporation provided support and no exceptions were noted; and 2) an unreconciled variance of $96,602.

TIGAR – Individual
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $593,570. The Corporation explained that the over 90 day balance was admitted because the aging report was not available prior to the Annual Statement due date.

A/R Prospective HighBAR
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $3,048,375. The Corporation explained that it evaluates non-admitted accounts receivable in total and not at an individual process level. Based on this, the Corporation determined that there was sufficient bad debt reserve related to the aggregate gross accounts receivable balance to offset this deficiency.

Non-Syndicate Receivable
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $175,197. The Corporation explained that the deficiency represents 1) an amount totaling $174,028 related to non-risk business that is included in the over 90 day balance per the aging report and was reclassified and non-admitted in line 14 of the Annual Statement for which the Corporation provided support and no exceptions were noted; and 2) an unreconciled variance of $1,169.

CMS
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $40,709. The Corporation explained that it admitted the entire amount over 90 days old as the amount relates to a receivable from CMS, which can be admitted in accordance with statutory accounting principles.

Freedom Blue
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $270. The Corporation explained that this was an immaterial difference.

A/R Prospective Legacy
The Corporation provided a summary of the non-admitted accounts receivable, which included an amount in excess of the non-admitted receivable of $1,748,754. The Corporation explained that it evaluates non-admitted accounts receivable in total and not at an individual process level. Based on this, the Corporation determined that the bad debt reserve was needed to offset deficiencies in other accounts receivable processes.

National
The Corporation provided a summary of the non-admitted accounts receivable, which included an amount in excess of the non-admitted receivable of $1,316,202. The Corporation explained that it evaluates non-admitted accounts receivable in total and not at an individual process level. Based on this, the Corporation determined that the bad debt reserve was needed to offset deficiencies in other accounts receivable processes.

Host CFA
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $2,594. The Corporation explained that this was an immaterial difference.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances (or 100% of the population if less than 20) from the aging detail for accounts 130302, 130303, 130304, 130306, 130309, 130310, 130324, 130328, 130391, 132002, 132007, 132010, 132016, 132017, 132018, 230012 and 230021 and performed the above procedures without exception. See Attachment A for a summary of the sample.

The Corporation explained that accounts 130302, 130303 and 130304 are included in the same accounts receivable/billing system (TIGAR). The detailed aging report obtained from the Corporation includes all three accounts on a combined basis. The Corporation splits out the accounts on the general ledger by type of business (i.e. med/surg., dental, vision) to better track the business. As there is one listing from one system, we have selected one sample of 20 which covers all three accounts.

The Corporation explained that accounts 132016, 132017 and 132018 are included in the same accounts receivable/billing system. The detailed aging report obtained from the Corporation includes all three accounts on a combined basis. The Corporation splits out the accounts on the general ledger by type of product to better track the business. As there is one listing from one system, we have selected one sample of 20 which covers all three accounts.

The Corporation explained that accounts 130316 and 130317, A/R Prospective Legacy Individual and Group, are supported by aging reports. However, the accounts receivable balances included in these accounts are estimated and not supported by individual invoices. The Corporation utilizes the aging reports to record the accounts receivable amounts to the general ledger and to assess the collectibility of the balances, including the establishment of non-admitted receivable balances. Due to the nature of the accounts and the absence of an invoice, the aging buckets were not tested for these accounts.

The Corporation explained that account 130325 is supported by an aging report. However, the accounts receivable balance included in this account is an estimate of billings performed by agent plans on behalf of the Corporation and not supported by individual invoices. The Corporation utilizes the aging report to record the accounts receivable amount to the general ledger and to assess the collectibility of the balance, including the establishment of non-admitted receivable balances. Due to the nature of the account and the absence of an invoice, the aging buckets were not tested for this account.

The Corporation explained that a portion of account 130416 is supported by an aging report. However, the accounts receivable balance included in this account is not supported by individual invoices as the account represents estimated amounts due the Corporation for retroactive adjustments for CMS. The Corporation utilizes the aging report to record the accounts receivable amount to the general ledger and to assess the collectibility of the balance. Due to the nature of the account and the absence of an invoice, the aging buckets were not tested for this account.

13. Obtain a summary of bad debt reserves related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: The Corporation explained that it has recorded a bad debt reserve for accounts receivable balances in excess of the over 90 day receivable balance related to account 130317, Legacy Group business, totaling $1,748,754 and accounts 130325, 132002, 132007, 132010, 230012 and 230021, National business, totaling $1,316,202. See step 11 above. The Corporation explained that it evaluates non-admitted accounts receivable in total and not at an individual process level. To the extent that there is excess reserve recorded for certain processes, the Corporation applies this excess against processes that are in a deficiency position.

14. For those accounts receivable balances supported by a detailed aging report and to which the Corporation applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results:

The Corporation explained that it evaluates non-admitted accounts receivable in total and not at an individual process level. To the extent that there is excess reserve recorded for certain processes, the Corporation applies this excess against processes that are in a deficiency.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: The Corporation explained that accounts 130308 and 130416, which are not supported by a detailed aging report, do not have any related bad debt reserve recorded by the Corporation.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description		Balance
220002	Unearned Revenue-Other	$	(1,250,433)
221001	Unearned Subscription Revenue - Legacy		(37,547,624)
221002	Unearned Subscription Revenue-TIGAR-Med/Surg		(12,145,008)
221003	Unearned Subscription Revenue-TIGAR-Dental		(18,597)
221004	Unearned Subscription Revenue-TIGAR-Vision		(1,398,381)
221006	Unearned Income-Unassigned TIGAR		(13,840,207)
221008	Unearned Revenue P-W West		(1,618,655)
221012	Unearned Revenue CMS		(459,625)
221018	Ceded Unearned Subscription Revenue & Other Liabilities		1,439,715
221021	Ceded Unearned-LTC		424,564
221022	Unearned Subscription Revenue-HighBAR		(20,136,571)
221091	Unearned Revenue Freedom Blue		(517,280)
221101	Unapplied Cash-Med/Surg		(17,020,666)
221102	Unapplied Cash-Dental		(1,347,654)
221103	Unapplied Cash-Vision		(393,058)
221106	Unapplied Direct Billed Cash		(1,783,848)
		$	(107,613,328)

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	General Ledger Balance	Balance per Detailed Support	Difference
220002	Unearned Revenue-Other	$ (1,250,433)	$ (1,250,433)	-
221001	Unearned Subscription Revenue - Legacy	(37,547,624)	(39,737,132)	2,189,508
221002	Unearned Subscription Revenue-TIGAR-Med/Surg	(12,145,008)		
221003	Unearned Subscription Revenue-TIGAR-Dental	(18,597)		
221004	Unearned Subscription Revenue-TIGAR-Vision	(1,398,381)		
		(13,561,986)	(13,453,276)	(108,710)
221006	Unearned Income-Unassigned TIGAR	(13,840,207)	(13,854,035)	13,828
221008	Unearned Revenue P-W West	(1,618,655)	(1,618,655)	-
221012	Unearned Revenue CMS	(459,625)	(459,832)	207
221018	Ceded Unearned Subscription Revenue & Other Liabilities	1,439,715	1,439,715	-
221021	Ceded Unearned-LTC	424,564	424,564	-
221022	Unearned Subscription Revenue-HighBAR	(20,136,571)	(20,136,571)	-
221091	Unearned Revenue Freedom Blue	(517,280)	(518,049)	769
221101	Unapplied Cash-Med/Surg	(17,020,666)		
221102	Unapplied Cash-Dental	(1,347,654)		
221103	Unapplied Cash-Vision	(393,058)		
		(18,761,378)	(18,752,349)	(9,029)
221106	Unapplied Direct Billed Cash	(1,783,848)	(1,056,480)	(727,368)
		$ (107,613,328)	$ (108,972,533)	

Results:

Account 221001
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule, which included a reconciling item of $2,189,508 for which support was unable to be provided by management. The Corporation explained that this variance was the result of a difference in an estimate calculated by management compared to actual results for a change in an internal process.

Accounts 221002, 221003 and 221004
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 221006
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 221012
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 221091
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

Accounts 221101, 221102, 221103
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 221106
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule, which included a reconciling item of $727,368. The Corporation explained that this variance was primarily due to a $570,714 manual adjustment recorded by the Corporation related to direct billed, direct pay business in the Mid-Atlantic region that was not included in the detail. The Corporation provided support for this adjustment and no exceptions were noted. This business is booked manually by the Corporation each month due to system limitations. The remaining reconciling item of $156,654 is less than $500,000.

3. Obtain a listing of accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Account Description	Accounts Receivable Balance	Premiums Received In Advance	
130302	A/R Subscription Fees-TIGAR-Med/Surg	$ 83,140,406		
130303	A/R Subscription Fees-TIGAR-Dental	841,676		
130304	A/R Subscription Fees-TIGAR-Vision	2,970,546		
		$ 86,952,628	$ (35,357,645)	(a)
130306	Subscription Income Receivable - Unassigned TIGAR	3,912,537	(13,840,207)	
130308	Non-Syndicate Res for Refund	163,594	-	
130309	A/R Prospective HighBAR	48,564,979	(20,136,571)	
130310	Non-Syndicate Receivable	3,636,490	-	
130316	A/R Direct Pay Subscription Fees	438,672	-	
130317	A/R Prospective Legacy	62,094,156	(37,547,624)	
130324	A/R - BlueCHIP	7,111	-	
130325	A/R - Risk Billed to Groups	130,382	-	
130328	A/R CHIP Adult Basic Participants	368,170	-	
130391	A/R Freedom Blue PPO	(63,875)	(517,280)	
130416	A/R CMS	94,661	(459,625)	
132002	Plan 865 Par A/R - HMARK as CNTL	71	-	
132007	Plan 865 Par A/R - ext CNTL Plan	13,575	-	
132010	NASCO Control Plan Receivable	46,142	-	
132016	A/R CFA Host BlueCard NPOS	12,566,103	-	
132017	A/R CFA Host BlueCard POS	390,421	-	
132018	A/R CFA Host Custom	109,252	-	
230012	Syndicate Applied Advances	73,907	-	
230021	Cntl Plan Rec Equal	212,034	-	
		$ 219,711,010	$ (107,858,952)	

(a) Consists of accounts 220002, 221002-221004, 221101-221103, 221106 as well as reclass adjustment to reduce balance in account 221002 for unearned revenue billed in December for January.

The Corporation explained that accounts 221008, 221018 and 221021 are not included in the above table as there is no corresponding accounts receivable balance. The Corporation provided explanations for the accounts as follows:

Account 221008 represents premium received in advance for a customer group that is accounted for separately by the Corporation. Accounts receivable related to this group are located in line 21 in the Annual Statement.

Account 221018 represents a reinsurance recoverable amount related to a reinsurance agreement the Corporation has with a related party. There are no accounts receivable balances included in the accident and health premiums due and unpaid line related to this account.

Account 221021 represents a reinsurance recoverable amount related to a reinsurance agreement the Corporation has with a third party. There are no accounts receivable balances included in the accident and health premiums due and unpaid line related to this account.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Account Description	Balance	Debit Balances
220002	Unearned Revenue-Other	$ (1,250,433)	$ -
221001	Unearned Subscription Revenue - Legacy	(37,547,624)	-
221002	Unearned Subscription Revenue-TIGAR-Med/Surg	(12,145,008)	-
221003	Unearned Subscription Revenue-TIGAR-Dental	(18,597)	-
221004	Unearned Subscription Revenue-TIGAR-Vision	(1,398,381)	-
221006	Unearned Income-Unassigned TIGAR	(13,840,207)	-
221008	Unearned Revenue P-W West	(1,618,655)	-
221012	Unearned Revenue CMS	(459,625)	-
221018	Ceded Unearned Subscription Revenue & Oth Liabilities	1,439,715	1,439,715
221021	Ceded Unearned-LTC	424,564	424,564
221022	Unearned Subscription Revenue-HighBAR	(20,136,571)	-
221091	Unearned Revenue Freedom Blue	(517,280)	-
221101	Unapplied Cash-Med/Surg	(17,020,666)	47,932
221102	Unapplied Cash-Dental	(1,347,654)	-
221103	Unapplied Cash-Vision	(393,058)	-
221106	Unapplied Direct Billed Cash	(1,783,848)	-
		$ (107,613,328)	$ 1,912,211

The balances in accounts 221018 and 221021 represent reinsurance recoverables under two separate reinsurance arranagements in which the Corporation has ceded business related to dental and long-term care insurance business. The Corporation provided supporting schedules for both accounts. We agreed the general ledger balances to the supporting schedules noting no exceptions.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from accounts 221001, 221002, 221003, 221004, 221006, 221008, 221012, 221022, 221091, 221101, 221102, 221103 and 221106 and performed the above procedures without exception. See Attachment B for a summary of the sample.

A detailed listing for account 220002 was unable to be provided by the Corporation. Balances for this account are based on information received from the Corporation's agent plans.

Accounts 221002, 221003 and 221004 as well as accounts 221101, 221102 and 221103 are accounted for by the same accounts receivable/billing system (TIGAR). The detailed listings of premiums received in advance were combined into one listing for accounts 221002, 221003 and 221004 as well as 221101, 221102 and 221103. The Corporation splits out the accounts on the general ledger by type of business (i.e. med/surg., dental, vision) to better track the business. As there is one listing from one system, we have selected one sample of 20 from each set of three accounts.

Accounts 221101, 221102, 221103 and 221106 include cash received prior to December 31, 2003 for billings before December 31, 2003. We have tested a sample of supporting cash remittances for these accounts.

Accounts 221018 and 221021 represent reinsurance recoverable amounts due to the Corporation. As a result, detailed listings of premiums received in advance were not applicable to these two accounts.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in Corporation's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in Corporation's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description	Balance
221005	FEP Unearned Premium Reserve	$ (69,992,265)
231001	Reserve for Refund	(7,183,152)
231002	Retrospective Credit Reserve for Refund	(4,232,671)
231008	Deferred Credit P-W Westinghouse Retain	(764,228)
231015	Amounts Held for Others	(2,497,397)
231017	CBC RSF Disposition	(315,628)
231018	Central Region Rate Stabilization Fund	(9,148,344)
231019	Western Region Rate Stabilization Fund	(4,094,000)
231050	Premium Deficiency	(28,000,000)
		$ (126,227,685)

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	General Ledger Balance	Balance per Detailed Support	Difference
221005	FEP Unearned Premium Reserve	$ (69,992,265)	$ (69,992,265.00)	-
231001	Reserve for Refund	(7,183,152)		
231002	Retrospective Credit Reserve for Refund	(4,232,671)		
		(11,415,823)	(11,582,182)	166,359
231008	Deferred Credit P-W Westinghouse Retain	(764,228)	(764,228)	-
231015	Amounts Held for Others	(2,497,397)	(2,497,397)	-
231017	CBC RSF Disposition	(315,628)	(315,628)	-
231018	Central Region Rate Stabilization Fund	(9,148,344)	(9,148,344)	-
231019	Western Region Rate Stabilization Fund	(4,094,000)	(4,094,000)	-
231050	Premium Deficiency	(28,000,000)	(28,000,000)	-
		$ (126,227,685)	$ (126,394,044)	

Results:

Accounts 231001 and 231002
The Corporation provided a reconciliation between the general ledger balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Accounts 130302, 130303, 130304

	Invoice #	Invoice Amount	Invoice Date
1	011877546	169,810.10	11/30/2003
2	011733018	169,918.44	7/31/2003
3	011738423	170,175.84	8/31/2003
4	011776564	171,777.96	9/30/2003
5	011982532	197,949.08	12/31/2003
6	011984421	205,732.40	12/31/2003
7	011929243	242,464.74	12/31/2003
8	011934127	283,127.33	12/31/2003
9	011931450	518,569.20	12/31/2003
10	011879821	529,880.49	11/30/2003
11	011934156	573,453.59	12/31/2003
12	011934064	659,990.88	11/30/2003
13	011982659	674,574.92	12/31/2003
14	011984421	879,061.30	12/31/2003
15	011984421	1,387,652.92	12/31/2003
16	011984421	1,591,754.71	12/31/2003
17	011934064	2,797,312.44	11/30/2003
18	011982659	2,809,589.32	12/31/2003
19	011982659	8,590,526.99	12/31/2003
20	011934064	8,711,143.46	11/30/2003

Account 130306

	Invoice Number	Invoice Amount
1	1085187	349.38
2	1373169	173.55
3	1382680	349.38
4	1656106	1,088.32
5	1839119	1,276.04
6	2037177	448.44
7	2127306	583.16
8	2226614	367.32
9	2238926	236.30
10	2349084	367.32
11	2382937	162.91
12	2387147	1,914.06
13	2616379	289.47
14	2618467	1,065.06
15	2620550	209.98
16	2747985	567.42
17	2753131	567.42
18	2758926	567.42
19	2762725	367.32
20	2769673	360.09

Account 130309

	Invoice #	Invoice Amount	Invoice Date
1	031217000796	105,230.59	1/2/2004
2	031112000019	14,700.20	11/20/2003
3	031205005683	19,277.94	12/22/2003
4	031217000599	771,341.28	1/2/2004
5	031121000099	46,213.18	12/1/2003
6	031105002941	50,874.49	11/20/2003
7	031202000065	76,774.37	12/12/2003
8	031125000211	84,892.48	12/10/2003
9	031205009841	102,839.23	12/22/2003
10	031205007404	161,799.20	12/22/2003
11	031028000075	56,060.97	11/7/2003
12	031217000925	53,759.78	1/2/2004
13	031223000065	105,556.40	1/1/2004
14	031219000038	189,719.23	12/27/2003
15	031017000728	36,031.75	11/3/2003
16	031007000035	26,948.79	9/22/2003
17	031114000757	30,998.47	12/1/2003
18	031205010110	25,903.30	12/22/2003
19	031205008304	22,764.42	12/22/2003
20	031205011701	4,166.55	12/22/2003

Account 130310

	Account Number	Amount
1	2874	2,678,317.78
2	3863	31,038.87
3	2547	6,274.84
4	4829	22,137.19
5	7820	16,042.75
6	1297	14,867.84
7	2944	9,729.54
8	9832	59,215.49
9	10411	2,259.87
10	1516	115,520.40
11	39881	5,125.81
12	1997	617,461.30
13	5468	42,280.96
14	205	62,906.05
15	8018	50,063.62
17	205	24,089.53
18	35898	16,024.08
19	3981	98,924.81
20	3981	72,148.01

Account 130324

	Date	Amount
1	Nov-03	3,440.45
2	Dec-03	3,670.19

Note: All amounts included in account were selected for testing.

Account 130328

	Invoice #	Amount	Invoice Date
1	9000001300401	70.00	11/20/2003
2	9000001170311	70.00	9/20/2003
3	9000000330403	60.00	1/20/2004
4	9000005080310	60.00	9/2/2003
5	9000014500401	60.00	11/20/2003
6	9000047900311	30.00	9/20/2003
7	9000038000401	60.00	12/15/2003
8	A	60.00	12/22/2003
9	9000046230401	70.00	11/20/2003
10	9000056060400	60.00	10/20/2003
11	9000004150401	60.00	11/20/2003
12	9000014890401	70.00	12/20/2003
13	0000867600402	222.26	12/20/2003
14	0000795200402	222.26	12/20/2003
15	A	222.26	11/26/2003
16	0000565510402	30.00	12/20/2003
17	0000266020402	30.00	12/20/2003
18	0000172810311	30.00	9/20/2003
19	0000819670402	222.26	12/20/2003
20	0000725180402	222.26	12/20/2003

No invoice was available for these selections. The Corporation explained that both selections became enrolled in the AdultBasic program after the Corporation had sent out its invoices.

Account 130391

	Invoice #	Aging Bucket	Amount	Invoice Date
1	6000007840401	0-30	468.00	12/15/2003
2	6000008650401	0-30	603.00	12/15/2003
3	6000008680401	0-30	603.00	12/15/2003
4	6000004120401	0-30	156.00	12/15/2003
5	6000008960401	0-30	156.00	12/15/2003
6	6000004970401	0-30	156.00	12/15/2003
7	6000000860401	0-30	156.00	12/15/2003
8	6000005200401	0-30	468.00	12/15/2003
9	6000010180401	0-30	312.00	12/15/2003
10	6000009350401	0-30	156.00	12/15/2003
11	6000007730401	0-30	177.00	12/15/2003
12	6000007510401	0-30	177.00	12/15/2003
13	6000012950401	0-30	394.00	12/15/2003
14	6000012830401	0-30	394.00	12/15/2003
15	6000007190401	0-30	333.00	12/15/2003
16	6000007150401	0-30	333.00	12/15/2003
17	6000008290401	0-30	156.00	12/15/2003
18	6000013250401	0-30	320.00	12/15/2003
19	6000011340401	0-30	156.00	12/15/2003
20	6000010260401	0-30	156.00	12/15/2003

Account 132002

	Invoice Number	Aging Bucket	Amount	Invoice Date
1	36100245	0-30 days	83.36	12/26/2003
2	36100280	0-30 days	101.97	12/26/2003
3	36100433	0-30 days	2,693.44	12/26/2003
4	36100449	0-30 days	382.00	12/26/2003
5	36100507	0-30 days	59,315.40	12/26/2003
6	36100644	0-30 days	8,283.69	12/26/2003
7	36100854	0-30 days	115.00	12/26/2003
8	36100887	0-30 days	12,340.86	12/26/2003
9	36102114	0-30 days	885.85	12/26/2003

All amounts included in account detail were selected for testing.

Account 132007

	Item ID	Invoice Date	Amount
1	304700141	2/8/2003	94.00
2	305400149	2/15/2003	169.00
3	306100154	2/22/2003	145.00
4	328800169	10/4/2003	48.00
5	329200176	10/11/2003	56.00
6	329200177	10/11/2003	54.00
7	329200178	10/11/2003	661.34
8	329200178	10/11/2003	1,778.00
9	329200179	10/11/2003	30.00
10	330600174	10/25/2003	131.00
11	331300178	11/1/2003	99.00
12	332000164	11/8/2003	126.00
13	332800175	11/15/2003	267.00
14	334300172	11/29/2003	188.00
15	334800161	12/6/2003	235.00
16	335500171	12/13/2003	99.00
17	336100158	12/20/2003	5,834.22
18	33610058	12/20/2003	408.40
19	336100159	12/20/2003	2,174.16
20	336100159	12/20/2003	152.20

Account 132010

	Run Date	Amount
1	11/28/2003	132.39
2	11/28/2003	1,155.00
3	4/28/2000	2,830.04
4	4/28/2000	1,025.10
5	4/28/2000	699.17
6	4/28/2000	2.34
7	12/29/2000	175.46
8	12/29/2000	388.49
9	1/31/2001	25.60
10	4/30/2001	200.39
11	5/31/2001	121.59
12	7/31/2001	5,395.76
13	11/30/2001	103.05
14	1/31/2002	7,514.82
15	1/31/2002	956.18
16	6/28/2002	73.79
17	10/31/2003	169.99

The Corporation explained that this account relates to National business in which Highmark (as a Control Plan) is owed money from other Participating Plans. The receivables are established by Highmark from dispositioned cash receipt reports. The Corporation provided the cash receipt reports, which we used to agree the above receivable amounts.

Accounts 132016, 132017, 132018

	ID Number	Amount
1	36320013400218801	3,076.10
2	45520033100038100	1,145.90
3	86520033221646600	151.62
4	45520033350178300	1,240.89
5	45520033580173900	876.90
6	86520033470052600	115.41
7	86520033520475400	667.50
8	86520033530178500	202.46
9	86520033570511000	359.94
10	37820030983004201	34,798.43
11	37820033510032200	4,339.84
12	37820033530048900	1,521.16
13	45520033430285500	9,495.02
14	45520033530072100	2,632.77
15	45520033530142400	4,367.04
16	86520032891309700	4,078.00
17	86520033231333500	210.00
18	86520033401127800	9,270.90
19	86520033452137400	1,326.50
20	86520033461747600	425.87

Account 230012

	Cycle	Amount
1	2576	249.14
2	2594	9539.45
3	2600	5491.05
4	2606	97.61
5	2612	10161.03
6	2623	138.6
7	2629	5146.17
8	2670	343.97
9	2676	4717.56
10	2707	977.84
11	2711	13668.68
12	2717	4140.5
13	2736	1235.98
14	2741	46.52
15	2754	630.59
16	2778	2906.4
17	2796	736
18	2806	805.33
19	2818	3009.54
20	2843	184.95

Account 230021

	Invoice Date	Amount
1	7/18/2003	(272.80)
2	10/10/2003	3,772.80
3	5/15/2003	45,866.91
4	7/18/2003	(840.00)
5	6/18/2003	(240.88)
6	12/31/2003	23,075.00
7	12/31/2003	1,261.00
8	12/31/2003	4,979.00
9	12/31/2003	(884.00)
10	12/31/2003	39,936.00
11	12/31/2003	95,381.00

Note: All amounts included in account were selected for testing.

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Account 221001

	Group Number	Coverage Date	Amount
1	10067-59	Jan-04	4,025.33
2	10114-04	Jan-04	3,906.66
3	10232-94	Jan-04	10,706.34
4	10439-01	Jan-04	2,871.50
5	10439-99	Jan-04	4,760.17
6	10480-71	Jan-04	2,206.65
7	10481-36	Jan-04	6,867.59
8	10646-26	Jan-04	13,919.79
9	10717-10	Jan-04	2,925.72
10	10717-53	Jan-04	4,089.96
11	10890-59	Jan-04	1,515.68
12	10971-92	Jan-04	1,304.58
13	11021-00	Jan-04	6,950.90
14	11055-91	Jan-04	7,490.22
15	11181-40	Jan-04	1,352.38
16	41982-00	Jan-04	41,566.45
17	42709-00	Jan-04	41,447.24
18	43642-43	Jan-04	33,384.86
19	43689-37	Jan-04	8,948.65
20	44855-02	Jan-04	9,492.86

Accounts 221002, 221003 and 221004

	Customer #	Coverage Date	Amount
1	6498	Jan-04	989.85
2	6273	Jan-04	1,010.72
3	12190	Jan-04	1,083.00
4	10279	Jan-04	1,102.86
5	12718	Jan-04	1,160.11
6	12267	Jan-04	1,212.14
7	8147	Jan-04	1,573.37
8	7068	Jan-04	1,619.54
9	7739	Jan-04	2,082.67
10	5750	Jan-04	2,221.62
11	8677	Jan-04	3,220.31
12	6989	Jan-04	3,441.16
13	10793	Jan-04	4,150.90
14	10105	Jan-04	4,550.30
15	9747	Jan-04	53,729.63
16	7653	Jan-04	56,579.19
17	5613	Jan-04	61,568.65
18	6342	Jan-04	163,316.32
19	7853	Jan-04	283,828.66
20	6277	Jan-04	301,946.64

Account 221006

	Group Number	Coverage Period	Amount
1	37812	Jan-04	22,295.25
2	37912	Jan-04	107,823.80
3	37912	Feb-04	18,577.78
4	38918	Jan-04	16,075.65
5	38918	Jan-04	24,743.97
6	38918	Mar-04	47,856.44
7	48097	Jan-04	326,557.17
8	48097	Jan-04	98,159.75
9	48098	Jan-04	101,283.91
10	48099	Jan-04	72,679.03
11	48100	Jan-04	2,788.38
12	66050	Jan-04	1,776.60
13	66050	Jan-04	5,872.65
14	66050	Jan-04	27,339.90
15	66050	Jan-04	12,077.20
16	66051	Jan-04	5,971.35
17	66051	Jan-04	13,625.50
18	66051	Jan-04	22,503.60
19	66051	Jan-04	658,032.90
20	66051	Jan-04	656,432.82

Account 221008

	Coverage Period	Amount
1	Jan-04	782.88
2	Jan-04	1,097.82
3	Jan-04	1,097.82
4	Jan-04	2,152.92
5	Jan-04	587.16
6	Jan-04	121.98
7	Jan-04	121.98
8	Jan-04	121.98
9	Jan-04	121.98
10	Jan-04	121.98
11	Jan-04	121.98
12	Jan-04	60.99
13	Jan-04	121.98
14	Jan-04	121.98
15	Jan-04	121.98
16	Jan-04	121.98
17	Jan-04	121.98
18	Jan-04	121.98
19	Jan-04	60.99
20	Jan-04	121.98

Account 221012

The Corporation provided support for the cash payment received on December 31, 2003 for 100% of the account balance related to the January 2004 coverage period.

Account 221022

	Receipt Date	Coverage Period	Amount
1	12/19/2003	Jan-04	2,522.66
2	12/17/2003	Jan-04	1,561.70
3	12/17/2003	Jan-04	4,200.54
4	12/23/2003	Jan-04	4,039.03
5	12/23/2003	Jan-04	1,315.86
6	12/29/2003	Jan-04	20,812.02
7	12/23/2003	Jan-04	1,955.48
8	12/29/2003	Jan-04	10,411.98
9	12/18/2003	Jan-04	531.64
10	12/19/2003	Jan-04	1,424.80
11	12/22/2003	Jan-04	2,751.02
12	12/19/2003	Jan-04	6,438.22
13	12/16/2003	Jan-04	10,872.49
14	12/24/2003	Jan-04	27,040.34
15	12/17/2003	Jan-04	5,070.04
16	12/23/2003	Jan-04	49,161.79
17	12/24/2003	Jan-04	33,193.40
18	12/29/2003	Jan-04	1,323.17
19	12/18/2003	Jan-04	1,664.21
20	12/17/2003	Jan-04	879.38

221091

	PM Record	Check #	Receipt Date	Amount	Coverage Date
1	600000404	1497	12/23/2003	156.00	January 2004
2	600000683	5107	12/23/2003	156.00	January 2004
3	600000740	2828	12/23/2003	156.00	January 2004
4	600000031	1865	12/24/2003	156.00	January 2004
5	600000054	1924	12/24/2003	156.00	January 2004
6	600000236	2510	12/24/2003	156.00	January 2004
7	600000352	17006	12/24/2003	156.00	January 2004
8	600000420	1063	12/24/2003	156.00	January 2004
9	600000649	609	12/24/2003	156.00	January 2004
10	600000788	6114	12/24/2003	156.00	January 2004
11	600000107	3343	12/26/2003	156.00	January 2004
12	600000112	1358	12/26/2003	156.00	January 2004
13	600000144	556	12/29/2003	156.00	January 2004
14	600000368	1032	12/29/2003	156.00	January 2004
15	600000735	209	12/29/2003	156.00	January 2004
16	600001018	1378	11/18/2003	156.00	January 2004
17	600001176	2426	12/1/2003	156.00	January 2004
18	600001193	948	11/21/2003	156.00	January 2004
19	600001229	637	11/20/2003	156.00	January 2004
20	600001241	2442	11/21/2003	156.00	January 2004

Accounts 221101, 221102 and 221103

	Account	Group	Year	Month	Amount
1	421479	56614	2004	1	904.81
2	421502	57454	2004	1	3,189.78
3	421520	56707	2004	1	920.64
4	421536	56662	2003	9	1,125.83
5	421551	50478	2004	1	353.00
6	421567	56287	2003	12	145.52
7	421581	57270	2004	1	638.52
8	421597	57213	2004	1	199.96
9	421605	56257	2004	1	1,901.53
10	421610	56752	2004	1	1,008.40
11	421640	56677	2004	1	1,250.90
12	421650	57479	2004	1	1,997.26
13	421674	50285	2004	1	1,770.28
14	421695	56177	2004	1	3,013.35
15	421715	50430	2004	1	2,155.90
16	421719	56297	2004	1	2,643.19
17	421760	56624	2004	1	354.04
18	421766	56729	2004	1	2,564.88
19	421767	56739	2004	1	687.87
20	421768	56710	2004	1	391.23

Account 221106

	Customer #	Year	Month	Amount
1	12857	2003	12	339.85
2	5318	2003	12	421.30
3	12056	2003	12	564.14
4	9751	2003	12	909.80
5	13001	2003	12	1,353.79
6	10109	2002	12	1,614.10
7	13068	2003	12	1,933.88
8	10602	2003	12	2,343.96
9	8081	2003	12	2,562.85
10	9733	2003	12	3,001.92
11	8876	2003	10	6,048.83
12	8876	2003	1	6,087.93
13	10307	2003	12	19,431.38
14	10976	2003	12	35,892.17
15	2805	2003	11	47,827.40
16	2805	2003	8	55,961.90
17	2805	2003	6	60,254.91
18	2805	2002	10	127,092.39
19	2805	2003	12	208,848.57
20	410	2003	12	536,295.90

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Keystone Health Plan West, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and the results, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	49,507,879
Less: Unapplied cash		(552,419)
Non-admitted receivables		(3,307,347)
Allowance for doubtful accounts		(4,060,000)
Miscellaneous debits / (credits)		(27,944,190)
Accident and health premiums due and unpaid	$	13,643,923

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debits/(credits) consists of credit balances totaling $(27,944,190), which represent amounts billed in advance of the coverage period that are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Account Description		Balance
130401	A/R Group Premiums Highbar	$	30,287,377
130405	A/R Individual Blue HMO		2,869,422
130411	A/R Caring for Kids		195,914
130416	A/R Security Blue HCFA		1,826,364
130418	A/R Security Blue Employer Group		8,282,864
130419	A/R Direct Pay Security Blue		6,045,938
		$	49,507,879

To the extent that any of the account balances above included credit balances, the Company made an adjustment to reclassify these credit balances to line 21 on page three in the Annual Statement. As a result, the above balances do not include any credit balances. We have agreed the reclassifications recorded by the Company to supporting schedules.

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging reports, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	General Ledger Balance	Aging Balance	Difference
130401	A/R Group Premiums Highbar	$ 30,287,377	$ 29,447,548	839,829
130405	A/R Individual Blue HMO	2,869,422	2,867,498	1,924
130411	A/R Caring for Kids	195,914	178,077	17,837
130416	A/R Security Blue HCFA	1,826,364	997,822	828,542
130418	A/R Security Blue Employer Group	8,282,864	8,158,543	124,321
130419	A/R Direct Pay Security Blue	6,045,938	5,522,074	523,864
		$ 49,507,879	$ 47,171,562	

Results: Aging reports were obtained for accounts 130401, 130405, 130411, 130416, 130418 and 130419. We compared the account balance, per the general ledger, to the aging report(s), noting the following exceptions:

Account 130401
The Company provided a reconciliation between the general ledger balance and the aging report, which included two reconciling items totaling $839,829. The Company explained the reconciling items as follows: 1) $398,197 related to credit balances included in the aging report but not the general ledger balance as they were reclassified to line 21 in the Annual Statement; 2) $441,632 related to estimated receivables billed by a third party for which an aging was not available.

Account 130405
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130411
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130416
The Company provided a reconciliation between the general ledger balance and the aging report, which included one reconciling item totaling $828,542. The Company provided support for this item and explained that it consists of an estimated receivable for retrospective adjustments due from the Centers for Medicare & Medicaid (CMS) for which an aging was not available (see step 5).

Account 130418
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 130419
The Company provided a reconciliation between the general ledger balance and the aging report, which included one reconciling item totaling $523,864. The Company provided support for this item and explained that it represents credit balances included in the aging report but not the general ledger balance as they were reclassified to line 21 in the Annual Statement.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

		Aging Category					
Acct. #	Account Description	Open Future	0-30	31-60	61-90	90+	Total
130401	HighBAR	13,259,546	9,951,905	2,895,623	806,244	2,534,230	29,447,548
130405	Individual HMO	2,529,174	(111)	303,501	34,934	-	2,867,498
130411	Caring for Kids	174,430	1,546	846	289	966	178,077
130416	A/R Security Blue HCFA	-	276,200	81,799	5,064	634,759	997,822
130418	Security Blue Group	5,910,516	1,183,572	191,102	96,363	776,990	8,158,543
130419	Security Blue Individual	4,720,382	137,198	53,404	89,949	521,141	5,522,074
	Total	26,594,048	11,550,310	3,526,275	1,032,843	4,468,086	47,171,562

The future category represents amounts due to the Company as of December 31, 2003 for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003.

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results:

Account 130416

The Company explained that a portion of the balance in account 130416 totaling $828,542 is not supported by a detailed aging report. The Company provided a reconciliation between the general ledger balance and the detailed schedule supporting the portion not supported by an aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

The Company explained that this amount represents an estimated receivable due from CMS for retroactive adjustments. As the estimate relates to retroactive adjustments, no aging is available.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: No credit balances were noted in any of the gross accounts receivable balances. The Company explained that it reclassified all credit balances included in the gross accounts receivable balances to line 21 in the Annual Statement.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Account Description	Balance
281501	Cash Clearing - Individual HMO	$ (192,679)
281502	Cash Clearing - Group HMO Direct Pay	(5,474)
281504	Cash Clearing - Caring for Kids HMO	(1,907)
281505	Cash Clearing - Security Blue Groups	(142,887)
281506	Cash Clearing - Security Blue Direct Pay	(209,472)
		$ (552,419)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Account Description	Balance	Unapplied Cash
130401	A/R Group Premiums Highbar	$ 30,287,377	$ -
130405	A/R Individual Blue HMO	2,869,422	(198,153)
130411	A/R Caring for Kids	195,914	(1,907)
130416	A/R Security Blue HCFA	1,826,364	-
130418	A/R Security Blue Employer Group	8,282,864	(142,887)
130419	A/R Direct Pay Security Blue	6,045,938	(209,472)
		$ 49,507,879	$ (552,419)

Accounts 281501 and 281502 both relate to the receivable in account 130405.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	Balance	Balance per Detailed Support	Difference
281501	Cash Clearing - Individual HMO	$ (192,679)	$ (208,525)	15,846
281502	Cash Clearing - Group HMO Direct Pay	(5,474)	-	(5,474)
281504	Cash Clearing - Caring for Kids HMO	(1,907)	-	(1,907)
281505	Cash Clearing - Security Blue Groups	(142,887)	(142,887)	-
281506	Cash Clearing - Security Blue Direct Pay	(209,472)	(209,472)	-
		$ (552,419)	$ (560,884)	

Results:

Account 281501
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 281502
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 281504
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. No debit balances were noted in any of the unapplied cash accounts.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above. In addition, identify any customer accounts receivable balances less than 90 days old that have been non-admitted as a result of the customer having an outstanding balance over 90 days old that is not considered to be di minimis.

	HighBAR	Individual HMO	Caring for Kids	Security Blue Group	Security Blue Individual	CMS	Total
Over 90 day balance per aging report	$ 2,534,230	$ -	$ 966	$ 776,990	$ 521,141	$ 634,759	$ 4,468,086
Non-admitted receivable balance per Annual Statement	(3,322,046)	100,000	(2,100)	(43,135)	(40,066)	-	(3,307,347)
Non-admitted balance (over)/under 90+ day balance	(787,816)	100,000	(1,134)	733,855	481,075	634,759	1,160,739
Bad debt reserve	(2,720,000)	(100,000)	-	(760,000)	(480,000)	-	(4,060,000)
Non-admitted/bad debt reserve (over)/under 90+ day balance	(3,507,816)	-	(1,134)	(26,145)	1,075	634,759	(2,899,261)
Receivables less than 90 days old requiring non-admission	3,467,639	-	-	-	-	-	3,467,639
Deficiency/(excess)	$ (40,177)	$ -	$ (1,134)	$ (26,145)	$ 1,075	$ 634,759	$ 568,378

Results: The Company explained that its process for recording non-admitted receivables is to evaluate the receivable and determine the amount that should be non-admitted in accordance with SSAP 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*, which includes accounts receivable balances over 90 days old as well as those accounts receivable balances less than 90 days old for which there is a related customer balance greater than 90 days old. The Company then compares the amount that should be non-admitted to the bad debt reserve that has been established and records a non-admitted asset for the incremental difference. As a result of the Company's methodology for assessing non-admitted receivables, the non-admitted receivable balance included in the Company's Annual Statement represents the sum of the over 90 day accounts receivable balance PLUS accounts receivable balances less than 90 days old that have been non-admitted as noted above LESS the reversal of any bad debt reserve recorded against the gross accounts receivable balance in column 1. As a result of the Company's methodology for recording its net admitted accounts receivable balances, we noted the following:

HighBAR
The Company provided a summary of the non-admitted accounts receivable, which included an amount in excess of the non-admitted receivable of $40,177. The Company explained that this excess represents credit balances over 90 days old that are included in the aging report and are admitted in the Annual Statement.

Caring for Kids
The Company provided a summary of the non-admitted accounts receivable, which included an amount in excess of the non-admitted receivable of $1,134. The Company explained that this was an immaterial difference.

Security Blue Group
The Company provided a summary of the non-admitted accounts receivable, which included an amount in excess of the non-admitted receivable of $26,145. The Company explained that this excess represents credit balances over 90 days old that are included in the aging report and are admitted in the Annual Statement.

Security Blue Individual
The Company provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $1,075. The Company explained that this was an immaterial difference.

CMS
The Company provided a summary of the non-admitted accounts receivable, which included a deficiency in the non-admitted receivable of $634,759. The Company explained that it admitted the entire amount over 90 days old as the amount relates to a receivable from CMS, which can be admitted in accordance with statutory accounting principles.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances (or 100% of the population if less than 20) from the aging detail for accounts 130401, 130405, 130411, 130418 and 130419 and performed the above procedures without exception. See Attachment A for a summary of the sample.

The Company explained that a portion of account 130416, A/R Security Blue HCFA, is supported by an aging report. However, the accounts receivable balance included in this account is not supported by individual invoices as the account represents estimated amounts due the Company for retroactive adjustments for CMS. The Company utilizes the aging report to record the accounts receivable amount to the general ledger and to assess the collectibility of the balance. The Company explained that due to the nature of the account and the absence of an invoice, the aging buckets were not tested for this account.

13. Obtain a summary of bad debt reserves related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** Not applicable. No bad debt reserves related to accounts receivable balances less than 90 days old are included in the accident and health premiums due and unpaid line.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. No bad debt reserves related to accounts receivable balances less than 90 days old are included in the accident and health premiums due and unpaid line.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** The Company explained that accounts 130401, 130405, 130418 and 130419 are supported by a detailed aging report. The Company explained that a portion of the balance in account 130416 is supported by an aging, while the remaining portion is not. The Company explained that it has not recorded a bad debt reserve related to this account.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description		Balance
221012	Unearned Premium-Security Blue	$	(113,757,344)
221001	Unearned Premium-Group		(873,444)
221011	Unearned Deposit-Individual HMO		(2,516,548)
221014	Unearned Premium-Caring for Kids		(301,571)
221019	Unearned Premium-Security Blue Groups		(1,433,165)
221020	Unearned Premium-Security Blue Direct Pay		(37,943,205)
		$	(156,825,277)

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description		General Ledger Balance		Balance per Detailed Support	Difference
221012	Unearned Premium-Security Blue	$	(113,757,344)	$	(113,757,344)	-
221001	Unearned Premium-Group		(873,444)		(873,444)	-
221011	Unearned Deposit-Individual HMO		(2,516,548)		(2,516,548)	-
221014	Unearned Premium-Caring for Kids		(301,571)		(301,571)	-
221019	Unearned Premium-Security Blue Groups		(1,433,165)		(1,433,165)	-
221020	Unearned Premium-Security Blue Direct Pay		(37,943,205)		(38,027,819)	(84,344)
		$	(156,825,277)	$	(156,909,891)	

Results:

Account 221020
The Company provided a reconciliation between the general balance and the detailed supporting schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Account Description	Accounts Receivable Balance	Premiums Received In Advance
130401	A/R Group Premiums Highbar	$ 30,287,377	$ (873,444)
130405	A/R Individual Blue HMO	2,869,422	(2,516,548)
130411	A/R Caring for Kids	195,914	(301,571)
130416	A/R Security Blue HCFA	1,826,364	(113,757,344)
130418	A/R Security Blue Employer Group	8,282,864	(1,433,165)
130419	A/R Direct Pay Security Blue	6,045,938	(37,943,205)
		$ 49,507,879	$ (156,825,277)

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Account Description	Balance	Debit Balances
221012	Unearned Premium-Security Blue	$ (113,757,344)	$ -
221001	Unearned Premium-Group	(873,444)	9,397
221011	Unearned Deposit-Individual HMO	(2,516,548)	-
221014	Unearned Premium-Caring for Kids	(301,571)	-
221019	Unearned Premium-Security Blue Groups	(1,433,165)	-
221020	Unearned Premium-Security Blue Direct Pay	(37,943,205)	-
		$ (156,825,277)	$ 9,397

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from accounts 221012, 221001, 221011, 221019 and 221020 and performed the above procedures without exception. See Attachment B for a summary of the sample.

The Company explained that there was no detailed listing supporting the balance in account 221014. We did obtain from the Company a detailed supporting reconciliation for the account. We agreed the general ledger balance to the detailed supporting reconciliation noting no exception.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate policy reserves line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate policy reserves line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Account 130401

	Invoice #	Aging Bucket	Amount	Due Date
1	031114000504	22-30	29,242	12/1/2003
2	031121000038	15-21	11,619	12/10/2003
3	031126000221	15-21	113,514	12/15/2003
4	031208000025	8-14	172,431	12/22/2003
5	031114000448	22-30	67,486	12/1/2003
6	031017000445	31-60	85,572	11/3/2003
7	031217000316	Future	73,494	1/2/2004
8	031217000337	Future	104,816	1/2/2004
9	031205003511	8-14	10,232	12/22/2003
10	031217000343	Future	739,003	1/2/2004
11	031114000330	22-30	57,816	12/1/2003
12	031205004727	8-14	23,788	12/22/2003
13	031121000041	15-21	5,465	12/10/2003
14	031017000227	31-60	35,384	11/3/2003
15	031111000047	22-30	311,074	12/1/2003
16	031126000260	31-60	302,117	11/26/2003
17	031017000702	31-60	19,726	11/3/2003
18	031003003520	61-90	58,678	10/20/2003
19	031290000053	8-14	100,993	12/22/2003
20	031224000027	Future	24,174	1/12/2004

Account 130405

	Invoice Number	Aging Bucket	Amount	Due Date
1	2771975	0-30	677.80	12/1/2003
2	2781940	0-30	225.93	12/1/2003
3	2773395	0-30	225.93	12/1/2003
4	2782032	0-30	165.93	12/1/2003
5	2774274	0-30	225.93	12/1/2003
6	2779846	0-30	225.93	12/1/2003
7	2778417	0-30	225.93	12/1/2003
8	2784536	0-30	181.20	12/1/2003
9	2776449	0-30	232.50	12/1/2003
10	2781421	0-30	256.21	12/1/2003
11	2777729	0-30	33.06	12/1/2003
12	2778661	0-30	451.86	12/1/2003
13	2784038	0-30	225.93	12/1/2003
14	2771849	0-30	225.93	12/1/2003
15	2783741	0-30	232.50	12/1/2003
16	2776555	0-30	369.25	12/1/2003
17	2780482	0-30	524.63	12/1/2003
18	2779590	0-30	255.93	12/1/2003
19	2779701	0-30	255.93	12/1/2003
20	2775399	0-30	212.05	12/1/2003

Account 130411

	Invoice #	Aging Bucket		Amount	Due Date
1	9000023220403	Future	$	193.15	2/15/2004
2	9000034090403	Future	$	193.15	2/15/2004
3	9000032620403	Future	$	96.55	2/15/2004
4	9000029890403	Future	$	96.55	3/31/2004
5	9000024130403	Future	$	96.55	2/15/2004
6	9000004720403	Future	$	193.15	2/15/2004
7	9000032240403	Future	$	96.55	2/15/2004
8	9000009250403	Future	$	265.55	2/15/2004
9	9000033800403	Future	$	96.55	2/15/2004
10	9000017580403	Future	$	265.55	2/15/2004
11	9000017370403	Future	$	265.55	2/15/2004
12	9000005240403	Future	$	96.55	2/15/2004
13	9000005580403	Future	$	193.15	2/15/2004
14	9000029840403	Future	$	96.55	2/15/2004
15	9000019640403	Future	$	96.55	2/15/2004
16	9000017240403	Future	$	96.55	2/15/2004
17	9000033180403	Future	$	96.55	2/15/2004
18	9000005730403	Future	$	96.55	2/15/2004
19	9000030790403	Future	$	96.55	2/15/2004
20	9000020730403	Future	$	96.55	2/15/2004

Account 130418

	Client Code	Aging Bucket	Amount	Invoice Date
1	1404800	0-30	209,847.00	12/8/2003
2	1411900	0-30	358,109.50	12/8/2003
3	1411900	31-60	167,249.32	11/5/2003
4	1413100	0-30	9,933.00	12/8/2003
5	1417300	0-30	30,778.50	12/8/2003
6	1542800	0-30	3,696.00	12/8/2003
7	1574000	0-30	8,220.00	12/8/2003
8	2193900	0-30	113,863.79	12/8/2003
9	2625600	0-30	2,247.50	12/8/2003
10	2625601	0-30	96.00	12/8/2003
11	2667000	Over 150 Days	47,660.38	4/7/2003
12	2688100	0-30	127,946.05	12/8/2003
13	2850400	0-30	25,421.00	12/8/2003
14	2882901	0-30	9,623.00	12/8/2003
15	3322000	0-30	48,714.00	12/8/2003
16	3474500	0-30	64,171.50	12/8/2003
17	3474500	31-60	33,471.70	11/5/2003
18	3502900	0-30	18,149.00	12/8/2003
19	3555300	0-30	20,628.00	12/8/2003
20	3701000	Over 150 Days	28,508.08	4/7/2003

Account 130419

	Invoice #	Aging Bucket	Amount	Invoice Date
1	0001280780402	Future	40.00	1/20/2004
2	0001328760402	Future	331.00	1/20/2004
3	0001565230402	Future	387.00	1/20/2004
4	0001157460404	Future	387.00	3/20/2004
5	0001274080402	Future	387.00	1/20/2004
6	0002598810402	Future	129.00	1/20/2004
7	0001857980402	Future	258.00	1/20/2004
8	0002430150402	Future	258.00	1/20/2004
9	0001123070402	Future	331.00	1/20/2004
10	0002133330402	Future	56.00	1/20/2004
11	0000897400402	Future	129.00	1/20/2004
12	0002068700402	Future	168.00	1/20/2004
13	0001180410402	Future	240.00	1/20/2004
14	0000788140402	Future	258.00	1/20/2004
15	0001792760404	Future	168.00	3/20/2004
16	0001363630402	Future	219.00	1/20/2004
17	0001485880402	Future	168.00	1/20/2004
18	0000930490402	Future	2,466.00	1/20/2004
19	0001056470402	Future	112.00	1/20/2004
20	0002642990402	Future	129.00	1/20/2004

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Account 221012

The Company provided support for the cash payment received on December 31, 2003 for 100% of the account balance related to the January 2004 coverage period.

Account 221001

	Invoice Number	Receipt Date	Amount	Coverage Period
1	31205007471	December 2003	37,258	January 2004
2	31205004719	December 2003	23,159	January 2004
3	31217000511	December 2003	8,954	January 2004
4	31217000420	December 2003	3,918	January 2004
5	31205008379	December 2003	12,220	January 2004
6	31205002105	December 2003	4,228	January 2004
7	31231000061	December 2003	7,854	January 2004
8	31205002939	December 2003	4,643	January 2004
9	31205003241	August 2003	1,062	January 2004
10	31205003546	December 2003	878	January 2004
11	31205000913	December 2003	10,259	January 2004
12	31205003316	December 2003	5,186	January 2004
13	31231000127	December 2003	2,338	January 2004
14	31231000167	December 2003	1,497	January 2004
15	31205006808	December 2003	8,376	January 2004
16	31217000207	December 2003	1,594	January 2004
17	31205003488	December 2003	9,741	January 2004
18	31205003534	December 2003	5,069	January 2004
19	31231000200	December 2003	865	January 2004
20	31205002112	December 2003	1,289	January 2004

Account 221011

	Invoice Number	Receipt Date	Amount	Coverage Period
1	2897333	11/19/2003	800.30	January 2004
2	2900931	11/26/2003	3,393.00	January 2004
3	2900010	12/1/2003	1,361.30	January 2004
4	2893945	12/3/2003	1,355.60	January 2004
5	2896433	12/11/2003	1,135.60	January 2004
6	2902830	12/19/2003	677.80	January 2004
7	2897793	12/22/2003	1,023.85	January 2004
8	2905817	12/23/2003	1,087.95	January 2004
9	2900130	12/26/2003	1,229.82	January 2004
10	2904242	12/29/2003	827.55	January 2004
11	2892744	12/29/2003	1,073.85	January 2004
12	2894050	12/29/2003	1,103.87	January 2004
13	2896388	12/29/2003	680.65	January 2004
14	2899640	12/29/2003	991.75	January 2004
15	2901509	12/29/2003	677.80	January 2004
16	2902425	12/29/2003	916.65	January 2004
17	2902811	12/29/2003	800.30	January 2004
18	2903816	12/29/2003	581.30	January 2004
19	2904517	12/29/2003	1,093.60	January 2004
20	2905648	12/29/2003	1,087.95	January 2004

Account 221019

	Check #	Receipt Date	Amount	Coverage Date
1	19702	12/29/2003	7,358.00	January 2004
2	10168	12/19/2003	10,582.50	January 2004
3	2169	12/12/2003	13,618.50	January 2004
4	732010	12/22/2003	10,718.00	January 2004
5	705904	12/22/2003	17,251.50	January 2004
6	4140	12/18/2003	63,375.00	January 2004
7	31023	12/29/2003	18,113.00	January 2004
8	124075	12/22/2003	34,947.50	January 2004
9	wire	12/22/2003	7,915.20	January 2004
10	83549	12/18/2003	26,350.00	January 2004
11	8965	12/29/2003	7,029.00	January 2004
12	138283	12/30/2003	141,148.50	January 2004
13	3077222	12/17/2003	28,487.00	January 2004
14	20258	12/2/2003	58,233.00	January 2004
15	588336	12/24/2003	14,556.00	January 2004
16	4253	12/22/2003	23,871.00	January 2004
17	wire	12/16/2003	9,699.50	January 2004
18	362272	12/8/2003	22,869.00	January 2004
19	wire	12/19/2003	25,071.00	January 2004

Account 221020

	Check #	Receipt Date	Amount	Coverage Date
1	7455	12/17/2003	138.00	January 2004
2	940	12/17/2003	133.00	January 2004
3	3931	12/8/2003	56.00	January 2004
4	1114	12/15/2003	56.00	January 2004
5	1582	12/12/2003	129.00	January 2004
6	727	12/18/2003	119.00	January 2004
7	1405	12/22/2003	56.00	January 2004
8	297	12/9/2003	56.00	January 2004
9	2443	12/10/2003	56.00	January 2004
10	705	12/15/2003	56.00	January 2004
11	5482	12/15/2003	179.00	January 2004
12	254	12/16/2003	231.00	January 2004
13	000001	12/19/2003	129.00	January 2004
14	680	12/18/2003	145.00	January 2004
15	2670	12/12/2003	129.00	January 2004
16	3777	12/11/2003	129.00	January 2004
17	285	12/15/2003	56.00	January 2004
18	3085	12/5/2003	56.00	January 2004
19	2795	12/18/2003	133.00	January 2004
20	3285	12/22/2003	179.00	January 2004

Highmark Life Insurance Company

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Highmark Life Insurance Company ("HLIC"), which were agreed to by Highmark Inc. (the "Company"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Company. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 12,661,281
Less: Unapplied cash	(722,733)
Non-admitted receivables	(266,197)
Allowance for doubtful accounts	-
Miscellaneous debits / (credits)	(10,341,421)
Accident and health premiums due and unpaid	$ 1,330,930

Results:
The majority of the miscellaneous debits/(credits) consist of a credit balance totaling ($10,161,072) which represent Ceded Premiums payable at December 31, 2003. We traced and agreed this amount to detail by Line of Business. The amount consists of premiums owed to reinsurers under HLIC's reinsurance agreements, which have been included in the gross accounts receivable at December 31, 2003.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Account Description	Balance
121100	Uncollected Premium Direct	$ 9,083,040
121250	Uncollected Premium Assumed	86,228
124150	Uncollected Premium Assumed Casualty	2,711,944
124152	A/R - Uncollected Premium Assumed Casualty	619,557
124950	Uncollected Premium Assumed KHPC	160,512
		$ 12,661,281

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	Balance per GL	Balance per Aging	Difference
121100	Uncollected Premium Direct	$ 9,083,040	$ 6,820,319	$ 2,262,721
124950	Uncollected Premium Assumed KHPC	160,512	160,512	-
Accounts not supported by an Aging				
121250	Uncollected Premium Assumed	86,228	-	86,228
124150	Uncollected Premium Assumed Casualty	2,711,944	-	2,711,944
124152	A/R - Uncollected Premium Assumed Casualty	619,557	-	619,557
		$ 12,661,281	$ 6,980,831	

Results: Aging Reports were obtained for accounts 121100 and 124950. We compared the account balance, per the general ledger, to the aging report, noting the following exceptions:

Account 121100
The Company provided a reconciliation between the general ledger and the aging report, which included 3 reconciling items totaling $2,262,721. The Company provided support for the three items as follows: 1) $1,006,656 related to policies not entered into the Company's aging system as of 12/31/03. This is due to policies that were either written in December, 2003 and not entered into the system; or, policies that HLC is still waiting on information (i.e. census data) or terms are still being negotiated; 2) $1,075,716 related to Davis Vision, an affiliate of the Company. This amount was agreed to the total A/R per Davis Vision, offset by the cash that had been received from Davis Vision during 2003; 3) $180,349 represents ASO claims that the Company paid, but has not yet been reimbursed by Consol at 12/31/03. The Company acts as the TPA for Consol Energy's self-insured plan.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

		Aging Category				
Acct. #	Description	0-30	31-60	61-90	90+	Total
121100	Uncollected Premium Direct	$ 5,663,849	647,945	242,328	266,197	6,820,319
124950	Uncollected Premium Assumed KHPC	160,512	-	-	-	160,512
	Total	5,824,361	647,945	242,328	266,197	6,980,831

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results:

Account 121100
As discussed in step 3, a portion of the balance in account 121100 totaling $2,262,721 is not supported by a detailed aging report. The company provided a reconciliation between the general ledger balance and the detailed schedule supporting the portion not supported by an aging report. Refer to the results within step 3 for documentation of detail provided to support this balance.

Account 121250
The entire balance in account 121250 totaling $86,228 is not supported by a detailed aging report. This balance is not supported by an aging report, as it is ceded premium receivable from a group where the Company was the reinsurer. We traced and agreed this amount to detail, noting no reconciling items, individually, or in the aggregate, over $500,000.

Account 124150
The entire balance in account 124150 totaling $2,711,944 is not supported by a detailed aging report. This balance represents a receivable from an affiliate, Highmark Casualty Company. We traced and agreed this amount to the related payable on the books of Highmark Casualty Company without exception.

Account 124152
The entire balance in account 124152 totaling $619,557 is not supported by a detailed aging report. This balance represents a receivable from an affiliate, Highmark Casualty Company. We traced and agreed this amount to the related payable on the books of Highmark Casualty Company without exception.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. No credit balances were noted in the gross accounts receivable balances.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Account Description	Balance
288200	Unapplied Lock Box	$ 722,733
		$ 722,733

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Account Description	Balance	Unapplied Cash
121100	Uncollected Premium Direct	$ 9,083,040	$ (722,733)
121250	Uncollected Premium Assumed	86,228	-
124150	Uncollected Premium Assumed Casualty	2,711,944	-
124152	A/R - Uncollected Premium Assumed Casualty	619,557	-
124950	Uncollected Premium Assumed KHPC	160,512	-
		$ 12,661,281	$ (722,733)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results:

Account 288200
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. No debit balances were noted in the unapplied cash account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Over 90 Day Balance per Aging Report	$ (317,548)
Non-admitted receivable balance per Annual Statement	(266,197)
Non-admitted receivable balance (over)/under 90+ day balance	51,351
Bad debt reserve	-
Non-admitted receivable balance (over)/under 90+ day balance	51,351
Receivables less than 90 days old requiring non-admission	504,362
Deficiency/(excess)	$ 555,713

Results: The Corporation's process for recording non-admitted receivables is to evaluate and classify as non-admitted those accounts receivable balances over 90 days old.

Life Company

The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency of $555,713. $51,351 of this amount represents premiums due from National Steel Company for increases in their premium; which took place the second half of 2003. There was a lack of communication between the Company and National Steel regarding this increase. Hence, the amount was improperly included in the ">90 day" bucket at 12/31/03 because the customer was not billed for these additional charges until late December, 2003. The remaining $504,362 represents amounts that, in accordance with SSAP 6, are less than 90 days old and deemed uncollectible.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging reports for LOBs noted in step 4 and performed the above procedures without exception. See Attachment A for the sample selected

The majority of the Company's groups are "self-billed." In each month, rather than the Company preparing and mailing an invoice, the group prepares a schedule of what they owe the Company. This schedule consists of the group's coverages and the respective rates for coverage/per employee. The group's responsibility is to calculate the premium owed, based on the number of employees covered under each product. For most customers, the premium is due on the first day of the coverage month. If the Company does not receive the premium by this time, an estimate, which is based on the last payment received from the group, is booked as the AR. As all of the selections made were "self-billed" groups, we could not view an invoice, as invoices are not sent to these groups. We obtained a "screen print" from System One which shows the last payment received from the group, the coverage month the payment is for, the check amount and the check number. From this detail, we were able to determine the proper aging bucket the AR should be in at 12/31/03. Of the 20 accounts receivable balances we tested, all were properly included in the respective aging bucket.

13. Obtain a summary of bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: Not applicable. No bad debt reserves for accounts receivable balances less than 90 days old are included in the accident and health premium due and unpaid line.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description	Balance
221000	Unearned Premium Direct	$(2,765,520)
221200	Unearned Premium Ceded	185,198
221502	Unearned Premium Assumed - L/C	(173,642)
		$(2,753,964)

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	G/L Balance	Detail Balance	Difference
221000	Unearned Premium Direct	$(2,765,520)	$(2,829,540)	$64,020
221200	Unearned Premium Ceded	185,198	185,198	-
221502	Unearned Premium Assumed – L/C	(173,642)	(173,642)	-
		$(2,753,964)	$(2,817,984)	$64,020

Results:

Account 221000
The Company provided a reconciliation between the general ledger balance and the detailed report. There were no reconciling items, individually or in the aggregate, over $500,000.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Account Description	A/R Balance	Premiums Received in Advance
121100	Uncollected Premium Direct	$ 9,083,040	$ (2,753,964)

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Account Description	Balance	Debit Balances
221000	Unearned Premium Direct	$(2,765,520)	$ 167,709
221200	Unearned Premium Ceded	185,198	-
221502	Unearned Premium Assumed – L/C	(173,642)	-
		$(2,753,964)	$167,709

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results:

221000
PwC selected a sample of 20 individual cash receipts from each detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

221200
No sample was tested for 221200. This amount is calculated by applying a ceding rate by the amount of related unearned premium as recorded in 221000. See Attachment B.

221502
No sample was selected for 221502. This balance represents premium assumed from an affiliate, Highmark Casualty Company. The Company acts as the reinsurer for some of Highmark Casualty Company's business. We traced and agreed this amount to the related payable on the books of Highmark Casualty Company without exception.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: This is not applicable to the Life Company.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: This is not applicable to the Life Company.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:***
>
> Not Applicable. Aggregate policy reserves were covered in our actuarial certification of the Company's reserves submitted to the Insurance Department; therefore they have not been tested as part of this agreed upon procedures report.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:***
>
> Not Applicable. Aggregate policy reserves were covered in our actuarial certification of the Company's reserves submitted to the Insurance Department; therefore they have not been tested as part of this agreed upon procedures report.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Group Number	Total AR Balance
2146 PA	17,152
3993 PA-01	7,087
910432 0010	10,438
910725 0020	100,817
911863 0010	3,482
911926 0010	3,816
912538 0010	10,238
912579 0010	19,798
912579 0050	5,092
912579 0130	7,291
912579 0150	10,796
912579 0190	9,553
912579 0210	5,315
912579 0230	8,049
902745 0010	1,244
905789 0010	1,818
912134 0010	2,244
912178 0010	6,831
941165 0010	1,080
941168 0010	9,916

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Group Number	Period Pre-Paid	Unearned Premium
907115 0010	Jan - Apr, 2004	67,733
907115 0010	Jan - Apr, 2004	9,346
907115 0010	Jan - Apr, 2004	8,757
902548 0010	Jan - Nov, 2004	110,331
902548 0020	Jan - Nov, 2004	243,667
902548 0040	Jan - Nov, 2004	23,386
1801PA	January, 2004	5,167
3555PA 0040	January, 2004	3,323
901219 0010	January, 2004	5,221
910638 0010	January, 2004	4,698
910875 0010	January, 2004	5,623
911509 0010	January, 2004	2,448
912246 0010	January, 2004	3,433
912803 0010	January, 2004	16,293
902523 0010	January, 2004	2,085
912102 0010	January, 2004	7,847
400140 0010	January, 2004	7,248
912804 0010	January, 2004	15,586
912621 0010	January, 2004	27,507
941168 0010	January, 2004	20,266

Highmark Life Insurance Company of New York

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Report of Independent Accountants

To the Board of Directors
of Highmark Life Insurance Company of New York

We have performed the procedures enumerated below related to Highmark Life Insurance Company of New York, which were agreed to by Highmark Inc. (the "Company"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Company. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 2,771,160
Less: Unapplied cash	(154,608)
Non-admitted receivables	(70,247)
Allowance for doubtful accounts	-
Miscellaneous debits (credits)	(735,134)
Accident and health premiums due and unpaid	$ 1,811,171

Results:
The majority of the miscellaneous debits/(credits) consist of a credit balance totaling ($719,573) which represent Ceded Premiums payable at December 31, 2003. This amount consists of premiums owed to reinsurers under the Company's reinsurance agreements, which have been included in the gross accounts receivable at December 31, 2003.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Account Description	Balance
121100	Uncollected Premium Direct	$ 2,771,160
		$ 2,771,160

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	Balance per GL	Balance per Aging	Difference
121100	Uncollected Premium Direct	$ 2,771,160	$ 407,604	2,363,556

Results: Aging Reports were obtained for account 121100. We compared the account balance, per the general ledger, to the aging report, noting the following exceptions:

Account 121100
The Company provided a reconciliation between the general ledger and the aging report, which included 3 major reconciling items totaling $ 2,252,881. The Company provided support for the three items as follows: 1) $550,781 relates to policies not entered into the Company's aging system as of 12/31/03. This is due to policies that were either written in December, 2003 and not entered into the system; or, policies that the Company is still waiting on information (i.e. census data) or terms are still being negotiated; 2) $768,582 related to accounts receivable due from the New York Disability Benefit Law line of business. We agreed this amount to detail provided by the third party administrator's report; 3) $933,518 related to Davis Vision, an affiliate of the Company. This amount was agreed to the total accounts receivable per Davis Vision, offset by the cash that had been received from Davis Vision during 2003.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

		Aging Category				
Acct.	Description	0-30	31-60	61-90	90+	Total
121100	Uncollected Premium Direct	290,467	81,897	1,568	33,672	407,604

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results:

Account 121100
As discussed in step 3, a portion of the balance in account 121100 totaling $2,363,556 is not supported by a detailed aging report. The company provided a reconciliation between the general ledger balance and the detailed schedule supporting the portion not supported by an aging report. Refer to the results within step 3 for documentation of detail provided to support this balance.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. No credit balances were noted in the gross accounts receivable balances.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Account Description		Balance
288200	Unapplied Lock Box	$	154,608

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Account Description	Balance	Unapplied Cash
121100	Uncollected Premium Direct	$ 2,771,160	(154,608)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results:

Account 288200
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. No debit balances were noted in the unapplied cash account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

	Life of NY Company
Over 90 Day Balance per Aging Report	(33,672)
Non-admitted receivable balance per Annual Statement	(70,247)
Non-admitted receivable balance (over)/under 90+ day balance	(36,575)
Bad debt reserve	-
Non-admitted receivable balance (over)/under 90+ day balance	(36,575)
Receivables less than 90 days old requiring non-admission	187
Deficiency/(excess)	(36,388)

Results: The Corporation's process for recording non-admitted receivables is to evaluate and classify as non-admitted those accounts receivable balances over 90 days old.

Life Company

The Corporation provided a summary of the non-admitted accounts receivable, which included a write-off related to a receivable not supported by an aging report. This write-off, in the amount of $36,575, is related to the NY Disability Benefit Law line of business, which is not supported by an aging report. Refer to step 3 for an explanation of why this balance is not supported by an aging. Also, we noted an additional $187, which represents amounts that, in accordance with SSAP 6, are less than 90 days old and deemed uncollectible.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results:

We selected a sample of 20 individual accounts receivable balances from the aging reports for LOBs noted in step 4 and performed the above procedures without exception. Of the 20 accounts receivable balances tested, we noted one exception. Due to the majority of the groups being self-billed, the Company must estimate the premium it will receive in future months, based on actual premium received in prior months. For group# 893207 0010, the AR balance per the aging detail was $96,337. However, through the results of testing, it was noted that the balance should be $53,446. This exception did not involve the accuracy of the aging system but rather the validity of the accounts receivable balance for the group. The Company's estimate was too high as they were using incorrect premium amounts to calculate the groups' premium receivable. This was the only exception we noted during our testing; all other balances were properly stated and included in their respective aging buckets.

13. Obtain a summary of bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: Not applicable. No bad debt reserves for accounts receivable balances less than 90 days old are included in the accident and health premium due and unpaid line.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description	Balance
221000	Unearned Premium Direct	$(47,893)
221200	Unearned Premium Ceded	2,100
		$(45,794)

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	G/L Balance	Detail Balance	Difference
221000	Unearned Premium Direct	$(47,893)	$(47,893)	-
221200	Unearned Premium Ceded	2,100	2,100	-
		$(45,793)	$(45,793)	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Account Description	Accounts Receivable Balance	Premiums Received in Advance
121100	Uncollected Premium Direct	$ 2,771,160	$ (47,893)

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. No debit balances were noted within the unearned premium detail.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from each detailed listing and performed the above procedures without exception. See Attachment B for further details.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: This is not applicable to the Life of New York Company.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: This is not applicable to the Life of New York Company.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not Applicable. Aggregate policy reserves were covered in our actuarial certification of the Company's reserves submitted to the Insurance Department; therefore they have not been tested as part of this agreed upon procedures report.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not Applicable. Aggregate policy reserves were covered in our actuarial certification of the Company's reserves submitted to the Insurance Department; therefore they have not been tested as part of this agreed upon procedures report.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Group Number	Total AR Balance
890746 0010	15,581
891037 0010	1,364
893190 0010	4,401
893208 0010	4,252
893234 0010	10,746
893269 0010	5,066
893274 0010	1,585
893181 0010	419
893234 0010	2,229
893181 0010	6,301
893190 0010	3,002
893265 0010	2,638
893274 0010	1,137
893190 0010	3,051
893207 0010	96,337
893208 0010	2,411
893142 0010	56,659
893195 0010	11,654
893220 0010	21,909
893237 0010	8,314

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Group Number	Period Pre-Paid	Unearned Premium
890142 0010	January, 2004	356
890751 0010	January, 2004	1,257
890751 0010	January, 2004	806
893124 0010	Jan & Feb, 2004	13,075
893161 0010	Jan - July, 2004	8,190
893161 0010	Jan - July, 2004	886
893161 0020	Jan - July, 2004	3,844
893210 0010	Jan & Feb, 2004	1,775
893210 0010	January, 2004	323
893226 0010	January, 2004	824
893244 0010	January, 2004	114
893244 0010	January, 2004	2,624
893244 0010	January, 2004	1,895
893244 0010	January, 2004	859
893256 0010	January, 2004	927
890454 0010	January, 2004	590
893131 0010	January, 2004	244
893154 0010	January, 2004	3,703
893227 0010	January, 2004	478
893242 0010	January, 2004	794

Highmark Casualty Insurance Company

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Report of Independent Accountants

To the Board of Directors
of Highmark Casualty Insurance Company

We have performed the procedures enumerated below related to Highmark Casualty Insurance Company, which were agreed to by Highmark Inc. (the "Company"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Company. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 15,972,335
Less: Unapplied cash	(121,785)
Non-admitted receivables	(58,889)
Allowance for doubtful accounts	-
Miscellaneous debits (credits)	(9,932,361)
Accident and Health Premiums Due and Unpaid	$ 5,859,300

Results:
The miscellaneous debits/(credits) consists of one credit balance totaling ($9,932,3610) which represents the GAAP to STAT adjustment for the workers' compensation receivable at December 31, 2003. For GAAP purposes, the accounts receivable for workers' compensation is composed of premium written, less premium earned. For STAT purposes, the receivable consists of premium billed, less premium earned. This $9.9 Million credit balance represents the difference between the total premium written and the total premium billed at December 31, 2003.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Account Description	Balance
121100	Uncollected Premium Direct	$ 15,930,863
121250	Uncollected Premium Assumed	41,472
		$ 15,972,335

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	Balance per GL	Balance per Aging	Difference
121100	Uncollected Premium Direct	$ 15,930,863	$ 1,283,631	14,647,232
121250	Uncollected Premium Assumed	41,473	-	41,473
		$ 15,972,336	$ 1,283,631	

Note: Refer to step 5 for an explanation of the accounts that are not supported by an Aging.

Results: Aging Reports were obtained for accounts 121100. We compared the account balance, per the general ledger, to the aging report, noting the following exceptions:

<u>Account 121100</u>
The Company provided a reconciliation between the general ledger and the aging report, which included 2 major reconciling items totaling $14,080,856. The Company provided support for the two items as follows: 1) $11,662,917 related to workers' compensation written in PA and NJ. This amount represents premium written, which is grossed up at year-end to reflect the true receivable from these LOB's based on the policy life. We agreed this amount to detail of written premium in PA and NJ and recalculated the amount without exception; 2) $2,417,939 related to a form of employers' liability insurance the Company began writing in Texas in the fourth quarter of 2003. This amount agreed to the detailed schedule provided by Combined Independent Agencies (CIA), the TPA that administers this LOB.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

		Aging Category				
Acct.	Description	0-30	31-60	61-90	90+	Total
121100	Uncollected Premium Direct	966,682	220,166	37,894	58,889	1,283,631

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results:

Account 121100
As discussed in step 3, a majority of the balance in account 121100 totaling $14,647,232 is not supported by a detailed aging report. The company provided a reconciliation between the general ledger balance and the detailed schedule supporting the portion not supported by an aging report. Refer to the results within step 3 for documentation of detail provided.

Account 121250
The entire balance in account 121250 totaling $41,473 is not supported by a detailed aging report. This balance is not supported by an aging report, as it is ceded premium receivable from a group where the Company was the reinsurer. We traced and agreed this amount to detail, noting no reconciling items, individually, or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. No credit balances were noted in the gross accounts receivable balances.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Account Description	Balance
288200	Unapplied Cash	$ 34,164
288200	Unapplied Lock Box	87,621
		$ 121,785

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Account Description	Balance	Cash
121100	Uncollected Premium Direct	$ 15,930,863	$ (121,785)
121250	Uncollected Premium Assumed	41,473	
		$ 15,972,336	$ (121,785)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results:

Account 288000
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

Account 288200
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. No debit balances were noted in the unapplied cash accounts.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Over 90 Day Balance per Aging Report	$	(58,889)
Non-admitted receivable balance per Annual Statement		(58,889)
Non-admitted receivable balance (over)/under 90+ day balance		-
Bad debt reserve		-
Non-admitted receivable balance (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		112,197
Deficiency/(excess)	$	112,197

Results: The Corporation's process for recording non-admitted receivables is to evaluate and classify as non-admitted those accounts receivable balances over 90 days old.

Life Company
The Corporation provided a summary of the non-admitted accounts receivable, which included a deficiency of $112,197. This amount represents those balances; that in accordance with SSAP 6; are less than 90 days old and deemed uncollectible.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results:

We selected a sample of 20 individual accounts receivable balances from the aging reports for LOBs noted in step 4 and performed the above procedures without exception. Of the 20 accounts receivable balances we tested, all were properly included in the respective aging bucket. See Attachment A for groups selected.

13. Obtain a summary of bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: Not applicable. No bad debt reserves for accounts receivable balances less than 90 days old are included in the accident and health premium due and unpaid line.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Account Description	Balance
221000	Unearned Premium Direct	$ 19,682,702
221200	Unearned Premium Ceded	(2,025,301)
221202	Unearned Premium Ceded - L/C	(173,642)
221500	Unearned Premium Assumed	106
		$ 17,483,865

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	G/L Balance	Detail Balance	Difference
221000	Unearned Premium Direct	$(19,682,702)	$(19,682,702)	-
221200	Unearned Premium Ceded	2,025,301	2,025,301	-
221202	Unearned Premium Assumed – L/C	173,642	173,642	-
221500	Unearned Premium Assumed	(106)	(106)	-
		$(17,483,865)	$(17,483,865)	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Account Description	A/R Balance	Premiums Received in Advance
121100	Uncollected Premium Direct	$ 15,930,863	$ (17,483,758)
121250	Uncollected Premium Assumed	41,473	(106)
		$ 15,972,336	$ (17,483,864)

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. No debit balances were noted within the unearned premium detail.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results:

221000
PwC selected a sample of 20 individual cash receipts from each detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

221200
No sample was tested for 221200. This amount is calculated by applying a ceding rate by the amount of related unearned premium as recorded in 221000.

221202
No sample was selected for 221202. This amount eliminates in consolidation with a corresponding amount on Life Co.

221500
No sample was selected for 221500.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: This is not applicable to the Casualty Company.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: This is not applicable to the Casualty Company.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: This is not applicable to the Casualty Company.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: This is not applicable to the Casualty Company.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Group Number	Total AR Balance
2982PA	10,455
3915PA	1,390
4383PA	3,791
4441PA 0014	455
4441PA 0020	607
4444PA	2,584
990077 0010	9,536
990124 0010	1,918
990190 0010	2,603
2262PA	46,269
2682PA	16,096
400040 0010	12,018
4315PA-02	2,686
4409PA	12,319
912324 0010	20,520
990069 0010	52,748
990080 0010	43,879
990107 0010	43,615
990160 0010	14,330
990190 0010	12,743

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Group Number	Invoice/ Policy Date	Unearned Premium
HCPA000011	7/1/03	20,809
HCPA000018	7/1/03	30,988
HMPAW000058-03	7/1/03	96,363
HMPAW000103-02	7/1/03	209,819
HMPAW000008-03	8/31/03	49,638
HMPAW000179	9/30/03	33,456
HCPA000051	10/1/03	25,981
HMPAW000109-02	10/22/03	41,256
HMNJW510265-02	4/23/03	31,040
HMPAW520049-02	6/1/03	55,917
HMPAW520188	6/19/03	34,849
HMNJW510314-02	6/30/03	7,153
HMPAW520128-03	7/1/03	19,347
HMNJW510089-03	8/1/03	82,704
HMPAW520142-03	10/15/03	34,752
990144 0010	1/1/04	1,457
990180 0010	1/1/04	2,294
2943PA	1/1/04	21,938
4306PA	2/1/04	12,576
990102 0010	1/1/04	27,855

United Concordia Companies, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Companies, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	19,413,223
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		(1,254,451)
Miscellaneous debits / (credits)		-
Uncollected premiums and agents' balances in the course of collection	$	18,158,772

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description		Balance
120401	A/R - Direct Pay	$	3,141,768
130101	A/R - TDP		16,204,426
130201	A/R - Oconus		67,029
		$	19,413,223

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. The accounts receivable balances in step 2 above are not supported by an aging report.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Results: Not applicable. The accounts receivable balances in step 2 above are not supported by an aging report.

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detailed Schedule	Difference
120401	A/R - Direct Pay	$ 3,141,768	$ 3,141,768	-
130101	A/R - TDP	16,204,426	16,204,426	-
130201	A/R - Oconus	67,029	67,029	-
		$ 19,413,223	$ 19,413,223	

Results:

Account 120401
The Company provided a reconciliation of the general ledger balance to the detailed support. The Company explained that there is an aging report available; however, the Company stated that the aging report is not valid and is not used for financial reporting purposes.

Account 130101
The Company provided a reconciliation of the general ledger balance to the detailed support. The Company explained that there is no aging report available for this balance because this receivable amount is based on the membership files of Tri-Care Management Activity, the administrator of the TDP contract, which generates an invoice and pays the premium on a monthly basis. The Company also explained that the amount is current and provided support for the collection of the balance in January 2004.

Account 130201
The Company provided a reconciliation of the general ledger balance to the detailed support. The Company explained that there is no aging report available because the billing and collection process is manual.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the accounts receivable balances in step 2 above.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: There are no non-admitted receivable balances included in the accident and health premiums due and unpaid line in the Annual Statement. See step 13 for explanation of the bad debt reserve recorded by the Company.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: Not applicable. The accounts receivable balances in step 2 above are not supported by an aging report. The Company did explain that there is an aging report for account 120401; however, the Company stated that the aging is not valid and therefore, the aging report was not tested.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: The Company has recorded a bad debt reserve related to account 120401 in the amount of $1,254,451. The Company explained that the bad debt reserve represents 90% of the receivable balances over 60 days old and 25% of the receivable balances under 60 days old.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company explained that the accounts receivable balances are not supported by a detailed aging report.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** The bad debt reserve of $1,254,451 calculated as a percentage of account 120401 is approximately 39.9%.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320001	Unearned Subscription Revenue - FFS	$	9,953,055
320101	Unearned Subscription Revenue - DHMO		22,670
320201	Unearned Subsription Revenue - ASO		30,766
320601	Unearned Subscription Revenue - Direct Pay		3,276,478
321101	Unapplied Cash		32,093
321301	Unapplied Cash - Direct Pay		778,689
125003	A/R Cash in Transit - TDP		252,537
		$	14,346,288

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description		General Ledger Balance		Balance per Detailed Schedule	Difference
320001	Unearned Subscription Revenue - FFS	$	9,953,055	$	9,953,055	-
320101	Unearned Subscription Revenue - DHMO		22,670		22,670	-
320201	Unearned Subsription Revenue - ASO		30,766		30,766	-
320601	Unearned Subscription Revenue - Direct Pay		3,276,478		3,276,478	-
321101	Unapplied Cash		32,093		32,093	-
321301	Unapplied Cash - Direct Pay		778,689		778,689	-
125003	A/R Cash in Transit - TDP		252,537		252,537	-
		$	14,346,288	$	14,346,288	

Account 320001 represents an advance payment from Tri-Care Management Activity for January 2004 portion of the premium payment deducted from the covered members paychecks. The Company provided support for the cash payment received in December 2003.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable Balance	Premiums Received in Advance
120401	A/R - Direct Pay	$ 3,141,768	$ 3,276,478
130101	A/R - TDP	16,204,426	N/A
130201	A/R - Oconus	67,029	N/A
		$ 19,413,223	$ 3,276,478

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. There are no debit balances included in the premiums received in advance account balances.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results:

Account 320001
This balance represents a cash payment received from Tri-Care Management Activity for the member's portion of the monthly premium deducted from payroll. The Company provided supporting documentation for the cash receipt in December 2003.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

United Concordia Life and Health Insurance Company

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Life and Health Insurance Company, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	27,443,215
Less: Unapplied cash		(906,885)
Non-admitted receivables		-
Allowance for doubtful accounts		(1,007,214)
Miscellaneous debits / (credits)		(15,415,881)
Accident and health premiums due and unpaid	$	10,113,235

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period of $(13,176,092), net of reinsurance of $2,239,789, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance. In addition, there is a credit related to ceded accounts receivable under a reinsurance agreement with the Company's parent, United Concordia Life and Health Insurance Company.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description		Balance
120101	A/R - FFS	$	22,444,800
120201	A/R - DHMO		3,345
120401	A/R - Direct Pay		23,622
120501	A/R Subscription Revenue - Reinsurance Assumed		1,459,246
120502	A/R Subscription Revenue - Reinsurance Assumed UCIC		3,512,202
		$	27,443,215

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description		Balance	Aging Balance	Difference
120101	A/R - FFS	$	22,444,800		
120201	A/R - DHMO		3,345		
			22,448,145	22,448,145	-
120401	A/R - Direct Pay		23,622	N/A	N/A
120501	A/R Subscription Revenue - Reinsurance Assumed		1,459,246	N/A	N/A
120502	A/R Subscription Revenue - Reinsurance Assumed UCIC		3,512,202	N/A	N/A
		$	49,891,360		

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
6,376,506	12,685,282	1,992,564	386,579	1,007,214	22,448,145

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: The Company provided a reconciliation between the general ledger and the detailed schedule for accounts 120401, 120501 and 120502. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120101	A/R - FFS	$ 22,444,800	
120201	A/R - DHMO	3,345	
		22,448,145	(110,661)
120401	A/R - Direct Pay	23,622	-
120501	A/R Subscription Revenue - Reinsurance Assumed	1,459,246	-
120502	A/R Subscription Revenue - Reinsurance Assumed UCIC	3,512,202	-
		$ 49,891,360	$ (110,661)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (906,885)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120101	A/R - FFS	$ 22,444,800	
120201	A/R - DHMO	3,345	
		22,448,145	(906,885)
120401	A/R - Direct Pay	23,622	-
120501	A/R Subscription Revenue - Reinsurance Assumed	1,459,246	-
120502	A/R Subscription Revenue - Reinsurance Assumed UCIC	3,512,202	-
		$ 49,891,360	$ (906,885)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $1,007,214 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $1,007,214, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	1,007,214
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		1,007,214
Bad debt reserve		(1,007,214)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $1,007,214 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320001	Unearned Subscription Revenue - FFS	$ 19,485,314
320501	Unearned Subscription Revenue - Reinsurance Assumed	1,439,717
320502	Unearned Subscription Revenue - Reinsurance Assumed UCIC	3,430,606
320601	Unearned Subscription Revenue - Direct Pay	20,028
321101	Unapplied Cash	651,645
321301	Unapplied Cash - Direct Pay	141,486
		$ 25,168,796
	Reclass to accounts receivable (see step 1)	(15,415,881)
		$ 9,752,915

Note: The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320001	Unearned Subscription Revenue - FFS	$ 19,485,314	$ 19,485,314	-
320501	Unearned Subscription Revenue - Reinsurance Assumed	1,439,717	1,439,717	-
320502	Unearned Subscription Revenue - Reinsurance Assumed UCIC	3,430,606	3,430,606	-
320601	Unearned Subscription Revenue - Direct Pay	20,028	20,028	-
321101	Unapplied Cash	651,645	651,645	-
321301	Unapplied Cash - Direct Pay	141,486	141,486	-
		$ 25,168,796	$ 25,168,796	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120101	A/R - FFS	$ 22,444,800	$ 19,485,314
120201	A/R - DHMO	3,345	-
120401	A/R - Direct Pay	23,622	20,028
120501	A/R Subscription Revenue - Reinsurance Assumed	1,459,246	1,439,717
120502	A/R Subscription Revenue - Reinsurance Assumed UCIC	3,512,202	3,430,606
		$ 27,443,215	$ 24,375,665

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320001	Unearned Subscription Revenue - FFS	$ 19,485,314	$ (119,895)
320501	Unearned Subscription Revenue - Reinsurance Assumed	1,439,717	-
320502	Unearned Subscription Revenue - Reinsurance Assumed UCIC	3,430,606	-
320601	Unearned Subscription Revenue - Direct Pay	20,028	-
321101	Unapplied Cash	651,645	-
321301	Unapplied Cash - Direct Pay	141,486	-
		$ 25,168,796	$ (119,895)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011927037	11/05/2003	208.00	30-59
011773223	08/05/2003	1527.56	> 90
011890491	11/01/2003	5585.59	30-59
011872121	10/03/2003	256.55	60-89
011973052	12/03/2003	742.49	0-29
011893599	11/01/2003	596.43	30-59
011939963	12/01/2003	7070.88	0-29
011890420	11/01/2003	2068.40	30-59
011940000	12/01/2003	11048.69	0-29
0101593260	03/21/2002	169.66	> 90
011889827	11/01/2003	23446.99	30-59
011939727	12/01/2003	6907.26	0-29
011939851	12/01/2003	40531.44	0-29
010131560	10/01/2001	218.86	> 90
011838132	10/02/2003	11246.87	30-59
009971860	08/01/2001	241.17	> 90
011893180	11/01/2003	448.23	30-59
011973562	12/03/2003	853.27	0-29
011939565	12/01/2003	14211.27	0-29
011927037	11/05/2003	208.00	30-59

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011939646	31,732.55
011939647	9,800.19
011939648	11,058.93
011939672	1,693.96
011939673	12,742.70
011939674	14,325.61
011939679	146,859.60
011939680	7,443.53
011939681	189.54
011939682	19,018.58
011939683	3,859.56
011939684	237.57
011939685	1,251.08
011942653	1,684.47
011966951	100.00
011966952	105.35
011966975	560.63
011966976	1,306.87
011966977	574.40
011966978	195.49

United Concordia Insurance Company

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Insurance Company, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 8,276,358
Less: Unapplied cash	(754,474)
Non-admitted receivables	-
Allowance for doubtful accounts	(497,481)
Miscellaneous debits / (credits)	(5,751,991)
Accident and health premiums due and unpaid	$ 1,272,412

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period of $(4,479,578), net of reinsurance of $2,239,789, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance. In addition, there is a credit related to ceded accounts receivable under a reinsurance agreement with the Company's parent, United Concordia Life and Health Insurance Company.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120101	A/R - FFS	$ 8,225,540
120201	A/R - DHMO	9,035
120401	A/R - Direct Pay	41,783
		$ 8,276,358

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120101	A/R - FFS	$ 8,225,540		
120201	A/R - DHMO	9,035		
		$ 8,234,575	$ 8,234,575	-
120401	A/R - Direct Pay	$ 41,783	N/A	N/A

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
1,473,378	4,614,720	866,069	782,927	497,481	8,234,575

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120101	A/R - FFS	$ 8,225,540	$ (25,574)
120201	A/R - DHMO	9,035	-
120401	A/R - Direct Pay	41,783	-
		$ 8,276,358	$ (25,574)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (754,474)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120101	A/R - FFS	$ 8,225,540	
120201	A/R - DHMO	9035	
		$ 8,234,575	$ (754,474)
120401	A/R - Direct Pay	$ 41,783	-

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

> ***Results:*** Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

> ***Results:*** The over 90 day balance of $497,481 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $497,481, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	497,481
Non-admitted receivable balance per Annual Statement	-
Non-admitted balance (over)/under 90+ day balance	497,481
Bad debt reserve	(497,481)
Non-admitted/bad debt reserve (over)/under 90+ day balance	-
Receivables less than 90 days old requiring non-admission	-
Non-admitted/bad debt reserve deficiency/(excess)	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $497,481 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320001	Unearned Subscription Revenue - FFS	$ 6,433,216
320101	Unearned Subscription Revenue - DHMO	137
320510	Unearned Subscription Revenue - Reinsurance Ceded	(3,430,606)
320601	Unearned Subscription Revenue - Direct Pay	29,612
321101	Unapplied Cash	387,600
321301	Unapplied Cash - Direct Pay	10,647
		3,430,606
	Reclass to accounts receivable (see step 1)	(2,239,789)
		$ 1,190,817

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320001	Unearned Subscription Revenue - FFS	$ 6,433,216	$ 6,433,216	-
320101	Unearned Subscription Revenue - DHMO	137	137	-
320510	Unearned Subscription Revenue - Reinsurance Cede	(3,430,606)	(3,430,606)	-
320601	Unearned Subscription Revenue - Direct Pay	29,612	29,612	-
321101	Unapplied Cash	387,600	387,600	-
321301	Unapplied Cash - Direct Pay	10,647	10,647	-
		$ 3,430,606	$ 3,430,606	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received in Advance
120101	A/R - FFS	$ 8,225,540	
120201	A/R - DHMO	9,035	
		$ 8,234,575	$ 6,433,353
120401	A/R - Direct Pay	$ 41,783	$ 29,612

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Balance
320001	Unearned Subscription Revenue - FFS	$ 6,433,216	
320101	Unearned Subscription Revenue - DHMO	137	
		6,433,353	(167,469)
320510	Unearned Subscription Revenue - Reinsurance Ceded	(3,430,606)	-
320601	Unearned Subscription Revenue - Direct Pay	29,612	-
321101	Unapplied Cash	387,600	-
321301	Unapplied Cash - Direct Pay	10,647	-
		$ 3,430,606	$ (167,469)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

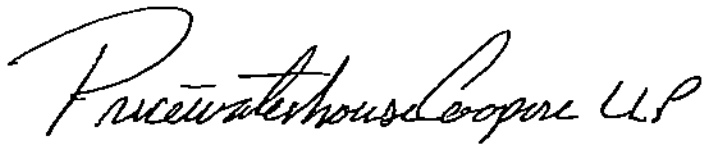
> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.



March 29, 2004

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011928842	11/07/2003	3577.83	30-59
010673516	05/01/2002	930.45	> 90
011926412	11/05/2003	243.35	30-59
011864762	10/03/2003	1175.30	60-89
011976198	12/05/2003	8712.15	0-29
011916446	11/03/2003	773.15	30-59
011976156	12/05/2003	1481.69	0-29
011889768	11/03/2003	159.88	30-59
011941387	12/01/2003	112.98	0-29
011206003	11/05/2002	2293.52	> 90
011889367	11/01/2003	3254.76	30-59
011939379	12/01/2003	3540.11	0-29
011963198	12/03/2003	7865.18	0-29
011806909	09/02/2003	127.26	> 90
011829351	09/20/2003	341.40	60-89
011934467	11/21/2003	373.75	0-29
011809118	09/02/2003	2315.34	> 90
011939152	12/01/2003	5215.50	0-29
011966128	12/03/2003	155.05	0-29
011966121	12/03/2003	412.60	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011977935	$ 383.49
011938996	$ 13,947.36
011938998	$ 18,985.43
011976957	$ 1,969.38
011938333	$ 708.01
011983805	$ 231.12
011978043	$ 2,566.00
011939019	$ 34,045.69
011978058	$ 240.81
011978061	$ 4,850.25
011943190	$ 1,275.51
011975452	$ 28,336.16
011978086	$ 11,508.79
011978175	$ 7,085.94
011978180	$ 320.24
011939043	$ 254.74
011978220	$ 63.50
011939044	$ 2,376.64
011939045	$ 3,075.85
011939046	$ 1,156.87

United Concordia Insurance Company of New York

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Insurance Company of New York, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	342,145
Less: Unapplied cash		(17,663)
Non-admitted receivables		-
Alowance for doubtful accounts		(14,648)
Miscellaneous debits / (credits)		(200,980)
Accident and health premiums due and unpaid	$	108,854

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - FFS	$ 342,145

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - FFS	$ 342,145	$ 342,145	-

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
58,755	233,493	21,936	13,313	14,648	342,145

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** Not applicable. The gross accounts receivable balance is supported by an aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 342,145	$ (599)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (17,663)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 342,145	$ (17,663)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $14,648 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $14,648, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	14,648
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		14,648
Bad debt reserve		(14,648)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $14,648 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	421,981
321101	Unapplied Cash		110,589
			532,570
	Reclass to accounts receivable (see step 1)		(200,980)
		$	331,590

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description		General Ledger Balance		Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$	421,981	$	421,981	-
321101	Unapplied Cash		100,589		100,589	-
		$	522,570	$	522,570	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 342,145	$ 421,981

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 421,981	$ (4,103)
321101	Unapplied Cash	110,589	-
		$ 532,570	$ (4,103)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011926582	11/05/2003	230.50	30-59
011740353	08/01/2003	161.20	> 90
011926737	11/05/2003	160.45	30-59
011835116	10/02/2003	3972.30	60-89
011963211	12/03/2003	342.40	0-29
011926547	11/05/2003	126.35	30-59
011975586	12/05/2003	1538.35	0-29
01188802	10/29/2003	254.45	60-89
011975570	01/01/2004	1473.90	0-29
011821257	10/01/2003	117.45	> 90
011926564	10/29/2003	107.00	60-89
011976593	12/05/2003	1360.89	0-29
011975580	12/05/2003	4742.76	0-29
011060056	09/05/2002	190.40	> 90
011874894	10/05/2003	189.50	30-59
011926489	11/05/2003	545.75	0-29
011725678	07/05/2003	275.85	> 90
011976289	12/05/2003	249.90	0-29
011976465	12/05/2003	371.70	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011966375	$ 153.65
011976246	$ 121.80
011976247	$ 332.08
011976248	$ 182.85
011976249	$ 82.34
011976250	$ 1,843.16
011942115	$ 125.67
011942147	$ 5,619.55
011976255	$ 306.27
011942148	$ 276.38
011942149	$ 734.87
011942150	$ 735.50
011942151	$ 213.39
011942176	$ 99.12
011942177	$ 147.66
011942178	$ 121.37
011942179	$ 796.22
011942180	$ 240.75
011942181	$ 150.50
011942182	$ 89.24

United Concordia Dental Plans, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	4,395,393
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		(635,429)
Miscellaneous debits / (credits)		(2,948,085)
Accident and health premiums due and unpaid	$	811,879

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 3,420,601
120401	A/R - Direct Pay	974,792
		$ 4,395,393

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 3,420,601	$ 3,420,601	-
120401	A/R - Direct Pay	974,792	N/A	N/A
		$ 4,395,393	$ 3,420,601	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
94,044	2,011,054	574,304	105,770	635,429	3,420,601

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 3,420,601	$ (40,534)
120401	A/R - Direct Pay	974,792	-
		$ 4,395,393	$ (40,534)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

> ***Results:*** Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 3,420,601	$ -
120401	A/R - Direct Pay	974,792	-
		$ 4,395,393	$ -

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $635,429 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $635,429, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$ 635,429
Non-admitted receivable balance per Annual Statement	-
Non-admitted balance (over)/under 90+ day balance	635,429
Bad debt reserve	(635,429)
Non-admitted/bad debt reserve (over)/under 90+ day balance	-
Receivables less than 90 days old requiring non-admission	-
Non-admitted/bad debt reserve deficiency/(excess)	$ -

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $635,429 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	2,160,443
320601	Unearned Subscription Revenue - Direct Pay		1,674,129
321101	Unapplied Cash		83,335
321301	Unapplied Cash - Direct Pay		14,163
125001	A/R - Cash In Transit		838,860
			4,770,930
	Reclass to accounts receivable (see step 1)		(2,948,085)
		$	1,822,845

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance		Balance per Detail		Difference
320101	Unearned Subscription Revenue - DHMO	$	2,160,443	$	2,160,443	-
320601	Unearned Subscription Revenue - Direct Pay		1,674,129		1,674,129	-
321101	Unapplied Cash		83,335		83,335	-
321301	Unapplied Cash - Direct Pay		14,163		14,163	-
125001	A/R - Cash In Transit		838,860		838,860	-
		$	4,770,930	$	4,770,930	

Account 125001 was agreed to a reconciliation provided by the Company and no reconciling items were noted.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 3,420,601	$ 2,160,443
120401	A/R - Direct Pay	974,792	1,674,129
		$ 4,395,393	$ 3,834,572

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 2,160,443	$ (1,387)
320601	Unearned Subscription Revenue - Direct Pay	1,674,129	-
321101	Unapplied Cash	83,335	-
321301	Unapplied Cash - Direct Pay	14,163	-
125001	A/R - Cash In Transit	838,860	N/A
		$ 4,770,930	$ (1,387)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011887427	10/26/2003	10950.37	30-59
010926514	08/02/2002	297.38	> 90
011893598	11/01/2003	647.41	30-59
011873674	10/03/2003	180.05	60-89
011963981	12/03/2003	561.15	0-29
011913731	11/03/2003	112.60	30-59
011975407	12/05/2003	760.55	0-29
011926237	11/05/2003	163.60	30-59
011975900	12/05/2003	710.50	0-29
009326868	11/08/2003	349.42	> 90
011914396	11/03/2003	308.40	30-59
011964121	12/03/2003	444.50	0-29
011964105	12/03/2003	310.50	0-29
010587492	03/05/2003	137.52	> 90
011862718	10/03/2003	335.46	60-89
011887449	10/26/2003	273.42	30-59
011811980	09/03/2003	108.70	> 90
011943266	12/01/2003	3383.75	0-29
011963316	12/03/2003	191.60	0-29
011943365	12/01/2003	637.65	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011963282	94.50
011963283	87.18
011963284	8.70
011963285	303.14
011963286	22.80
011963287	6.85
011963288	103.05
011963289	73.85
011963290	332.79
011913631	68.40
011963291	29.39
011963292	1,737.15
011975382	2,168.92
011975383	1,298.65
011975384	1,075.30
011963333	82.60
011963334	403.18
011963335	327.95
011963336	143.72
011963337	211.10

United Concordia Dental Corporation of Alabama, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Corporation of Alabama, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	160,074
Less: Unapplied cash		(7,753)
Non-admitted receivables		-
Allowance for doubtful accounts		(45,069)
Miscellaneous debits / (credits)		(86,337)
Accident and health premiums due and unpaid	$	20,915

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120101	A/R - FFS	$ 159,289
120401	A/R - Direct Pay	785
		$ 160,074

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120101	A/R - FFS	$ 159,289	$ 159,289	-
120401	A/R - Direct Pay	785	N/A	N/A
		$ 160,074	$ 159,289	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
38,638	63,116	11,972	494	45,069	159,289

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120101	A/R - FFS	$ 159,289	$ (211)
120401	A/R - Direct Pay	785	-
		$ 160,074	$ (211)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (7,753)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120101	A/R - FFS	$ 159,289	$ (7,753)
120401	A/R - Direct Pay	785	-
		$ 160,074	$ (7,753)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $45,069 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $45,069, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	45,069
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		45,069
Bad debt reserve		(45,069)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $45,069 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320001	Unearned Subscription Revenue - FFS	$	137,231
320101	Unearned Subscription Revenue - DHMO		2,267
320601	Unearned Subscription Revenue - Direct Pay		2,002
321101	Unapplied Cash		13,692
321301	Unapplied Cash - Direct Pay		113
			155,305
	Reclass to accounts receivable (see step 1)		(86,337)
		$	68,968

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description		General Ledger Balance		Balance per Detail	Difference
320001	Unearned Subscription Revenue - FFS	$	137,231			
320101	Unearned Subscription Revenue - DHMO		2,267			
		$	139,498	$	139,498	-
320601	Unearned Subscription Revenue - Direct Pay		2,002		2,002	-
321101	Unapplied Cash		13,692		13,692	-
321301	Unapplied Cash - Direct Pay		113		113	-
		$	155,305	$	155,305	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received in Advance
120101	A/R - FFS	$ 159,289	$ 137,231
120201	A/R - DHMO	785	2,267
		160,074	139,498
120401	A/R - Direct Pay	10,295	2,002
		$ 170,369	$ 141,500

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320001	Unearned Subscription Revenue - FFS	$ 137,231	
320101	Unearned Subscription Revenue - DHMO	2,267	
		$ 139,498	$ -
320601	Unearned Subscription Revenue - Direct Pay	2,002	-
321101	Unapplied Cash	13,692	-
321301	Unapplied Cash - Direct Pay	113	-
		$ 155,305	$ -

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011925982	11/05/2003	22.30	30-59
011343349	01/05/2003	349.00	> 90
011925948	11/05/2003	69.97	30-59
011862347	10/03/2003	49.83	60-89
011997572	12/05/2003	2748.76	0-29
011926034	11/05/2003	37.20	30-59
011975736	12/05/2003	113.47	0-29
011925588	11/05/2003	3445.85	30-59
011975746	12/05/2003	431.55	0-29
011058352	11/05/2003	366.24	> 90
011926049	11/05/2003	291.35	30-59
011926018	11/05/2003	2067.00	30-59
011975778	12/05/2003	641.70	0-29
011820535	09/06/2003	379.78	> 90
011862346	10/03/2003	23.70	60-89
011975723	12/05/2003	115.34	0-29
011419510	02/12/2003	156.02	> 90
011914094	11/03/2003	269.75	30-59
011963750	12/03/2003	1148.40	0-29
011925966	11/05/2003	232.98	30-59

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011975360	848.21
011975361	169.31
011975362	7,179.51
011938921	1,582.59
011975366	1,532.95
011975367	1,438.18
011975711	46.80
011975712	151.75
011975713	46.80
011975714	37.50
011975715	106.55
011975716	27.30
011975717	328.80
011975721	1,614.90
011975722	1,023.88
011975724	58.00
011975725	448.35
011975726	299.24
011975747	1,045.28
011975748	334.62

United Concordia Dental Plans of Arizona, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Arizona, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 8,973
Less: Unapplied cash	210
Non-admitted receivables	-
Allowance for doubtful accounts	-
Miscellaneous debits / (credits)	(8,121)
Accident and health premiums due and unpaid	$ 1,062

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 8,973

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 8,973	$ 8,973	-

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
910	7,097	966	-	-	8,973

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The gross accounts receivable balance is supported by an aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the gross accounts receivable balance.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

> ***Results:*** Not applicable. There are no non-admitted accounts receivable balances as the Company does not have any accounts receivable balances over 90 days old.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320101	Unearned Subscription Revenue - DHMO	$ 8,795
321101	Unapplied Cash	795
		$ 9,590
	Reclass to accounts receivable (see step 1)	(8,121)
		$ 1,469

Note: The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 8,795	$ 8,795	
321101	Unapplied Cash	795	795	
		$ 9,590	$ 9,590	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 8,973	$ 8,795

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. There are no debit balances included in account 120201.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011943187	12/01/2003	1498.85	0-29
011940193	12/01/2003	28.18	0-29
011978415	12/07/2003	637.66	0-29
011978282	12/07/2003	223.38	0-29
011940189	12/01/2003	143.08	0-29
011943165	12/01/2003	2919.70	0-29
000011802	12/07/2003	136.36	0-29
011978262	12/07/2003	299.44	0-29
011928364	11/07/2003	137.40	30-59
011978134	12/07/2003	137.40	0-29
011928487	11/07/2003	28.14	30-59
011978257	12/7/2003	28.14	0-29
011927484	11/07/2003	800.83	30-59
011977299	12/06/2003	926.14	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011978222	30.50
011978554	179.80
011938922	365.31
011940188	52.69
011940191	45.06

United Concordia Dental Plans of California, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of the California, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 3,768,935
Less: Unapplied cash	(192,271)
Non-admitted receivables	-
Allow ance for doubtful accounts	(186,417)
Miscellaneous debits / (credits)	30,080
Accident and health premiums due and unpaid	$ 3,420,327

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit balance represents the net amount due from providers and subscribers for claim overpayments. The California Department of Managed Health Care requires health maintenance organizations domiciled in California to file annual financial statements in accordance with generally accepted accounting principles and does not require the filing of a statutory annual statement.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 3,722,627
120401	A/R - Direct Pay	46,308
		$ 3,768,935

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 3,722,627	$ 3,722,627	-
120401	A/R - Direct Pay	46,308	N/A	N/A
		$ 3,768,935	$ 3,722,627	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
1,193,881	1,531,300	776,693	81,460	139,293	3,722,627

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** Not applicable. There are no credit balances included in the gross accounts receivable balance.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (192,271)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 3,722,627	$ (192,271)
120401	A/R - Direct Pay	46,308	-
		$ 3,768,935	$ (192,271)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: Not applicable. As noted in step 1 above, the California Department of Managed Health Care requires health maintenance organizations domiciled in California to file financial statements in accordance with generally accepted accounting principles rather than statutory accounting principles. Non-admitted receivables are a statutory concept and, therefore, no such amount has been recorded against the Company's accounts receivable balance.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $186,417 has been recorded by the Company as noted in the below table. The bad debt reserve related to account 120201 represents 100% of the over 90 day balance plus $40,000 for a reserve related to a specific customer account. The bad debt reserve related to account 120401 is based on historical collections.

Acct. #	Acct. Description	Balance	Bad Debt Reserve
120201	A/R - DHMO	$ 3,722,627	$ (179,293)
120401	A/R - Direct Pay	46,308	(7,124)
		$ 3,768,935	$ (186,417)

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Account 120201 is supported by and aging report. The bad debt reserve represents 100% of the over 90 day balance plus a reserve totaling $40,000 for a specific customer account. The Company does not base the bad debt reserve on a percentage of the aging categories other than the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** The bad debt reserve related to account 120401 represents approximately 15.4% of the receivable balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	2,584,252
320601	Unearned Subscription Revenue - Direct Pay		17,617
321101	Unapplied Cash		125,790
321301	Unapplied Cash - Direct Pay		2,492
			2,730,151
	Reclass to accounts receivable (see step 1)		-
		$	2,730,151

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 2,584,252	$ 2,584,252	-
320601	Unearned Subscription Revenue - Direct Pay	17,617	17,617	-
321101	Unapplied Cash	125,790	125,790	-
321301	Unapplied Cash - Direct Pay	2,492	2,492	-
		$ 2,730,151	$ 2,730,151	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 3,722,627	$ 2,584,252
120401	A/R - Direct Pay	46,308	17,617
		$ 3,768,935	$ 2,601,869

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 2,584,252	$ (1,179)
320601	Unearned Subscription Revenue - Direct Pay	17,617	-
321101	Unapplied Cash	125,790	-
321301	Unapplied Cash - Direct Pay	2,492	-
		$ 2,730,151	$ (1,179)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011928336	11/07/2003	20621.69	30-59
01775487	08/07/2003	418.54	> 90
011927719	11/07/2003	10039.99	30-59
011875639	10/07/2003	269.73	60-89
011978431	12/07/2003	588.27	0-29
011927118	11/05/2003	65.15	30-59
011978327	12/07/2003	2781.25	0-29
011882897	11/21/2003	15405.17	30-59
011978532	12/07/2003	432.26	0-29
011744168	08/07/2003	364.88	> 90
011928590	11/07/2003	486.38	30-59
011927748	11/07/2003	85.63	30-59
011977469	12/07/2003	2281.71	0-29
011822584	09/07/2003	43.57	> 90
011829386	9/20/2003	2757.39	60-89
011978021	12/07/2003	47556.21	0-29
011678123	06/07/2003	99.60	> 90
011927520	11/07/2003	1067.51	30-59
011978054	12/07/2003	3655.48	0-29
011927816	11/07/2003	264.38	30-59

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011977309	$ 1,536.81
011977901	$ 842.23
011977904	$ 385.87
011977844	$ 115.29
011977925	$ 1,638.56
011977951	$ 179.28
011977845	$ 100.23
011977846	$ 76.90
011977847	$ 95.26
011977972	$ 811.41
011977286	$ 287.06
011978012	$ 117.36
011978015	$ 2,456.91
011983106	$ 57,624.28
011983008	$ 15,322.49
011978042	$ 2,701.75
011978057	$ 66.99
011978060	$ 275.39
011978085	$ 2,873.77
011978127	$ 1,401.01

United Concordia Dental Plans of Delaware, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Delaware, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	112,026
Less: Unapplied cash		(6,546)
Non-admitted receivables		-
Allowance for doubtful accounts		(29,743)
Miscellaneous debits / (credits)		(11,248)
Accident and health premiums due and unpaid	$	64,489

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 110,586
120401	A/R - Direct Pay	1,440
		$ 112,026

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 110,586	$ 110,586	-
120401	A/R - Direct Pay	1,440	N/A	N/A
		$ 112,026	$ 110,586	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
65,647	10,003	3,181	2,012	29,743	110,586

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 110,586	$ (207)
120401	A/R - Direct Pay	1,440	-
		$ 112,026	$ (207)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (6,546)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 110,586	$ (6,546)
120401	A/R - Direct Pay	1,440	-
		$ 112,026	$ (6,546)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $29,743 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $29,743, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	29,743
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		29,743
Bad debt reserve		(29,743)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $29,743 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	24,983
320601	Unearned Subscription Revenue - Direct Pay		2,454
321101	Unapplied Cash		5,381
321301	Unapplied Cash - Direct Pay		720
			33,538
	Reclass to accounts receivable (see step 1)		(11,248)
		$	22,290

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 24,983	$ 24,983	
320601	Unearned Subscription Revenue - Direct Pay	2,454	2,454	-
321101	Unapplied Cash	5,381	5,381	-
321301	Unapplied Cash - Direct Pay	720	720	-
		$ 33,538	$ 33,538	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 110,586	$ 24,983
120401	A/R - Direct Pay	1,440	2,454
		$ 112,026	$ 27,437

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 24,983	$ (72)
320601	Unearned Subscription Revenue - Direct Pay	2,454	-
321101	Unapplied Cash	5,381	-
321301	Unapplied Cash - Direct Pay	720	-
		$ 33,538	$ (72)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011889279	11/01/2003	671.00	30-59
011675441	06/06/2003	1090.05	> 90
011887683	10/26/2003	90.55	30-59
011833093	09/26/2003	122.38	60-89
011975883	12/05/2003	921.84	0-29
011925592	11/05/2003	253.56	30-59
011963785	12/03/2003	227.75	0-29
011914141	11/03/2003	277.40	30-59
011975369	12/05/2003	419.00	0-29
011525153	03/27/2003	146.10	> 90
011887697	09/26/2003	218.82	30-59
011975875	12/05/2003	278.80	0-29
011963769	12/03/2003	161.25	0-29
011723988	07/05/2003	1104.25	> 90
011773003	08/05/2003	1104.24	> 90
011975368	12/05/2003	680.56	0-29
011525152	03/27/2003	48.40	> 90
011811526	09/03/2003	70.80	> 90
011977016	12/05/2003	120.76	0-29
011963777	12/03/2003	85.35	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011975369	$ 2,907.55
011977008	$ 37.20
011977013	$ 57.10
011977023	$ 118.20
011977026	$ 467.36
011977033	$ 39.80
011975219	$ 210.65
011975371	$ 37.20
011978404	$ 98.28
011963760	$ 206.90
011975874	$ 874.38
011963761	$ 106.60
011975875	$ 81.00
011963765	$ 380.60
011963766	$ 211.20
011963767	$ 36.10
011963768	$ 156.20
011963774	$ 66.20
011975881	$ 515.62
011963775	$ 21.85

United Concordia Dental Plans of Florida, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Florida, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	7,974
Less: Unapplied cash		(11,648)
Non-admitted receivables		-
Alowance for doubtful accounts		(673)
Miscellaneous debits / (credits)		8,676
Accident and health premiums due and unpaid	$	4,329

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 7,865
120401	A/R - Direct Pay	109
		$ 7,974

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 7,865	$ 7,865	-
120401	A/R - Direct Pay	109	N/A	N/A
		$ 7,974	$ 7,865	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
1,909	3,079	1,164	1,041	672	7,865

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 7,865	$ (97)
120401	A/R - Direct Pay	109	-
		$ 7,974	$ (97)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (11,648)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 7,865	$ (11,648)
120401	A/R - Direct Pay	109	-
		$ 7,974	$ (11,648)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $673 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $673, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$ 673
Non-admitted receivable balance per Annual Statement	-
Non-admitted balance (over)/under 90+ day balance	673
Bad debt reserve	(673)
Non-admitted/bad debt reserve (over)/under 90+ day balance	-
Receivables less than 90 days old requiring non-admission	-
Non-admitted/bad debt reserve deficiency/(excess)	$ -

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $673 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	3,879
320601	Unearned Subscription Revenue - Direct Pay		523
321101	Unapplied Cash		1,287
321301	Unapplied Cash - Direct Pay		40
			5,729
	Reclass to accounts receivable (see step 1)		8,676
		$	14,405

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description		General Ledger Balance		Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$	3,879	$	3,879	-
320601	Unearned Subscription Revenue - Direct Pay		523		523	-
321101	Unapplied Cash		1,287		1,287	-
321301	Unapplied Cash - Direct Pay		40		40	-
		$	5,729	$	5,729	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 7,865	$ 3,879
120401	A/R - Direct Pay	109	523
		$ 7,974	$ 4,402

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 3,879	$ (740)
320601	Unearned Subscription Revenue - Direct Pay	523	-
321101	Unapplied Cash	1,287	-
321301	Unapplied Cash - Direct Pay	40	-
		$ 5,729	$ (740)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011675948	06/06/2003	78.80	> 90
011940204	12/01/2003	52.11	0-29
011833466	09/26/2003	923.04	60-89
011938676	12/27/2003	362.88	0-29
011875149	10/05/2003	70.65	60-89
011927027	11/05/2003	70.65	30-59
011976856	12/05/2003	70.65	0-29
011975837	12/05/2003	69.65	0-29
011943202	12/01/2003	43.32	0-29
011975835	12/05/2003	35.10	0-29
011976970	12/05/2003	116.75	30-59
011774450	09/06/2003	125.99	> 90
011938310	11/26/2003	359.09	0-29
011978337	12/07/2003	753.04	0-29
011977878	12/07/2003	755.45	0-29
011975829	12/05/2003	78.76	0-29
011975836	12/05/2003	46.35	0-29
0119785840	12/05/2003	225.63	0-29
011934740	11/23/2003	19.00	0-29
011925523	11/03/2003	42.95	30-59

HIGHMARK 00264

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011977283	$ 349.15
011976979	$ 74.59
011938923	$ 40.10
011978463	$ 185.41
011978591	$ 85.20
011975830	$ 27.50
011975831	$ 595.30
011975834	$ 68.66
011975838	$ 46.35
011975839	$ 22.50
011975840	$ 97.22

United Concordia Dental Plans of Illinois, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Illinois, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	5,632
Less: Unapplied cash		(454)
Non-admitted receivables		-
Allowance for doubtful accounts		(140)
Miscellaneous debits / (credits)		(4,865)
Accident and health premiums due and unpaid	$	173

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 5,432
120401	A/R - Direct Pay	200
		$ 5,632

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 5,432	$ 4,089	1,343
120401	A/R - Direct Pay	200	N/A	N/A
		$ 5,632	$ 4,089	

Results: The Company provided a reconciliation between the general ledger and the aging report. No reconciling items, individually or in the aggregate, over $500,000.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
43	4,419	708	(2,144)	1,063	4,089

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance
120201	A/R - DHMO	$ 5,432
120401	A/R - Direct Pay	200
		$ 5,632

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (454)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 5,432	$ (454)
120401	A/R - Direct Pay	200	-
		$ 5,632	$ (454)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $1,063 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. The Company has recorded a bad debt reserve of $140, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. However, this balance does not equal the over 90 day receivable balance. The Company provided an explanation stating that the difference of $923 between the aging report and the non-admitted receivable balance is due to the Company writing off the receivable through a manual adjustment to the general ledger subsequent to the aging report being generated for December 2003. The Company explained that the manual adjustment to write off the $923 was recorded against the bad debt reserve. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	1,063
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		1,063
Bad debt reserve		(140)
Non-admitted/bad debt reserve (over)/under 90+ day balance		923
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	923

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $140 is included in the accident and health premiums due and unpaid line related to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320101	Unearned Subscription Revenue - DHMO	$ 7,973
320601	Unearned Subscription Revenue - Direct Pay	200
321101	Unapplied Cash	605
		$ 8,778
	Reclass to accounts receivable (see step 1)	(4,865)
		$ 3,913

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 7,973	$ 7,973	
320601	Unearned Subscription Revenue - Direct Pay	200	200	-
321101	Unapplied Cash	605	605	-
		$ 8,778	$ 8,778	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received in Advance
120201	A/R - DHMO	$ 5,432	$ 7,973
120401	A/R - Direct Pay	200	200
		$ 5,632	$ 8,173

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. There are no debit balances included in the premiums received in advance line.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
0110177219	11/01/2002	22.00	> 90
011873672	10/03/2003	76.55	60-89
011925466	11/03/2003	677.20	30-59
011975201	12/03/2003	480.07	0-29
011420084	1/15/2003	51.83	> 90
011934741	11/23/2003	27.90	0-29
011940206	12/03/2003	173.60	0-29
011978338	12/07/2003	1094.61	0-29
011806461	09/02/2003	923.34	> 90
011978395	12/07/2003	728.69	0-29
011977879	12/07/2003	417.79	0-29
011943257	12/01/2003	1565.30	0-29
011976990	12/05/2003	11.13	0-29
011156463	12/01/2002	22.00	> 90
011229064	01/03/2003	22.00	> 90
011333306	02/01/2003	22.00	> 90

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011977879	1.29
011978004	58.51
011976990	44.52
011975347	101.99
011976994	105.30
011943279	203.22
011975350	2,176.80
011977633	415.91

United Concordia Dental Plans of Kentucky, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Kentucky, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	101,540
Less: Unapplied cash		(51,384)
Non-admitted receivables		-
Allowance for doubtful accounts		(7,446)
Miscellaneous debits / (credits)		(20,003)
Accident and health premiums due and unpaid	$	22,707

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 101,461
120401	A/R - Direct Pay	79
		$ 101,540

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 101,461	$ 101,461	-
120401	A/R - Direct Pay	79	N/A	N/A
		$ 101,540	$ 101,461	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
45,992	36,331	11,050	642	7,446	101,461

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** Not applicable. There are no credit balances included in the gross accounts receivable balance.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (51,384)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 101,461	$ (51,384)
120401	A/R - Direct Pay	79	-
		$ 101,540	$ (51,384)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $7,446 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $7,446, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	7,446
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		7,446
Bad debt reserve		(7,446)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $7,446 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320101	Unearned Subscription Revenue - DHMO	$ 25,344
320601	Unearned Subscription Revenue - Direct Pay	2,550
321101	Unapplied Cash	13,898
321301	Unapplied Cash - Direct Pay	145
		41,937
	Reclass to accounts receivable (see step 1)	(20,003)
		$ 21,934

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 25,344	$ 25,344	-
320601	Unearned Subscription Revenue - Direct Pay	2,550	2,550	-
321101	Unapplied Cash	13,898	13,898	-
321301	Unapplied Cash - Direct Pay	145	145	-
		$ 41,937	$ 41,937	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances..

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120201	A/R - DHMO	$ 101,461	$ 25,344
120401	A/R - Direct Pay	79	2,550
		$ 101,540	$ 27,894

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 5,344	$ (78)
320601	Unearned Subscription Revenue - Direct Pay	2,550	-
321101	Unapplied Cash	13,898	-
321301	Unapplied Cash - Direct Pay	145	-
		$ 21,937	$ (78)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011927079	11/05/2003	250.92	30-59
010429579	01/06/2002	185.65	> 90
011927039	11/05/2003	259.49	30-59
011875198	10/05/2003	278.23	60-89
011976928	12/05/2003	862.83	0-29
011927042	11/05/2003	929.79	30-59
011975866	12/05/2003	882.11	0-29
011887417	10/26/2003	9163.44	30-59
011976919	12/05/2003	5781.39	0-29
011821753	09/06/2003	82.30	> 90
0119271223	11/05/2003	12.45	30-59
011976987	12/05/2003	758.45	30-59
011975843	12/05/2003	123.79	0-29
011821608	09/06/2003	274.47	> 90
011875170	10/05/2003	199.87	60-89
011976898	12/05/2003	334.76	0-29
011278409	12/06/2002	2186.38	> 90
011975845	12/05/2003	306.24	0-29
011976892	12/05/2003	206.79	0-29
011976913	12/05/2003	358.32	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011976895	$ 51.20
011976919	$ 814.88
011982519	$ 670.20
011976928	$ 10.80
011976951	$ 55.28
011976959	$ 219.40
011983311	$ 154.95
011975842	$ 176.93
011975846	$ 188.65
011975850	$ 181.97
011975851	$ 10.94
011975859	$ 147.60
011975860	$ 169.24
011975861	$ 103.30
011975862	$ 43.96
011975864	$ 1,558.34
011975865	$ 307.00
011975857	$ 60.24
011975869	$ 325.97
011975873	$ 72.11

United Concordia Dental Plans of the Midwest, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of the Midwest, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$ 874,166
Less: Unapplied cash	(414,929)
Non-admitted receivables	-
Allowance for doubtful accounts	(129,688)
Miscellaneous debits / (credits)	(105,928)
Accident and health premiums due and unpaid	$ 223,621

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous debit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 872,809
120401	A/R - Direct Pay	1,357
		$ 874,166

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 872,809	$ 872,809	-
120401	A/R - Direct Pay	1,357	N/A	N/A
		$ 874,166	$ 872,809	

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
119,517	576,403	12,029	35,172	129,688	872,809

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 872,609	$ (1,283)
120401	A/R - Direct Pay	1,357	-
		$ 874,166	$ (1,283)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (414,929)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 872,809	$ (414,929)
120401	A/R - Direct Pay	1,357	-
		$ 874,166	$ (414,929)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

> ***Results:*** Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

> ***Results:*** The over 90 day balance of $129,688 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $129,688, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	129,688
Non-admitted receivable balance per Annual Statement	-
Non-admitted balance (over)/under 90+ day balance	129,688
Bad debt reserve	(129,688)
Non-admitted/bad debt reserve (over)/under 90+ day balance	-
Receivables less than 90 days old requiring non-admission	-
Non-admitted/bad debt reserve deficiency/(excess)	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $129,688 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320101	Unearned Subscription Revenue - DHMO	$	174,976
320601	Unearned Subscription Revenue - Direct Pay		12,785
321101	Unapplied Cash		164,518
321301	Unapplied Cash - Direct Pay		26,630
			378,909
	Reclass to accounts receivable (see step 1)		(105,928)
		$	272,981

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 174,976	$ 174,976	-
320601	Unearned Subscription Revenue - Direct Pay	12,785	12,785	-
321101	Unapplied Cash	164,518	164,518	-
321301	Unapplied Cash - Direct Pay	26,630	26,630	-
		$ 378,909	$ 378,909	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received in Advance
120201	A/R - DHMO	$ 872,809	$ 174,976
120401	A/R - Direct Pay	357	12,785
		$ 873,166	$ 187,761

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320101	Unearned Subscription Revenue - DHMO	$ 174,976	$ (9,928)
320601	Unearned Subscription Revenue - Direct Pay	12,785	-
321101	Unapplied Cash	164,518	-
321301	Unapplied Cash - Direct Pay	26,630	-
		$ 378,909	$ (9,928)

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued Medical Incentive Pool and Bonus Payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011927456	11/06/2003	221.70	30-59
011414633	02/06/2003	935.40	> 90
011928673	11/07/2003	253.89	30-59
011875414	10/06/2003	199.25	60-89
011977215	12/06/2003	913.60	0-29
011927323	11/06/2003	911.50	30-59
011977244	12/06/2003	204.50	0-29
011927414	11/06/2003	377.30	30-59
011977170	12/06/2003	386.00	0-29
010429783	01/06/2002	136.88	> 90
011928909	11/08/2003	686.65	30-59
011977124	01/01/2004	376.05	0-29
011977083	12/06/2003	1202.50	0-29
011541305	04/06/2003	179.60	> 90
011875511	10/06/2003	229.60	60-89
011975372	12/05/2003	733.45	0-29
011720232	02/21/2003	211.10	> 90
011977081	12/06/2003	118.50	0-29
011978708	12/08/2003	5981.02	0-29
011977201	12/06/2003	141.10	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011977284	$ 945.90
011978682	$ 13.80
011977287	$ 1,382.00
011977289	$ 41.70
011977082	$ 2,433.35
011943362	$ 667.63
011975375	$ 103.52
011943371	$ 2,294.86
011977103	$ 2.36
011977104	$ 186.65
011977105	$ 81.00
011977106	$ 285.00
011977125	$ 84.50
011983072	$ 596.10
011977126	$ 73.00
011977127	$ 137.70
011977128	$ 208.05
011977129	$ 270.70
011977130	$ 42.50
011977145	$ 1,114.15

United Concordia Dental Plans of Pennsylvania, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Pennsylvania, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	3,226,301
Less: Unapplied cash		(265,426)
Non-admitted receivables		-
Allowance for doubtful accounts		(231,323)
Miscellaneous debits / (credits)		(1,802,852)
Accident and health premiums due and unpaid	$	926,700

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 3,216,006
120401	A/R - Direct Pay	10,295
		$ 3,226,301

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 3,216,006	$ 3,841,110	(625,104)
120401	A/R - Direct Pay	10,295	N/A	N/A
		$ 3,226,301	$ 3,841,110	

Results:

Account 120201
The Company provided a reconciliation between the general ledger balance and the aging report. There was one reconciling item in the amount of $625,104. The Company explained the reconciling item as manual adjustments recorded to the general ledger related to accounts receivable balances that were written off in December 2003 due to cancellation of certain contracts that had already been billed.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
305,880	2,391,428	730,201	182,278	231,323	3,841,110

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

> ***Results:*** The Company provided a reconciliation between the general ledger and the detailed schedule. There were no reconciling items, individually or in the aggregate, over $500,000.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

> ***Results:*** The Company provided a detailed listing of credit balances included in the gross accounts receivable balances. The total credit balances, per the detailed listing, related to each gross accounts receivable balance are shown below.

Acct. #	Acct. Description	General Ledger Balance	Credit Balances
120201	A/R - DHMO	$ 3,216,006	$ (105,442)
120401	A/R - Direct Pay	10,295	-
		$ 3,226,301	$ (105,442)

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Acct. #	Acct. Description	Balance
125001	A/R - Cash in Transit	$ (265,426)

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Acct. #	Acct. Description	Accounts Receivable Balance	Unapplied Cash Balances
120201	A/R - DHMO	$ 3,216,006	$ (265,426)
120401	A/R - Direct Pay	10,295	-
		$ 3,226,301	$ (265,426)

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the supporting reconciliation. There were no reconciling items, individually or in the aggregate, over $500,000.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. Due to the nature of the cash-in-transit account, a detailed listing is not available. On a monthly basis, the Company compared the cash received to the cash applied in the accounts receivable system. Any differences between the cash received and applied, which are primarily related to timing, are recorded in the cash-in-transit account.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $231,323 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $231,323, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	231,323
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		231,323
Bad debt reserve		(231,323)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** A bad debt reserve of $231,323 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description		Balance
320001	Unearned Subscription Revenue - FFS	$	463
320101	Unearned Subscription Revenue - DHMO		2,337,233
320601	Unearned Subscription Revenue - Direct Pay		23,068
321101	Unapplied Cash		111,716
321301	Unapplied Cash - Direct Pay		7,443
		$	2,479,923
	Reclass to accounts receivable (see step 1)		(1,802,852)
		$	677,071

Note: The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320001	Unearned Subscription Revenue - FFS	$ 463		
320101	Unearned Subscription Revenue - DHMO	2,337,233		
		2,337,696	2,059,690	278,006
320601	Unearned Subscription Revenue - Direct Pay	23,068	23,068	-
321101	Unapplied Cash	111,716	111,716	-
321301	Unapplied Cash - Direct Pay	7,443	7,443	-
		$ 2,479,923	$ 2,201,917	

Results: The Corporation provided a reconciliation between the general ledger and the supporting detail. There were no reconciling items, individually or in the aggregate, over $500,000.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received In Advance
120101	A/R - FFS	$ -	$ 463
120201	A/R - DHMO	3,216,006	2,337,233
		3,216,006	2,337,696
120401	A/R - Direct Pay	10,295	23,068
		$ 3,226,301	$ 2,360,764

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Acct. #	Acct. Description	Balance	Debit Balances
320001	Unearned Subscription Revenue - FFS	$ 463	
320101	Unearned Subscription Revenue - DHMO	2,337,233	
		2,337,696	6,448
320601	Unearned Subscription Revenue - Direct Pay	23,068	-
321101	Unapplied Cash	111,716	-
321301	Unapplied Cash - Direct Pay	7,443	-
		$ 2,479,923	$ 6,448

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011915824	11/3/2003	$ 810.65	30-59
011427843	2/26/2003	2,560.50	90+
011915871	11/3/2003	343.72	30-59
011863604	10/3/2003	293.90	60-89
011943148	12/1/2003	4,686.38	0-29
011915270	11/3/2003	289.18	30-59
011964679	12/3/2003	672.73	0-29
011893663	11/1/2003	517.55	30-59
011940344	12/1/2003	65,565.17	0-29
010420605	1/2/2002	335.11	90+
011890704	11/1/2003	542.70	30-59
011975279	12/4/2003	1,321.87	0-29
011940316	12/1/2003	9,397.75	0-29
011807866	9/2/2003	682.48	90+
011864047	10/3/2003	172.96	60-89
011964996	12/3/2003	317.40	0-29
011717401	7/3/2003	155.59	90+
011965535	12/3/2003	646.74	0-29
011965075	12/3/2003	763.38	0-29
011938961	12/1/2003	1,417.14	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011963415	1,933.13
011963416	168.99
011963417	256.45
011938940	157.78
011938941	5,651.83
011943182	4,435.02
011963442	263.93
011975198	460.86
011963443	337.23
011963444	162.10
011938964	6,342.86
011938965	1,854.51
011938966	20,641.21
011938967	1,147.70
011963488	102.86
011943316	1,557.47
011975255	1,556.76
011943320	30.41
011943322	984.70
011975280	1,669.34

United Concordia Dental Plans of Texas, Inc.

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to United Concordia Dental Plans of Texas, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	4,127
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		(914)
Miscellaneous debits / (credits)		(2,257)
Accident and health premiums due and unpaid	$	956

The gross accounts receivable balance represents amounts due to the Company as of December 31, 2003 for coverage periods through December 31, 2003 as well as amounts due to the Company for coverage periods subsequent to December 31, 2003 that have been billed as of December 31, 2003. The miscellaneous credit represents amounts billed in advance of the coverage period, which are included in the gross accounts receivable balance and are required to be excluded from the statutory accounts receivable balance.

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
120201	A/R - DHMO	$ 4,127

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Aging Balance	Difference
120201	A/R - DHMO	$ 4,127	$ 4,127	-

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Open Future	0-29	30-59	60-89	90+	Total
995	1,887	285	46	914	4,127

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The gross accounts receivable balance is supported by an aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the gross accounts receivable balance.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $914 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line on the Annual Statement. However, the Company has recorded a bad debt reserve of $914, which is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	914
Non-admitted receivable balance per Annual Statement		-
Non-admitted balance (over)/under 90+ day balance		914
Bad debt reserve		(914)
Non-admitted/bad debt reserve (over)/under 90+ day balance		-
Receivables less than 90 days old requiring non-admission		-
Non-admitted/bad debt reserve deficiency/(excess)	$	-

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual accounts receivable balances from the aging detail and performed the above procedures without exception. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: A bad debt reserve of $914 is included in the accident and health premiums due and unpaid line, which is equal to the over 90 day accounts receivable balance per the aging report. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
320101	Unearned Subscription Revenue - DHMO	$ 2,878
321101	Unapplied Cash	1,008
125001	A/R - Cash In Transit	1,341
		$ 5,227
	Reclass to accounts receivable (see step 1)	(2,257)
		$ 2,970

The Company recorded certain unapplied cash accounts in the premiums received in advance line as the Company has determined that the amounts included in the unapplied cash account represent premiums received in advance of the coverage period.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Acct. Description	General Ledger Balance	Balance per Detail	Difference
320101	Unearned Subscription Revenue - DHMO	$ 2,878	$ 2,878	-
321101	Unapplied Cash	1,008	1,008	-
125001	A/R - Cash In Transit	1,341	1,341	-
		$ 5,227	$ 5,227	

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Acct. #	Acct. Description	Accounts Receivable	Premiums Received in Advance
120201	A/R - DHMO	$ 4,127	$ 2,877

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. There are no debit balances included in account 120201.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
011943189	12/01/2003	366.88	0-29
011978079	12/07/2003	230.85	0-29
011940383	12/01/2003	180.55	0-29
011978417	12/07/2003	74.23	0-29
011943185	12/01/2003	94.09	0-29
011943204	12/01/2003	332.55	0-29
011978422	12/07/2003	136.77	0-29
011928674	11/07/2003	112.95	30-59
011893528	11/01/2003	94.09	30-59
010448006	02/02/2002	137.52	> 90
010613361	04/02/2002	105.03	> 90
011005114	09/01/2002	87.56	> 90
011157812	11/01/2002	87.56	> 90
011230504	12/01/2002	87.56	> 90
011334679	01/03/2003	87.56	> 90
011886935	10/22/2003	78.34	30-59
011978445	12/07/2003	97.94	0-29
011943189	12/01/2003	366.88	0-29
011978079	12/07/2003	230.85	0-29
011940383	12/01/2003	180.55	0-29

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

Invoice #	Cash Received
011943259	195.41
011940379	34.60
011836056	142.86
011940380	52.64
011940381	100.94
011940382	93.84

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to HealthGuard of Lancaster, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	1,693,086
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		(100,000)
Miscellaneous debits / (credits)		-
Accident and health premiums due and unpaid	$	1,593,086

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
1399	Premiums Receivable	$ 1,693,086

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation between the general ledger balance and the detailed aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

0-29	30-60	61-90	90+	Total
1,547,918	50,957	(256)	56,363	1,654,982

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The gross accounts receivable balance in step 2 above is supported by a detailed aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: The Company provided the detailed aging report, which included credit balances totaling $28,607, which were aged as follows: 0-29, $15,899; 31-60, $3,253; 61-90, 256; 90+, $9,199.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: The over 90 day balance of $56,363 per the aging report does not agree to the non-admitted receivables per the accident and health premiums due and unpaid line in the Annual Statement. However, the Company has recorded a bad debt reserve of $100,000, which exceeds the over 90 day balance is recorded as a reduction to the gross accounts receivable balance included in the accident and health premiums due and unpaid line. See below for an analysis of the over 90 day balance and the related non-admitted receivables and bad debt reserve.

Over 90 day balance per aging report	$	56,363
Non-admitted receivable balance per Annual Statement		-
Admitted over 90 day balance		56,363
Bad debt reserve		(100,000)
Bad debt reserve in excess of over 90 day balance	$	(43,637)

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual invoices and agreed the invoice date to a supporting invoice and recalculated the aging of the receivable balance. No exceptions were noted. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** The Company explained that the bad debt reserve of $100,000 is included in the accident and health premiums due and unpaid line, of which $43,637 relates to accounts receivable balances in excess of the over 90 day balance (see step 10).

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** The Company explained that the bad debt reserve of $43,637 has been recorded against accounts receivable balances in excess of the over 90 day balance; however, the reserve is not based on a percentage of each individual aging category but rather as a general reserve. The bad debt reserve as a percent of the accounts receivable balance in excess of the 90 day balance per the detailed aging report is approximately 2.7%.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The gross accounts receivable balance is supported by a detailed aging report.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
2501	Unearned Premiums	$ 3,774,634
2502	Unearned Premiums	248
		$ 3,774,882

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:***
>
> Account 2501
> The Company provided a reconciliation between the general ledger balance and the detailed support. There were no reconciling items, individually or in the aggregate, over $500,000.
>
> Account 2502
> The Company provided a reconciliation between the general ledger balance and the detailed support. There were no reconciling items, individually or in the aggregate, over $500,000.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

> ***Results:*** Unearned premium accounts numbers 2501 and 2502 both relate to premiums receivable account number 1399.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

> ***Results:*** The Company provided the detailed support for the premiums received in advance balance, which included debit balances totaling $24,794.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

> ***Results:*** We selected a sample of 20 individual cash receipts from the detailed listing and performed the above procedures. No exceptions were noted. See Attachment B for a summary of the sample.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** The Company provided a summary of the accounts comprising the accrued medical incentive pool and bonus payments line, which is comprised of a physician incentive liability totaling $1,184,042.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** The Company provided a reconciliation of the general ledger balance to the detailed support. There were no reconciling items, individually or in the aggregate, over $500,000.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line.

2. Agree the individual premiums account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no amounts recorded in the aggregate health policy reserve line.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

Invoice Number	Invoice Date	Amount	Aging Category
459686	11/6/03	906	1-30 days
460432	11/7/03	7,531	1-30 days
462370	12/1/03	7,799	1-30 days
461848	11/18/03	7,808	1-30 days
A	A	8,188	over 90 days
459537	11/6/03	10,291	1-30 days
457050	10/9/03	720	31-60 days
461099	11/10/03	10,842	1-30 days
461133	11/10/03	11,740	1-30 days
459541	11/6/03	22,110	1-30 days
459536	11/6/03	24,267	1-30 days
459693	11/6/03	69,178	1-30 days
B	B	6,629	over 90 days
461080	11/10/03	626	1-30 days
459758	11/6/03	1,103	1-30 days
457417	10/10/03	552	30-60 days
459542	11/6/03	1,122	1-30 days
460603	11/7/03	1,132	1-30 days
457065	10/9/2003	497.78	31-60 days
459919	11/7/2003	1187.5	1-30 days

Note: For those balances selected from the aging report that were over 90 days old, the balance consisted of multiple invoices. Therefore, we obtained copies of each invoice making up the balance and tested them for proper aging. See **A** and **B** below.

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

A:

Invoice Number	Invoice Date	Balance	Aging Category
454203	9/9/2003	909.78	over 90 days
451357	8/9/2003	909.78	over 90 days
448531	7/9/2003	909.78	over 90 days
445571	6/9/2003	909.78	over 90 days
442741	5/9/2003	909.78	over 90 days
439584	4/9/2003	909.78	over 90 days
435963	3/9/2003	909.78	over 90 days
433473	2/9/2003	909.78	over 90 days
429752	1/9/2003	909.78	over 90 days
		8,188.02	

B:

Invoice Number	Invoice Date	Balance	Aging Category
439367	4/10/2003	4,019.47	over 90 days
442518	5/9/2003	941.23	over 90 days
445359	6/9/2003	(1,873.63)	over 90 days
448306	7/7/2003	928.16	over 90 days
456335	9/29/2003	2,614.09	over 90 days
		6,629.32	

Attachment B

Premiums Received in Advance/Unearned Premiums (Step 5)
Sample Selection

	Receipt Date	Invoice Amount	Period Covered
1	12/31/03	(138,162.83)	1/1/04 to 1/31/04
2	12/29/03	(91,915.26)	1/1/04 to 1/31/04
3	12/24/03	(67,664.99)	1/1/04 to 1/31/04
4	12/22/03	(58,523.42)	1/1/04 to 1/31/04
5	12/22/03	(49,982.31)	1/1/04 to 1/31/04
6	12/15/03	(45,582.47)	1/1/04 to 1/31/04
7	12/26/03	(43,075.04)	1/1/04 to 1/31/04
8	12/16/03	(39,114.02)	1/1/04 to 1/31/04
9	12/15/03	(36,266.56)	1/1/04 to 1/31/04
10	12/18/03	(32,450.45)	1/1/04 to 1/31/04
11	12/30/03	(29,676.21)	1/1/04 to 1/31/04
12	12/29/03	(28,016.45)	1/1/04 to 1/31/04
13	12/22/03	(28,010.39)	1/1/04 to 1/31/04
14	12/11/03	(27,228.90)	1/1/04 to 1/31/04
15	12/15/03	(26,006.35)	1/1/04 to 1/31/04
16	12/24/03	(25,971.82)	1/1/04 to 1/31/04
17	12/29/03	(25,879.93)	1/1/04 to 1/31/04
18	12/18/03	(25,286.88)	1/1/04 to 1/31/04
19	12/16/03	(23,599.00)	1/1/04 to 1/31/04
20	12/12/03	(23,193.90)	1/1/04 to 1/31/04

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Davis Vision of Michigan, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	250,000
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		-
Miscellaneous debits / (credits)		-
Accident and health premiums due and unpaid	$	250,000

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Accl. Description	Balance
1111	Accounts Receivable	$ 250,000

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. The accounts receivable balance of $250,000 represents an estimate for the December billing related to one customer.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Results: Not applicable. The accounts receivable balance of $250,000 represents an estimate for the December billing related to one customer.

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The accounts receivable balance of $250,000 represents an estimate for the December billing related to one customer. The Company has estimated the receivable based on the prior month's (November 2003) cash collections.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the gross accounts receivable balance.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. There are no unapplied cash balances included in the accident and health premiums due and unpaid line.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above.

Results: Not applicable. There are no non-admitted accounts receivable balances as the Company does not have any accounts receivable balances over 90 days old.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: Not applicable. The accounts receivable balance of $250,000 represents an estimate for the December billing related to one customer and there is no aging report.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve in excess of the over 90 day balance.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. The Company has not recorded any amounts in the premiums received in advance line on the Annual Statement.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. The Company has not recorded any amounts in the premiums received in advance line on the Annual Statement.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Results: Not applicable. The Company has not recorded any amounts in the premiums received in advance line on the Annual Statement.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. The Company has not recorded any amounts in the premiums received in advance line on the Annual Statement.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: Not applicable. The Company has not recorded any amounts in the premiums received in advance line on the Annual Statement.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate health policy reserve line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and the Insurance Department, and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

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Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Gateway Health Plan, L.P. and subsidiary (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our results, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

	Total
Gross accounts receivable	$ 9,570,048
Less: Unapplied cash	-
Non-admitted receivables	-
Alowance for doubtful accounts	-
Miscellaneous debits / (credits)	-
Accident and health premiums due and unpaid	$ 9,570,048

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Account Description	Balance
1210	A/R-DPW Revenue	$ 4,823,740
1235	A/R-Maternity	3,696,976
1240	A/R-HIV Risk Pool	1,049,332
		$ 9,570,048

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging reports, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Acct. #	Account Description	General Ledger Balance	Aging Balance	Difference
1210	A/R-DPW Revenue	$ 4,823,740	$ 4,823,740	-
1235	A/R-Maternity	3,696,976	3,711,448	(14,472)
1240	A/R-HIV Risk Pool	1,049,332	1,049,332	-
		$ 9,570,048	$ 9,584,520	

Results: Aging reports were obtained for accounts 1210, 1235 and 1240. We compared the account balance, per the general ledger, to the aging report(s), noting the following exceptions:

Account 1235
The Company provided a reconciliation between the general ledger balance and the aging report. There were no reconciling items, individually or in the aggregate, over $500,000.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

Acct. #	Account Description	0-30	31-60	61-90	90+	Total
1210	A/R-DPW Revenue	4,823,740	-	-	-	4,823,740
1235	A/R-Maternity	3,656,158	6,003	31,423	17,864	3,711,448
1240	A/R-HIV Risk Pool	1,049,332	-	-	-	1,049,332
	Total	9,529,230	6,003	31,423	17,864	9,584,520

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. All gross accounts receivable balances included in the accident and health premiums due and unpaid line are supported by an aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: No credit balances were noted in any of the gross accounts receivable balances.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There were no unapplied cash account balances included in the accident and health premiums due and unpaid line.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There were no unapplied cash account balances included in the accident and health premiums due and unpaid line.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There were no unapplied cash account balances included in the accident and health premiums due and unpaid line.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

> ***Results:*** Not applicable. There were no unapplied cash account balances included in the accident and health premiums due and unpaid line.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above. In addition, identify any customer accounts receivable balances less than 90 days old that have been non-admitted as a result of the customer having an outstanding balance over 90 days old that is not considered to be di minimis.

> ***Results:*** There were no non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line. We noted that the Company did have $17,864 of accounts receivable greater than 90 days old which was admitted related to account 1235, A/R-Maternity.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** Accounts 1210, 1235 and 1240 are supported by aging reports. The accounts receivable balances are estimated amounts due from the Pennsylvania Department of Public Welfare (DPW) based on membership data maintained by the Company and contracts rates agreed to with the DPW. As the amounts are estimated, the accounts are not supported by individual invoices. The Company utilizes the aging reports to record the accounts receivable amount to the general ledger and to assess the collectibility of the balance, including the establishment of a non-admitted receivable balance, if applicable. Due to the nature of the accounts and the absence of invoices, the aging buckets were not tested for these accounts. The Company provided supporting schedules for each of the accounts receivable balances. We agreed the detail on the supporting schedules to the amounts on the general ledger noting no reconciling items.

13. Obtain a summary of bad debt reserves related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** Not applicable. No bad debt reserves related to accounts receivable balances less than 90 days old are included in the accident and health premiums due and unpaid line.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company does not have any bad debt reserve against the gross accounts receivable balances.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company does not have any bad debt reserve against the gross accounts receivable balances.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no account balances included in the accident and health premiums received in advance line in the Health Annual Statement.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no account balances included in the accident and health premiums received in advance line in the Health Annual Statement.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

> ***Results:*** Not applicable. There are no account balances included in the accident and health premiums received in advance line in the Health Annual Statement.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

> ***Results:*** Not applicable. There are no account balances included in the accident and health premiums received in advance line in the Health Annual Statement.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

> ***Results:*** Not applicable. There are no account balances included in the accident and health premiums received in advance line in the Health Annual Statement.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

Results: Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payments line in the Company's Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate policy reserves line in the Company's Annual Statement.

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no amounts recorded in the aggregate policy reserves line in the Company's Annual Statement.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Inter-County Health Plan, Inc.

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Two Commerce Square, Suite 1700
2001 Market Street
Philadelphia PA 19103-7042
Telephone (267) 330 3000
Facsimile (267) 330 3300

Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Inter-County Health Plan, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	777,954
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		-
Miscellaneous debits / (credits)		-
Accident and health premiums due and unpaid	$	777,954

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
1210-01	Uncollected Group	$ 284,516
1201-02	Uncollected Direct	5,358
1210-04	Uncollected Premiums - GISI II	121,345
1210-05	Uncollected Premiums - Weston	366,735
		$ 777,954

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation of the general ledger balance to the detailed aging report. No exceptions were noted.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

0-29	30-59	60-89	90+	Total
370,589	404,717	2,648	-	777,954

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The gross accounts receivable balances in step 2 above are supported by a detailed aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the accident and health premiums due and unpaid line in the Annual Statement.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

> ***Results:*** Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

> ***Results:*** Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

> ***Results:*** Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

> ***Results:*** Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above. In addition, identify any customer accounts receivable balances less than 90 days old that have been non-admitted as a result of the customer having an outstanding balance over 90 days old that is not considered to be di minimis.

> ***Results:*** There are no non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line in the Annual Statement.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

> ***Results:*** We selected a sample of 20 individual invoices and agreed the invoice date to a supporting invoice and recalculated the aging of the receivable balance. No exceptions were noted. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

> ***Results:*** Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payment line in the Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payment line in the Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
2750-00	Unearned Subscription Revenue	$ 436,289
2745-02	A/P Par Refund Agreements	51,835
2750-12	Unearned Subscription Revenue - GISI II	169,266
		$ 657,390

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company's systems are not capable of providing a detailed report by group of unearned premium account balances. Therefore, we were unable to perform the procedure specified above. The Company did provide a reconciliation of the general ledger account balance to a system report or unearned premium broken out by product. No exceptions were noted.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Attachment A

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

	Invoice Number	Invoice Date	Invoice Amount	Aging Category
1	044630	12/1/2003	21,461.57	16-30
2	088443	1/1/2004	19,867.48	16-30
3	087360	12/1/2003	15,147.42	16-30
4	085940	12/1/2003	13,624.43	16-30
5	087363	12/1/2003	12,251.77	16-30
6	087362	12/1/2003	12,234.61	16-30
7	087369	12/1/2003	17,311.97	16-30
8	092571	12/1/2003	12,270.65	16-30
9	089980	12/15/2003	10,927.41	1-15
10	092140	12/15/2003	11,909.52	1-15
11	091860	11/1/2003	5,940.73	46-60
12	090310	11/1/2003	6,777.77	46-60
13	090311	11/1/2003	5,405.92	46-60
14	089660	12/1/2003	8,628.91	16-30
15	090311	12/1/2003	5,422.02	16-30
16	090310	12/1/2003	6,733.03	16-30
17	077008	11/1/2003	163.47	46-60
18	082040	11/1/2003	25.94	46-60
19	090312	11/1/2003	1,079.65	46-60
20	090962	11/1/2003	85.29	46-60

Inter-County Hospitalization Plan, Inc.

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Two Commerce Square, Suite 1700
2001 Market Street
Philadelphia PA 19103-7042
Telephone (267) 330 3000
Facsimile (267) 330 3300

Report of Independent Accountants

To the Board of Directors
of Highmark Inc.

We have performed the procedures enumerated below related to Inter-County Hospitalization Plan, Inc. (the "Company"), which were agreed to by Highmark Inc. (the "Corporation") and the Insurance Department of the Commonwealth of Pennsylvania (the "Insurance Department"), solely to assist the Corporation in its compliance with the guidelines set forth by the Insurance Department in its letter to the Corporation dated January 5, 2004. The Corporation is responsible for complying with the guidelines set forth in the Insurance Department's letter. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Corporation and the Insurance Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed, and our findings, are described below.

Accident and health premiums due and unpaid

1. Obtain a summary of the account balances that comprise the accident and health premiums due and unpaid line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements). The summary should be presented as follows: Gross accounts receivable LESS unapplied cash LESS non-admitted receivables LESS allowance for doubtful accounts PLUS/LESS miscellaneous debits/credits.

Gross accounts receivable	$	1,464,855
Less: Unapplied cash		-
Non-admitted receivables		-
Allowance for doubtful accounts		-
Miscellaneous debits / (credits)		-
Accident and health premiums due and unpaid	$	1,464,855

2. Obtain a summary of the general ledger accounts that comprise the gross accounts receivable balance.

Acct. #	Acct. Description	Balance
1210-01	Uncollected Group - Hospital	$ 480,730
1201-02	Uncollected Direct - Hospital	20,253
1210-04	Uncollected Premiums - GISI II - Hospital	199,673
1210-05	Uncollected Premiums - Weston	764,199
		$ 1,464,855

3. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are supported by one or more detailed aging report, agree the account balance, per the general ledger, to the aging report(s). Identify any reconciling items between each general ledger account and the related aging report(s) and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company provided a reconciliation of the general ledger balance to the detailed aging report. No exceptions were noted.

4. Summarize the aging buckets (e.g., 0-30 / 30-60 / 60-90 / 90+) for each of the aging reports obtained in step 3 above.

0-29	30-59	60-89	90+	Total
631,095	829,227	4,533	-	1,464,855

5. For the gross accounts receivable balances included in the accident and health premiums due and unpaid line (in step 2 above) that are not supported by a detailed aging report, agree the account balance, per the general ledger, to a supporting schedule or reconciliation prepared by the Company. Identify any reconciling items between each general ledger account and the related supporting schedule or reconciliation and obtain written explanations for reconciling items in excess of $500,000. Obtain an explanation from the Company as to why the accounts receivable balance is not supported by an aging report.

Results: Not applicable. The gross accounts receivable balances in step 2 above are supported by a detailed aging report.

6. Obtain a detailed listing of all credit balances recorded in each gross accounts receivable balance.

Results: Not applicable. There are no credit balances included in the accident and health premiums due and unpaid line in the Annual Statement.

7. Obtain a listing of all unapplied cash account balances included in the accident and health premiums due and unpaid line.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

8. Identify the related gross accounts receivable balance to which the unapplied cash account (from step 7 above) relates.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

9. Agree the unapplied cash account balances to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

10. Obtain a detailed listing of all debit balances recorded in each unapplied cash account.

Results: Not applicable. There are no unapplied cash accounts included in the accident and health premiums due and unpaid line in the Annual Statement.

11. Obtain a listing of all non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line and agree the non-admitted receivables to the over 90 day category on the aging reports obtained in step 3 above. In addition, identify any customer accounts receivable balances less than 90 days old that have been non-admitted as a result of the customer having an outstanding balance over 90 days old that is not considered to be di minimis.

Results: There are no non-admitted accounts receivable balances included in the accident and health premiums due and unpaid line in the Annual Statement.

12. Select a sample of 20 individual accounts receivable balances from each aging report and examine supporting documentation to verify the accuracy of the aging by agreeing the invoice date to a supporting invoice and performing a recalculation of the aging of the individual balances.

Results: We selected a sample of 20 individual invoices and agreed the invoice date to a supporting invoice and recalculated the aging of the receivable balance. No exceptions were noted. See Attachment A for a summary of the sample.

13. Obtain a summary of the bad debt reserve related to accounts receivable balances less than 90 days old that are included in the accident and health premium due and unpaid line and identify the related accounts receivable balance (from step 2 above) to which the bad reserve relates.

Results: Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

14. For those accounts receivable balances supported by a detailed aging report and to which the Company applied a bad debt reserve percentage to each aging category, calculate the bad debt reserve related to the respective aging category as a percent of each aging category.

Results: Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

15. For those accounts receivable balances that are not supported by a detailed aging report, calculate the bad debt reserve related to the respective account balance as a percent of the total accounts receivable balance.

Results: Not applicable. The Company has not recorded a bad debt reserve related to the accounts receivable balances.

Premiums received in advance / unearned premiums

1. Obtain a summary of the account balances that comprise the accident and health premiums received in advance line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

   Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

2. Agree the individual premiums received in advance/unearned premium account balances (in step 1 above) to a detailed aging report or other detailed listing that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

   Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

3. Obtain a listing of the accounts receivable balances and the premiums received in advance balances that relate to the respective accounts receivable balances.

   Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

4. Obtain a detail listing of all debit balances recorded in each account balance included in the accident and health premiums received in advance line.

   Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

5. Select a sample of 20 cash receipts from each detailed listing of premiums received in advance and examine the supporting cash remittance and/or the underlying invoice to determine whether the coverage period for which the premium payment relates was 1/1/04 or later.

   Results: Not applicable. There are no amounts recorded in accident and health premiums received in advance line in the Annual Statement.

Accrued medical incentive pool and bonus payments

1. Obtain a summary of the components that comprise the accrued medical incentive pool and bonus payments line in the Health Annual Statement.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payment line in the Annual Statement.

2. Agree the individual account balances to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger.

> ***Results:*** Not applicable. There are no amounts recorded in the accrued medical incentive pool and bonus payment line in the Annual Statement.

Aggregate policy reserves

1. Obtain a summary of the account balances that comprise the aggregate policy reserves line in the Health Annual Statement (or similar lines in the Property / Casualty and Life / Accident and Health Annual Statements).

Acct. #	Acct. Description	Balance
2750-00	Unearned Subscription Revenue	$ 1,383,310
2745-00	Group Receipts Suspense	56,502
2745-02	A/P Par Refund Agreements	90,414
2750-12	Unearned Subscription Revenue - GISI II	278,527
		$ 1,808,753

2. Agree the individual account balances (in step 1 above) to a detailed supporting schedule or reconciliation that supports the balance recorded on the general ledger. Identify any reconciling items between the aging report/detailed listing and the general ledger and obtain written explanations for reconciling items in excess of $500,000.

Results: The Company's systems are not capable of providing a detailed report by group of unearned premium account balances. Therefore, we were unable to perform the procedure specified above. The Company did provide a reconciliation of the general ledger account balance to a system report or unearned premium broken out by product. No exceptions were noted.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the account balances. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Corporation's Board of Directors, committees of directors, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

March 29, 2004

Accident and Health Premiums Due and Unpaid (Step 12)
Sample Selection

	Invoice Number	Invoice Date	Invoice Amount	Aging Category
1	044630	12/1/2003	36,542.66	16-30
2	088443	1/1/2004	33,828.41	16-30
3	087360	12/1/2003	25,791.55	16-30
4	085940	12/1/2003	23,198.35	16-30
5	087363	12/1/2003	20,861.12	16-30
6	087362	12/1/2003	20,831.90	16-30
7	087369	12/1/2003	29,477.13	16-30
8	092571	12/1/2003	20,893.28	16-30
9	089980	12/15/2003	18,606.14	1-15
10	092140	12/15/2003	20,278.36	1-15
11	091860	11/1/2003	10,115.29	46-60
12	090310	11/1/2003	11,540.53	46-60
13	090311	11/1/2003	9,204.68	46-60
14	089660	12/1/2003	14,692.47	16-30
15	090311	12/1/2003	9,232.08	16-30
16	090310	12/1/2003	11,464.35	16-30
17	077008	11/1/2003	278.34	46-60
18	082040	11/1/2003	44.16	46-60
19	090312	11/1/2003	1,838.33	46-60
20	090962	11/1/2003	145.23	46-60

HIGHMARK.

March 22, 2004

Stephen J. Johnson
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Commonwealth of Pennsylvania
1345 Strawberry Square
Harrisburg, PA 17120

Randolph L. Rohrbaugh
Deputy Insurance Commissioner
Office of Insurance Product Regulation
& Market Enforcement
Commonwealth of Pennsylvania
1311 Strawberry Square
Harrisburg, PA 17120

RE: Highmark, Inc
March 22 Data Call - Reserves and Surplus
Your Letter Dated January 5, 2004

Dear Mssrs. Johnson and Rohrbaugh:

Highmark, Inc. hereby submits our response to your letter to Kenneth R. Melani, M.D. President and Chief Executive Office of Highmark dated January 5, 2004.

You set forth five (5) sections of information to be provided. You have requested this information in electronic as well as paper form. Due to the size of some of the submissions, we will be sending each section (a-e) in separate e-mails.

If you have any further questions, please contact me at (412) 544-5250, or via e-mail at david.obrien@highmark.com, or to the attention of Candy Gallaher at (717) 302-3982.

Sincerely,

David M. O'Brien

David O'Brien
Executive Vice President,
Government Services.

Cc: S. Ykema, Esq.

Corporate Offices:
Camp Hill PA 17089
Fifth Avenue Place • 120 Fifth Avenue • Pittsburgh PA 15222-3099
www.highmark.com

HIGHMARK 00380

HIGHMARK.

Stephen J. Johnson
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Commonwealth of Pennsylvania
1345 Strawberry Square
Harrisburg, PA 17120

April 1, 2004

Randolph L. Rohrbaugh
Deputy Insurance Commissioner
Office of Insurance Product Regulation
& Market Enforcement
Commonwealth of Pennsylvania
1311 Strawberry Square
Harrisburg, PA 17120

RE: Highmark Inc.
March 22 Data Call - Reserves and Surplus
Additional Materials

Dear Mssrs. Johnson and Rohrbaugh:

Highmark Inc. previously submitted information in response to your letter to Kenneth R. Melani, M.D. President and Chief Executive Office of Highmark dated January 5, 2004. We provided the independent actuarial certifications in response to section (a), but requested additional time needed to prepare and submit some of the detailed materials.

We hereby provide the Agreed Upon Procedures for the reviews of Highmark Inc. and its subsidiary and affiliate insurance companies, in binders prepared on our behalf by PricewaterhouseCoopers LLP (PwC). Two copies are provided.

Also included are five copies of the Executive Summary of the Point Estimate as of December 31, 2003, a document to be inserted in the five binders previously submitted, at Tab A.

For discussion on this or any other information, please contact Candy Gallaher at (717) 302-3982 or candy.gallaher@highmark.com, or you may contact me at (412) 544-5250, or david.obrien@highmark.com.

Sincerely,

David M. O'Brien

David O'Brien
Executive Vice President,
Government Services

Enclosures

Cc: S. Ykema, Esq.

Item A

INDEPENDENT

ACTUARIES CERTIFICATIONS

HIGHMARK, INC.

Actuarial Review of Recorded Reserves

As of December 31, 2003

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Mark F. St. George
One International Place
Boston, MA 02110
Telephone (617) 530-4206
Facsimile (813) 207-8392

March 22, 2004

William J. Cashion
Vice President & Chief Actuary
Highmark, Inc.
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

Dear Bill:

We are pleased to present the results of our review of Highmark Inc.'s (Highmark's) recorded reserves as of December 31, 2003.

Highmark retained PricewaterhouseCoopers LLP (PwC) to perform an independent analysis of Highmark's recorded reserves as of December 31, 2003. This review has been conducted in accordance with generally accepted actuarial principles and practices, giving consideration to the guidelines put forth by the Pennsylvania Insurance Department in its letter to Highmark dated January 5, 2004.

The actuaries involved in this engagement are members of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and meet the "General and Specific Qualification Standards for Public Statements of Actuarial Opinion" relating to their particular areas of practice.

Our calculations were based on unaudited claims data, exposure data, and other plan information furnished by Highmark.

The review followed generally accepted actuarial methods and we performed such tests as we considered necessary to assure the accuracy of the results. The amounts presented in this report have been determined according to the actuarial assumptions and methods stated herein. It should be recognized, however, that because future events frequently do not occur as expected, there are usually differences between estimated and actual results. Accordingly, there can be no assurance that the estimated values will materialize.

Should you have any questions, please call us.

Respectfully submitted,

PRICEWATERHOUSECOOPERS LLP

Mark F. St. George, FSA
Member of the American Academy of Actuaries
(617) 530-4206

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Section I - Certifications

Section I – Certifications

I, Mark F. St. George, am associated with the firm of PricewaterhouseCoopers LLP. I am a Fellow of the Society of Actuaries and also a Member of the American Academy of Actuaries. I meet the American Academy of Actuaries' General and Specific Qualification Standards for Prescribed Statements of Actuarial Opinion for Health Insurance Organizations and have been retained by Highmark Inc. to provide an opinion with regard to loss reserves, actuarial liabilities and related items.

I have examined the actuarial assumptions and methods used in determining the net liability for those items listed below, as included in the Annual Statement of Highmark Inc. as prepared for filing with the state regulatory officials as of December 31, 2003. I relied upon records, summaries, and other supporting data prepared by responsible officers and employees of the company. In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary.

Based on my expertise and qualifications, I have limited the scope of my review to the recorded reserves for Highmark and the following subsidiaries and affiliates of Highmark, Inc.:

- United Concordia Companies, Inc.
- Keystone Health Plan West
- Healthguard
- Gateway Health Plan
- Inter-county Health Plan
- Inter-county Hospitalization Plan
- Davis Vision of Michigan

Highmark has certain subsidiaries that primarily engage in writing life and casualty insurance. In putting forth my overall opinion with regard to Highmark and its subsidiaries and affiliates, I have relied on the separate opinions prepared by other actuaries who specialize in lines of business other than Health, and are qualified to render such opinions. The following entities are included in these separate reviews:

- Highmark Casualty Insurance Company
- Highmark Life Insurance Company
- Highmark Life Insurance Company of New York
- HCI, Inc.

In my opinion, the amounts carried in the Annual Statements and identified in the attached exhibits

- are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

- are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;
- meet the requirements of the laws of the Commonwealth of Pennsylvania;
- all claims unpaid amounts are computed on the basis of actuarial assumptions and methods consistent in all material respects with those used in computing the corresponding items in the Annual Statement of the preceding year-end; and
- include appropriate provision for all actuarial items which ought to be established.

Except where otherwise noted, actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion. I certify that the items above have been determined appropriately; however, because future events frequently do not occur exactly as expected, there are usually differences between estimated and actual results.

Respectfully submitted,

PricewaterhouseCoopers LLP

March 22, 2004

Mark F. St. George, FSA
Member, American Academy of Actuaries

Date

HIGHMARK 00388

Highmark Casualty Insurance Company
Statement of Actuarial Opinion
As of December 31, 2003

I, Mark R. Proska, am a Senior Manager with the firm of PricewaterhouseCoopers LLP. I am a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries meeting its qualification standards. I was appointed by the Board of Directors of the Highmark Casualty Insurance Company (the Company) on November 14, 1997 to render this Opinion. The loss and loss adjustment expense reserves are the responsibility of the Company's management; my responsibility is to express an opinion on loss and loss adjustment expense reserves based on my review.

I have examined the reserves listed below, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 2003.

(A)	Reserve for Unpaid Losses (Page 3, Line 1)	$33,080,288
(B)	Reserve for Unpaid Loss Adjustment Expenses (Page 3, Line 3)	$3,346,550
	Total of (A) and (B)	*$36,426,838*
(C)	Reserve for Unpaid Losses – Direct and Assumed (Schedule P – Part 1, Total of Columns 13 and 15)	$59,310,000
(D)	Reserve for Unpaid Loss Adjustment Expenses – Direct and Assumed (Schedule P – Part 1, Total of Columns 17, 19, and 21)	$5,279,000
	Total of (C) and (D)	*$64,589,000*
(E)	The Total Claims-made Extended Loss and Expense Reserve (Schedule P Interrogatories)	$0
(F)	Reserve for Retroactive Reinsurance Assumed (Page 3, Lines 23)	$0
	Total of (A), (B), and (F)	*$36,426,838*

The amounts on the previous page reflect the following items:

(a) Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P - Analysis of Losses and Loss Expenses and on Page 3 - Liabilities, Surplus and Other Funds, Line 1, $0;

(b) Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P - Analysis of Losses and Loss Expenses and on Page 3 - Liabilities, Surplus and Other Funds, Lines 1 and 3, non-tabular discount, $4,089,000, and tabular discount, $0;

(c) The net reserves for losses and loss adjustment expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and expenses which are included in reserves shown on Page 3 - Liabilities, Surplus and Other Funds, Lines 1 and 3, $1,722,213;

(d) The net reserves for losses and loss adjustment expenses that the Company carries for Asbestos liabilities, $0, and Environmental liabilities, $0, which are included in the reserves on Page 3 - Liabilities, Surplus and Other Funds, Lines 1 and 3, and disclosed in the Notes to Financial Statements; and

(e) The total reserves for losses and loss adjustment expenses that the Company carries for the extended loss and expense reserve, $0, as reported in the Schedule P Interrogatories.

In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by the responsible officers or employees of the Company or group to which it belongs. I evaluated the data used directly in my analysis for reasonableness and consistency. I have reviewed the Company's loss reserves on an undiscounted basis, the sufficiency of the investment yield on invested assets to fund the discount, and the reasonableness of the matching of invested assets and loss reserves attributable to workers' compensation business to provide an adequate income stream to fund the discount. I also reconciled that data to Schedule P - Part 1 of the Company's current Annual Statement, a copy of which management intends to file. In other respects, my examination included the use of such actuarial assumptions and methods and such tests of calculations as I considered necessary.

OPINION

In my opinion, the amounts carried in the Scope paragraph for the sum of items A and B, the sum of items C and D, the sum of items A, B and F, and item E:

(A) meet the requirements of the insurance laws of Pennsylvania;

(B) are computed in accordance with generally accepted loss reserving standards and principles; and

(C) make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.

RELEVANT COMMENTS

The Company significantly increased its net of reinsurance workers' compensation business in 2002. Effective with business written July 1, 2002 and thereafter, the Company retains all the risk on the first $250,000 per occurrence and participates in excess layers up to $1,000,000 per occurrence. I have identified this growth in net workers' compensation writings as a major risk factor affecting the variability of the Company's reserves. At this time, neither the Company nor I have assessed the resulting potential for adverse deviation to be material. The potential impact of this risk factor relates to the slow development of workers' compensation losses, and the volatility this can have on reserve estimates. The absence of other factors from this listing does not imply that additional factors will not be identified in the future as having been a significant influence on the Company's reserves.

The accident and health stop loss business has been reviewed on a policy month basis. In prior years this business has been reviewed on an accident quarter basis. Grouping the data by policy month will provide more consistency in the data than an accident period grouping allows. Other than this, there have been no material changes in the actuarial assumptions and/or methods from those used in the previous period. I have assumed that coverages will not be broadened by legislative action or judicial interpretation. In evaluating whether the reserves make a reasonable provision for unpaid losses and loss adjustment expenses, it was necessary to project future loss and loss adjustment expense payments. Actual future losses and loss adjustment expenses will not develop exactly as projected and may, in fact, vary significantly from the projections. The estimates of the reserves cited in the Scope paragraph make no provision for extraordinary future emergence of new classes of losses or types of loss not sufficiently represented in the Company's historical database or which are not yet quantifiable.

Mark R. Proska

Mark R. Proska, FCAS, MAAA
Senior Manager
PricewaterhouseCoopers LLP
2001 Market Street
Philadelphia, PA 19103
(267) 330-6612

February 24, 2004

Highmark Life Insurance Company

I, Jennifer H. Liang, am associated with the firm of PricewaterhouseCoopers LLP. I am a Fellow of the Society of Actuaries and also a member of the American Academy of Actuaries. I meet the Academy of Actuaries' qualification standards for prescribed statements of rendering this opinion and am familiar with the valuation requirements applicable to life and health insurance companies.

I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the Annual Statement of the Company, as prepared for filing with state regulatory officials, as of December 31, 2003.

	Statement Reference	Amount
Aggregate reserve for life contracts included in Exhibit 5	Page 3, Line 1	$ 26,041,857
Aggregate reserve for accident and health contracts included in Exhibit 6	Page 3, Line 2	$ 110,190,167
Liability for deposit-type contracts included in Exhibit 7	Page 3, Line 3	$ 905,340
Policy and contract claims– liability end of current year included in Exhibit 8, Part 1		
Life	Page 3, Line 4.1	$ 6,913,647
Accident and Health	Page 3, Line 4.2	$ 32,448,833

In forming my opinion, I have relied upon listings and summaries of policies and contracts and other liabilities in force prepared by responsible officers and employees of the Company. In other respects, my examination included such review of actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary.

In my opinion, the reserves and related actuarial values concerning the statement items identified above:

(a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

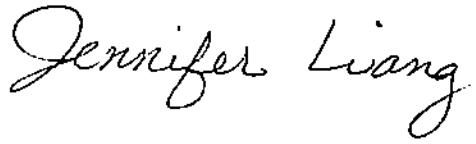
(b) Are based on actuarial assumptions which produce reserves at least as great as those called for in any policy or contract provision as to reserve basis and method, and are in accordance with all other policy or contract provisions;

(c) Meet the requirements of the Insurance Law & Regulations of the State of Pennsylvania and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year-end; and

(e) Include provision for all actuarial reserves and related statement items which ought to be established.

Except where otherwise noted, actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion. I certify that the items above have been determined appropriately; however, because future events frequently do not occur exactly as expected, there are usually differences between estimated and actual results.



Jennifer H. Liang, FSA, MAAA
PricewaterhouseCoopers
March 19, 2004
(312) 298-4063

Highmark Life Insurance Company of New York

I, Jennifer H. Liang, am associated with the firm of PricewaterhouseCoopers LLP. I am a Fellow of the Society of Actuaries and also a member of the American Academy of Actuaries. I meet the Academy of Actuaries' qualification standards for prescribed statements of rendering this opinion and am familiar with the valuation requirements applicable to life and health insurance companies.

I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the Annual Statement of the Company, as prepared for filing with state regulatory officials, as of December 31, 2003.

	Statement Reference	Amount
Aggregate reserve for life contracts included in Exhibit 5	Page 3, Line 1	$ 3,112,678
Aggregate reserve for accident and health contracts included in Exhibit 6	Page 3, Line 2	$ 6,155,414
Liability for deposit-type contracts included in Exhibit 7	Page 3, Line 3	- 0 -
Policy and contract claims– liability end of current year included in Exhibit 8, Part 1		
Life	Page 3, Line 4.1	$ 819,706
Accident and Health	Page 3, Line 4.2	$ 2,912,700

In forming my opinion, I have relied upon listings and summaries of policies and contracts and other liabilities in force prepared by responsible officers and employees of the Company. In other respects, my examination included such review of actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary.

In my opinion, the reserves and related actuarial values concerning the statement items identified above:

(a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

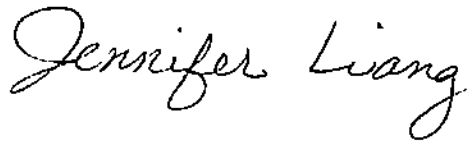
(b) Are based on actuarial assumptions which produce reserves at least as great as those called for in any policy or contract provision as to reserve basis and method, and are in accordance with all other policy or contract provisions;

(c) Meet the requirements of the Insurance Law & Regulations of the State of Pennsylvania and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(d) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year-end; and

(e) Include provision for all actuarial reserves and related statement items which ought to be established.

Except where otherwise noted, actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion. I certify that the items above have been determined appropriately; however, because future events frequently do not occur exactly as expected, there are usually differences between estimated and actual results.



Jennifer H. Liang, FSA, MAAA
PricewaterhouseCoopers
March 19, 2004
(312) 298-4063

Section II – Executive Summary

INTRODUCTION

The Commonwealth of Pennsylvania Insurance Department (PID) has requested that Highmark, Inc. (Highmark) submit an independent actuarial review and certification of all claims unpaid, accrued medical incentive pool and bonus payments, unpaid claims adjustment expenses, aggregate policy reserves, aggregate claim reserves, accident and health premiums due and unpaid, and premiums received in advance/unearned premiums posted to the companies' statutory annual statements for 2003, and such related accounts on the life and property and casualty annual statement blanks, for each of its insurance subsidiaries and affiliates in order to assess the statement of reserves, surplus, and RBC ratios. Highmark retained PricewaterhouseCoopers LLP (PwC) to perform this independent analysis.

Certain of the annual statement items included in the PID request are not primarily the result of actuarial analysis and, therefore, are not deemed to be actuarially determined. The annual statement line items that were not considered to be primarily the result of actuarial analysis include, but are not limited to (1) accident and health premiums due and unpaid, (2) premiums received in advance/unearned premiums, (3) accrued medical incentive pool and bonus payments, and (4) aggregate policy reserves for all Health Insurance related subsidiaries and affiliates. These annual statement line items were addressed through the performance of Agreed Upon Procedures, and are contained in a separate report. In addition to the items noted above, there are other reconciling items that affect the annual statement line items reviewed in this report, but which are not actuarially determined. These items are noted and the methodologies used for reviewing such items are described herein.

Separate reviews were performed for the following subsidiaries or affiliates of Highmark:

- Highmark
- United Concordia Companies, Inc. (UCCI)
- Keystone Health Plan West (KHPW)
- Healthguard (HG)
- Highmark Casualty Insurance Company (HCIC)
- Highmark Life Insurance Company (HLIC)
- Highmark Life Insurance Company of New York (HLICNY)
- HCI, Inc. (HCI)
- Gateway Health Plan (GHP) (50% owned affiliate)
- Inter-county Health Plan (ICHeP) (50% owned affiliate)
- Inter-county Hospitalization Plan (ICHoP) (50% owned affiliate)
- Davis Vision of Michigan (DVM)

POINT ESTIMATE AS OF DECEMBER 31, 2003

PwC performed an actuarial analysis to certify Highmark and each of its insurance subsidiaries' and affiliates' reserves as of December 31, 2003. In performing our review supporting these certifications, PwC has concluded that Highmark's and each of its subsidiaries' and affiliates' recorded reserves fall within a range of reasonable results.

At the request of Highmark, PwC has provided supplemental information to assist Highmark in complying with the PID request of obtaining a point estimate from an independent actuary as of December 31, 2003. This report is intended to support the requested point estimate which is within the overall range of reasonable results for Highmark and each subsidiary and affiliate. The identified point estimate represents our "best" estimate, and as such for each subsidiary or affiliate is neither excessive nor deficient in representing the relevant items for December 31, 2003. It should be recognized that because the determination of estimates of reserve liabilities involves estimating future events and that because future events do not occur as expected there are usually differences between point estimates developed by different actuaries and there are usually differences between estimated and actual results.

Table I details the reserve point estimates we determined for Highmark and its subsidiaries and affiliates, by subsidiary or affiliate and in total, compared to the estimated amounts determined and recorded by Highmark.

	Highmark Recorded Reserve	*PwC Point Estimate*	*Difference*	*Percentage Difference*
Highmark Risk	451,774,393	444,285,829	7,488,564	1.69%
United Concordia Companies, Inc. (UCCI)	56,770,845	55,570,471	1,200,374	2.16%
Keystone Health Plan West (KHPW)	197,583,486	194,913,166	2,670,320	1.37%
Healthguard	23,090,178	21,453,396	1,636,782	7.63%
Highmark Casualty Insurance Company	36,426,838	36,179,489	247,349	0.68%
Highmark Life Insurance Company	176,499,844	176,488,102	11,742	0.01%
Highmark Life Insurance Company of New York	13,000,498	13,117,584	(117,086)	-0.89%
HCI, Inc.	441,847	441,847	-	0.00%
Geteway Health Plan (GHP)[1]	33,516,300	29,064,919	4,451,381	15.32%
Inter-county Health Plan[1]	3,472,227	3,489,561	(17,334)	-0.50%
Inter-county Hospitalization Plan[1]	6,135,273	6,104,354	30,919	0.51%
Davis Vision of Michigan	463,853	462,113	1,840	0.40%
Total	999,175,682	981,570,830	17,604,852	1.79%

[1] Gateway Health Plan, Inter-county Health Plan and Inter-county Hospitalization Plan are 50% owned affiliates of Highmark. As a result, Highmark is responsible for 50% of all liabilities. In order to facilitate the comparison above, we have included 50% of each of the recorded reserve and the PwC point estimate in our analysis.

In preparing the results of this review, we have relied upon claims, exposure and other data provided to us by Highmark. PwC actuaries reviewed the data provided for reasonableness, but did not audit the data nor provide independent verification of the data. The accuracy of the results presented in this report is dependent upon the accuracy and completeness of the underlying data.

The following page displays a reconciliation of the line item adjustments to the reserve estimate to the insurance blanks, by subsidiary or affiliate.

Section II – Executive Summary

		Highmark		United Concordia Companies, Inc.		Keystone Health Plan West		HealthGuard		Highmark Casualty Insurance Company		Highmark Life Insurance Company	
		Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate
Health Annual Statement		451,774,393	444,293,629	6,092,747	5,649,843	197,383,496	194,913,166	23,090,778	21,453,396	-	-	-	-
Line 1	Claims Unpaid	434,982,455	427,750,205	5,658,750	5,274,920	193,279,367	190,886,047	22,748,130	21,111,257	-	-	-	-
Line 3	Unpaid Claims Adjustment Expenses	16,791,938	16,525,824	423,997	395,223	4,304,119	4,247,119	342,039	342,039	-	-	-	-
Line 5	Aggregate Claim Reserves	-	-	-	-	-	-	-	-	-	-	-	-
Life Annual Statement		-	-	54,680,458	49,946,629	-	-	-	-	-	-	176,493,844	176,498,192
Line 1	Aggregate Reserve for Life Contracts	-	-	-	-	-	-	-	-	-	-	28,041,857	28,041,857
Line 2	Aggregate Reserve for Accident and Health Contracts	-	-	-	-	-	-	-	-	-	-	110,190,167	109,287,055
Line 3	Liability for Deposit-type Contracts	-	-	-	-	-	-	-	-	-	-	905,340	905,340
Line 4.1	Contract Claims - Life	-	-	-	-	-	-	-	-	-	-	6,913,647	7,445,091
Line 4.2	Contract Claims - Accident and Health	-	-	50,580,098	49,900,629	-	-	-	-	-	-	32,442,833	32,808,759
Property/Casualty Annual Statement		-	-	-	-	-	-	-	-	34,426,838	34,173,499	-	-
Line 1	Losses	-	-	-	-	-	-	-	-	30,980,266	32,832,839	-	-
Line 3	Loss Adjustment Expenses	-	-	-	-	-	-	-	-	3,346,550	3,340,550	-	-
Total By Company		451,774,393	444,293,629	56,773,845	55,576,471	197,383,496	194,913,166	23,090,778	21,453,396	34,426,838	34,173,499	176,493,844	176,498,192

		Highmark Life Insurance Company of New York		HCSC		Gateway Health Plan		Inter-County Health Plan		Inter-County Hospitalization Plan		Davis Vision of Michigan		Total	
		Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate	Highmark Recorded Reserves	PwC Point Estimate
Health Annual Statement		-	-	-	-	33,516,309	29,964,979	3,472,227	3,499,561	6,735,273	6,704,354	463,953	462,773	722,118,557	705,443,194
Line 1	Claims Unpaid	-	-	-	-	32,526,789	28,210,554	3,345,500	3,363,201	5,897,000	5,862,307	346,003	344,163	698,770,013	682,581,583
Line 3	Unpaid Claims Adjustment Expenses	-	-	-	-	989,502	854,235	126,727	127,260	243,273	242,047	117,950	117,950	23,330,545	22,851,597
Line 5	Aggregate Claim Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Life Annual Statement		73,666,498	73,117,584	-	-	-	-	-	-	-	-	-	-	340,788,448	338,586,314
Line 1	Aggregate Reserve for Life Contracts	3,112,578	3,112,578	-	-	-	-	-	-	-	-	-	-	29,154,535	29,154,535
Line 2	Aggregate Reserve for Accident and Health Contracts	6,155,414	6,104,036	-	-	-	-	-	-	-	-	-	-	116,345,581	115,391,091
Line 3	Liability for Deposit-type Contracts	-	-	-	-	-	-	-	-	-	-	-	-	905,340	905,340
Line 4.1	Contract Claims - Life	819,706	861,458	-	-	-	-	-	-	-	-	-	-	7,733,353	8,306,549
Line 4.2	Contract Claims - Accident and Health	2,912,700	3,019,412	-	-	-	-	-	-	-	-	-	-	86,349,831	85,729,799
Property/Casualty Annual Statement		-	-	441,847	441,847	-	-	-	-	-	-	-	-	34,868,685	34,615,346
Line 1	Losses	-	-	347,918	347,918	-	-	-	-	-	-	-	-	33,428,208	33,180,857
Line 3	Loss Adjustment Expenses	-	-	93,929	93,929	-	-	-	-	-	-	-	-	3,440,478	3,440,478
Total By Company		73,666,498	73,117,584	441,847	441,847	33,516,309	29,964,979	3,472,227	3,499,561	6,735,273	6,704,354	463,953	462,773	922,775,682	907,578,854

HIGHMARK 00400

DEVELOPMENT OF POINT ESTIMATES

The items that the PID has requested be included in this analysis consist of a combination of actuarially determined and non-actuarially determined amounts. It is the nature of the actuarially determined amounts that they are dependent upon the underlying assumptions and methods used in their estimation.

For Highmark, Inc. and each of its subsidiaries and affiliates, PwC developed a range of reasonable estimates, as well as an independent point estimate of the reserves. The point estimate represents our "best" estimate of the expected reserve value, and as such is believed to be neither excessive nor deficient.

HEALTH INSURANCE COMPANIES

PwC Health Insurance Actuaries reviewed the actuarially determined reserve values developed by Highmark for inclusion in the December 31, 2003 Annual Statements and concluded that these amounts were reasonable and adequate.

Point estimates were developed by PwC for claims incurred but not reported (IBNR) and the cost of processing outstanding claims (CPOC) for all major lines of business for the following subsidiaries and affiliates of Highmark:

- Highmark
- United Concordia Companies, Inc.
- Keystone Health Plan West
- Healthguard
- Gateway Health Plan
- Inter-county Health Plan
- Inter-county Hospitalization Plan
- Davis Vision of Michigan

DATA

Highmark and its subsidiaries and affiliates provided paid claims data by service month and payment month for each line of business through December 2003. For most lines of business, four years of paid claims data was received; in cases where a line of business has not been in existence for four years, paid claims data was provided as of the plan's inception. Highmark and its subsidiaries and affiliates also provided exposure data by service month for each month in which claims data was provided.

METHODOLOGY

The primary method used by PwC to develop estimates of Highmark's IBNR is the modified lag method. This method relies primarily on historical claim payment patterns to estimate the IBNR (completion method). The method is modified for months for which the completion method is judged by the actuary to be less reliable, and projections of incurred claims are incorporated into the calculations.

For historical incurral months, completion factors were calculated which allowed claims for incurred months with incomplete runout to be projected. The completion factor approach generally yields less reliable results for the more recent incurral months, since the cumulative payouts at these shorter durations are lower and less predictable than more mature months. Therefore, for the most recent incurral months (generally those months assumed to be less than 80% complete), in addition to the calculation of a completion factor, a theoretical estimate of ultimate incurred claims per member per month (PMPM) was determined based on historical ultimate incurred claims levels PMPM which included appropriate provisions for claims trend and seasonality factors.

For each line of business, the estimate of IBNR for the most recent incurral months was developed using a combination of the completion factor method and the method of developing ultimate claims' estimates on a PMPM basis (i.e., a credibility approach was used), with appropriate adjustments for claims trend and seasonality. It should be noted that different data smoothing techniques and trend assumptions will lead to different results.

For certain lines of business, variations of the basic methodology outlined above were employed to account for circumstances or nuances peculiar to specific lines of business or other subsets of the business.

PwC evaluated the percentage of IBNR held by Highmark and each subsidiary or affiliate to cover the cost of processing outstanding claims (CPOC). In each case, that percentage was determined to be reasonable. PwC applied that same percentage to its point estimates to determine the point estimate of the CPOC.

CASUALTY INSURANCE COMPANIES

Highmark Casualty Insurance Company (HCIC) is a wholly-owned subsidiary of Highmark, Inc., a not-for-profit hospital and medical plan corporation. HCIC writes accident and health business, primarily stop loss coverages in Pennsylvania. Marketing is currently focused on the employee benefits area and HCIC targets Highmark, Inc. clients. HCIC began writing workers' compensation business, primarily in Texas, in 1996. This business is now in runoff. In 1999, HCIC began writing workers' compensation business in Pennsylvania and New Jersey. This business has been underwritten by Advantage Comp and HCIC.

PwC Casualty Insurance Actuaries reviewed the actuarially determined reserve values developed by Highmark for inclusion in the December 31, 2003 Annual Statements and concluded that these amounts were reasonable and adequate.

Point estimates were developed by PwC for losses net of reinsurance and gross of reinsurance (direct plus assumed business). All PwC analysis was done gross of salvage and subrogation. Allocated loss adjustment expenses (ALAE) are included with losses for all lines. Unallocated loss adjustment expenses (ULAE) were reviewed separately.

DATA

The Company provided the following data for our analysis:

- Paid Loss and ALAE;
- Case Loss Reserves; and
- Earned Premiums.

PwC was also provided with the relevant pages of the Company's 2003 Annual Statement

ACTUARIAL METHODOLOGIES AND ASSUMPTIONS

Direct & Assumed Loss

In developing the loss reserve estimates shown in this report, PwC first projected paid and incurred losses to estimated ultimate values using several actuarial methods. We selected an ultimate value by reviewing the various ultimate estimates and applying actuarial judgment to achieve a reasonable point estimate for the ultimate liability. The selected reserves were then determined as the difference between the selected ultimate loss and the paid loss. The difference between the selected ultimate loss and the incurred loss is PwC's estimate of the reserve for losses which were incurred but not reported (IBNR). Thus IBNR includes a provision for both development on known cases as well as a provision for late reported claims. The following actuarial methods were used in projecting net ultimate losses:

- Paid Loss Development;
- Incurred Loss Development;
- Bornhuetter-Ferguson Using Ultimate Premium and Paid Loss; and
- Bornhuetter-Ferguson Using Ultimate Premium and Incurred Loss.

Paid loss development assumes that the ratio of losses paid in one period to losses paid in an earlier period is approximately constant over time. For example, if, on average, paid losses at 24 months after the start of the year were 150% of losses at 12 months, loss development from 12 to 24 months is projected to be 50%. Similarly if losses at 36 months were 120% of losses at 24 months, then the combined loss development from 12 to 36 months is projected to be 80% (1.50 x 1.20 = 1.80). The process of estimating period to period development factors is normally continued until a level of maturity is reached at which point no additional movement is expected.

Incurred loss development is similar to the prior method but uses incurred losses (paid loss plus case loss reserves) instead of paid losses.

The Bornhuetter-Ferguson method based on premiums and incurred (or paid) loss is a variation on the traditional development approach. The basic premise underlying this technique is that loss varies proportionately with premiums. Expected loss ratios are selected based on historical loss experience and resulting trends. This is balanced by assuming that only future losses will develop at this rate. The percent of incurred (or paid) loss to ultimate loss implied from the incurred (or paid) loss development method is used to determine what percentage of ultimate loss is yet to be developed. Current losses are added to losses yet to be developed, yielding an estimate for each year.

The Bornhuetter-Ferguson approaches are particularly useful for the most recent years because of their relative stability compared with that of development techniques. Paid loss development factors, in particular, can be very large for the most recent years; a relatively small change in the reporting or payment pattern could significantly distort the calculated result.

Unallocated Loss Adjustment Expenses

Unallocated loss adjustment expense (ULAE) reserves were estimated using a modification of the New York Insurance Department Rule, also known as the "50-50 Rule". This method assumes the existence of a relationship between incremental calendar year paid loss and paid unallocated loss adjustment expense. The model also assumes that ULAE payments are associated with only two events - a claim being reported and a claim being closed, and that these events each require half of the ULAE payment. Therefore, for the establishment of a reserve for ULAE, half of the calendar year ratio of ULAE to loss is applied to the case loss reserve because it is presumed that ULAE payments associated with open claims have already been paid. The full ratio of calendar year ULAE to loss is applied to the IBNR reserve since no portion of the ULAE is presumed to have been paid on unreported claims. Note that for New Jersey workers' compensation business, claims are handled by a third-party administrator and the Company records the full cost for this service in the commission.

Discounting

The Company discounts its loss and loss adjustment expense reserves. Workers' compensation loss reserves are discounted on a non-tabular basis, using a discount rate of 4.0%.

Salvage and Subrogation

The Company does not take credit for expected future salvage and subrogation recoveries in its reserves.

Pools and Associations

The Company participates in a small number of pooling arrangements. The Company includes its pool participation in individual lines of business. Company practice is to record its share of the reported reserves for these pools and associations without any adjustment for reporting lag. Reserve exposure with respect to pools is considered to be immaterial.

Extended Loss and Expense Reserves

The Company does not carry reserves for extended loss and expenses.

Unearned Premium Reserve
The Company represented to me that it does not have exposure to long duration contracts defined as being single or fixed premium policies with coverage periods of thirteen months or greater which are non-cancellable and not subject to premium adjustment (excluding financial guaranty contracts, mortgage guaranty policies, and surety contracts).

LIFE INSURANCE COMPANIES

Highmark Life Insurance Company (HLIC) and Highmark Life Insurance Company of New York (HLICNY) are stock life insurance companies selling group insurance products such as Group Long Term Disability (GLTD), Short Term Disability, Stop Loss, Group Life Insurance, Dependent Life, AD&D, Vision, and New York Disability Benefits Policy (sold through HLICNY only). All products are written on a renewable term basis. Several individual life conversions policies have been issued as of 12/31/2003. Over 90% of the liabilities to which the Statement of Actuarial Opinion applied were for GLTD, Premium Waiver of Group Life Insurance, and Stop-Loss.

PwC Life Insurance Actuaries reviewed the actuarially determined reserve values developed by Highmark for inclusion in the December 31, 2003 Annual Statements and concluded that these amounts were reasonable and adequate.

GROUP LONG TERM DISABILITY (GLTD)

Disabled Life Reserves (DLR)
An independent reserve calculation based on an Excel worksheet was performed to validate the Companies' DLR calculation. Disabled Life Reserves (DLR) represent the present value of all potential prospective future benefit payments (net of any offsets). DLR, for general diseases and AIDS, are computed based on the 1987 Commissioners Group Disability Table (1987 CGDT), with modification factors depending on the incurred date. Maternity DLR is calculated based on specific termination rates.

Valuation interest rates are set in accordance with the limits established in the minimum valuation standard of Codification.

Seriatim DLR were computed for each benefit year separately, accumulating present values for the final DLR. Benefit offsets, except for Social Security benefits, are computed as 100% reduction of LTD's monthly benefit income for the amount of the reduction. For Social Security benefits, a 65% benefit reduction is applied to LTD's monthly benefit for the amount of the reduction. If the offset amount has not been estimated and claim duration is less than 18 months, the offset amount is calculated based on the Social Security Administration probability table.

The cost of living adjustment (COLA) benefit amount is calculated from actual COLA rates input for each year prior to valuation; for future years, the discount rate is reduced by the adjusted COLA%.

From the reserve detail testing, it appears that the DLRs were properly calculated by HLIC and HLICNY.

Incurred But Not Reported Reserves (IBNR)
IBNR is set up to cover the period from the date of disability to the later of date approved or the end of the elimination period. The primary method used by PwC to develop estimates of LTD claim reserves is the estimates on the "BULK" IBNR to account for true IBNR claims and experience adjustments on tabular reserves during the latest eight quarters. The method used by PwC to develop estimates of "BULK" IBNR is the discounted incurred development method. Due to the similarities on products sold by HLIC and HLICNY, we performed the independent estimates on an aggregate basis. The statutory valuation interest rates for each incurred year were used for discounting. The present value of total incurred claims at the beginning of year of disability were calculated for each incurred quarter. Claim payments were assumed to be paid in the middle of the quarter and the reserves were held at the end of the quarter.

Survivorship Benefit, Re-Open, and Loss Adjustment Expenses
Survivorship benefit reserves are set to 1.5% of DLR. The claim settlement expenses (i.e., Loss Adjustment Expenses) are set to 2% of total reported reserves.

GLTD – Kemper Service
During the 2nd quarter 2003, HLIC had a service agreement with Kemper Service ("Kemper", renamed as Broadspire in 2004), of which, Kemper marketed and administered the new GLTD contracts. As of 12/31/2003, there are four GLTD claims associated with HLIC and zero claims associated with HLICNY. The DLR was set to equal the present values of future benefits. IBNR was estimated for each group based on the group's pricing loss ratio times the earned premiums. Since the claim experience as of 12/31/2003 is not credible, we concluded that the Companies' IBNR method for Kemper block appeared appropriate. No LAE was set up by the Companies due to the service agreement. Kemper is responsible for continuing claims administration without further compensation from HLIC or HLICNY.

GROUP LIFE INSURANCE

Group Life Insurance reserves have three components: Active Life Reserves (ALR), IBNR claim reserves and premium waiver reserves. Pended or suspended claims are not held as a separate reserve; instead they are implicitly included in the IBNR.

Active Life Reserves (ALR)
The unearned premium reserves were held as ALR. The unearned premium reserve is equal to the amount of gross premium received which is greater than the current billing cycle's bill amount.

Premium Waiver Reserves (PWR)
The premium waiver reserve is established based on the present value of the death benefit for the disabled participant, which extends beyond the one year term period and has a higher chance of occurrence. The premium waiver coverage typically ends at age 65. For statutory reporting on

the approved waiver claims, the premium waiver reserves are based on 100% of Krieger tables (1970 Intercompany Valuation table) with margins recommended by such tables (130% applied to mortality and 60% applied to recovery or termination other than death). The valuation interest rates are set in accordance with the limits established in the minimum valuation standard of the Codification.

IBNR

Similar to GLTD reserves, the IBNR was estimated to account for both true IBNR, in course of settlements, and pending claims (fraction of which may be eventually approved). Based on the most recent studies of the lag patterns in the claim payments, the IBNR reserve is set at 15.5% annualized premiums. Due to the volatilities on the historical paid claims through 12/31/2003 for premium waiver, we did not develop point estimates. We independently estimated the IBNR for Group Life (non-waiver) based on paid-development method. The claim settlement expense reserves are set to 1.2% of total gross reserves before reinsurance ceded.

STOP-LOSS INSURANCE

Stop-Loss reserves are calculated for specific and aggregate stop-loss separately. The majority of stop-loss contracts are written on a paid basis. This limits the time period over which the reserve will run out. The reserve is set up based on a loss ratio method that was developed based on historical data.

An undiscounted IBNR reserve was set up for the period between the incurred date and the date the final settlement for the contract year is paid. We independently estimated the reserves for stop-loss specific direct business based on Bornhuetter-Ferguson method. The loss ratio used was determined based on the Company's most recent claims experience.

HIGHMARK 00407

HIGHMARK

March 22, 2004

Stephen J. Johnson
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Commonwealth of Pennsylvania
1345 Strawberry Square
Harrisburg, PA 17120

Randolph L. Rohrbaugh
Deputy Insurance Commissioner
Office of Insurance Product Regulation
& Market Enforcement
Commonwealth of Pennsylvania
1311 Strawberry Square
Harrisburg, PA 17120

RE: Highmark, Inc
March 22 Data Call - Reserves and Surplus
Item (a) and (b)

Dear Mssrs. Johnson and Rohrbaugh:

Highmark, Inc. hereby submits our response to items (a) and (b) of your request for information to be provided by March 22, 2004 as contained in your letter to Kenneth R. Melani, M.D. President and Chief Executive Office of Highmark dated January 5, 2004.
You set forth five (5) sections of information to be provided. Sections (c), (d), and (e) are provided separately. With this letter we provide a limited response to section (a), and section (b) in entirety.

With respect to section (a), enclosed you will find the independent actuarial certifications related to actuarial claim reserves recorded as of December 31, 2003 and reported within the 2003 statutory financial statements of Highmark and its insurance subsidiaries.

With respect to section (b), we find that no amendment of Highmark's annual statement blank, nor that of its insurance subsidiaries, is required. Highmark's booked entries differ from the independent actuary's estimates by $17,604,851 which approximates 0.59 % of Highmark's surplus on a tax-affected basis. This difference is deemed immaterial by management, in relation to Highmark surplus. Our consideration of materiality is guided by the Preamble, Section VI of the NAIC Accounting Practices and Procedures Manual. A comparison of amounts posted to annual statements and the independent actuary's estimate of these amounts is summarized in Exhibit A immediately following this letter.

If you have any further questions regarding this information, please contact me at (412) 544-8322, or via e-mail at nanette.deturk@highmark.com. Or you may contact Candy Gallaher at (717) 302-3982.

Sincerely,

Nanette P. DeTurk
Senior Vice President,
Finance and Corporate Controller

Attachments

cc: S. Ykema, Esq.

Item (b)
ATTACHMENT A

Comparison to PwC Point Estimates

	December 31, 2003			
	Claims and Related Reserves	PwC Point Estimate	Difference	Percentage Difference
Highmark Inc.	451,774,393	444,285,829	7,488,564	1.69%
Gateway Health Plan, Inc.	33,516,300	29,064,919	4,451,381	15.32%
HealthGuard of Lancaster, Inc.	23,090,178	21,453,396	1,636,782	7.63%
HCI, Inc.	441,847	441,847	-	0.00%
Highmark Casualty Insurance Company	36,426,838	36,179,489	247,349	0.68%
Highmark Life Insurance Company	176,499,844	176,488,102	11,742	0.01%
Highmark Life Insurance Company of New York	13,000,498	13,117,584	(117,086)	-0.89%
Davis Vision of Michigan, Inc.	463,953	462,113	1,840	0.40%
Inter-County Health Plan, Inc.	3,472,227	3,489,561	(17,334)	0.50%
Inter-County Hospitalization Plan, Inc.	6,135,273	6,104,354	30,919	0.51%
Keystone Health Plan West, Inc.	197,583,486	194,913,166	2,670,320	1.37%
United Concordia Companies, Inc. (combined)	56,770,845	55,570,471	1,200,374	2.16%
Total	999,175,682	981,570,831	17,604,851	1.79%
	Statutory Tax Effect (estimated)		4,577,261	
	Difference, net of taxes		13,027,590	
	Highmark Inc. Capital and Surplus		2,194,710,174	
	Difference, net of taxes as a percentage of Highmark Inc. Capital and Surplus		0.59%	

Western Pennsylvania Caring Foundation

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Description

Caring Foundation

Mission

The Caring Foundation believes that all children and adults, families and communities deserve to be healthy— physically and emotionally, mentally and spiritually, socially and economically.

The Caring Foundation believes that all children, adults, families and communities deserve to be able to maximize their potential and to attain optimal health.

Goals

The central goal of the Caring Foundation is to serve those in need—to help improve the lives of children and adults, families and communities. The Caring Foundation seeks to make an impact in improving the health and well being of our children, our families, our communities and our region.

The Caring Foundation provides hope—offering hope to those who need health care coverage (and the health care that this coverage opens the door to), supplying hope to those grieving the death of a loved one, making hope available to children with special health care needs, along with their parents, giving hope to communities whose problems are so numerous as to appear hopeless.

The Caring Foundation creates working solutions—building innovative models that amplify the original impact, improving the health, the well-being, the lives of more and more children and adults, families and communities, models that afford hope to more and more of those in need, those who felt hope to be out of reach.

The goal of the Caring Foundation is to maximize potentials—of each individual, and of the 49-county region we serve.

Major Programs

Children's Health Insurance Program (CHIP) and adultBasic

The Caring Foundation with its partner Highmark Blue Cross Blue Shield administer both CHIP and adultBasic on behalf of the Commonwealth of Pennsylvania. More than 300,000 Pennsylvania children and adults have been enrolled in CHIP or adultBasic through the Caring Foundation. The Caring Foundation has referred more than 1,000 children and adults to Medical Assistance each month. More than 60,000 children have been enrolled in the Caring Program.

In 1985, before "the uninsured" became an issue, the Caring Foundation began to respond to the needs of uninsured children, children falling through the cracks of the health care system. The Caring Program for Children was the first program of its kind in the nation, offering primary and preventive health care coverage to uninsured children from low-income families. The Caring Program was replicated throughout the United States, and became the model for Pennsylvania's Children's Health Insurance Program (CHIP), and ultimately for the federal CHIP program.

CHIP was also the model for adultBasic, Pennsylvania's health insurance program for low-income adults.

Key goals for the uninsured child and adult programs include:

1. Reaching uninsured children and adults who are eligible for CHIP and adultBasic, and provide a pathway for them to gain health care coverage, to receive health care services, and to improve their health.
2. Referring all eligible children and adults to Medical Assistance.
3. Empowering community partners to reach uninsured children and adults in their own communities.

The Caring Place

Since 1996 the Caring Foundation began its work for children and families who are grieving the death of a loved one. Currently there are Caring Place sites in Pittsburgh, Erie, and Central Pennsylvania. Since its inception, The Caring Place has helped more than 8,000 family members with their grief.

The Caring Place provides peer support services for children and their families who have experienced the death of a family member. The services are offered at no cost.

The Caring Place has become a community resource in each of its three locations. In addition to providing support to families, The Caring Place provides written resources on various subjects related to grief, such as *Coping With Grief At the Holidays, Questions Kids Ask,* and *Grief Is Not A Disease.*

The Caring Place also provides ongoing education, training and consultation to counselors, teachers, therapists and other professionals who serve children.

Key Goals for Grieving Children, Adolescents and Their Families include:

1. Reaching grieving children, adolescents and their families to let them know of the services available to them.
2. Finding adult volunteers who would like to help make a difference in the lives of grieving children and adults.
3. Enabling providers and other professionals to help children cope with their grief.

Division of Community Health

The Caring Foundation's Division of Community Health is dedicated to improving the health of underserved and at risk individuals and communities. Through the Community Health Division, the Caring Foundation serves as a catalyst for health improvement.

The Caring Foundation's Division of Community Health works as a conduit to improve community health, partnering with community organizations to enhance their missions, helping them to leverage resources and empowering them with measurable and replicable strategies to effect lifestyle changes in the individuals they serve.

The Division of Community Health builds strong partnerships with health providers, human-service agencies, educational and faith-based agencies, and other key stakeholders for the purpose of improving community health. A key place to begin when serving those at-risk or underserved is listening to the needs and hopes, barriers and dreams of the communities as expressed by the community leadership. The Division of Community Health listens to the community, assesses its needs, and works to dramatize those needs. In this way, the Division of Community Health serves as a catalyst for change by establishing partnerships to create initiatives and programs addressing the problems voiced by the community.

Key Goals for Those At-Risk and Underserved include:

A Community Diagnosis Project in six target areas: Fayette County, Greene County, Westmoreland County, and in Allegheny County, the communities of McKeesport, McKees Rocks, and the Hill District.

Findings from these diagnoses show these common health concerns throughout these communities such as: Obesity, Respiratory Diseases, Cancer, Diabetes, Cardiovascular diseases, Adolescent Pregnancy, Drug and Alcohol Abuse, and Behavioral Health Issues.

Immunization and Preventive Care Resources

One of the key goals of the Caring Foundation is maintaining or improving the health of our children. Immunizations and ongoing preventive pediatric care are essential to keeping children healthy.

Through an exciting partnership with Mister Rogers, and with Hines Ward and Mark Bruener of the Pittsburgh Steelers, immunization and preventive care materials have been produced to further this aim.

Working with schools, day care centers and other community organizations, more than 500,000 preventive care resources have been sent to families throughout western Pennsylvania.

This initiative includes eight booklets featuring Mister Rogers, along with two companion videos. In the booklets and videos, Mister Rogers explains the importance of healthy behaviors such as going to the doctor, getting immunized, and wearing bicycle helmets.

Immunization guides featuring Pittsburgh Steelers Mark Bruener and Hines Ward are also available to families and groups. The booklets, videos and guides are available free or at a low cost.

Health Education Center, Inc

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Description

Health Education Center, Inc. (merged with Caring Foundation in 2003)

Mission
Health Education Center, Inc. (HEC) was dedicated to improving the health of underserved individuals, special needs populations, and at-risk communities.

HEC was committed to being in those communities that are at-risk, and listening to those who know the communities the best, and then working as a catalyst in partnership with others to help those who are often forgotten find a way to living longer, healthier lives, and maximizing their own potentials.

Major Programs
Effective August 1, 2003, HEC merged into the Caring Foundation, and the activities of the former HEC constitute the Division of Community Health of Caring Foundation. Prior to the merger, in calendar year 2002, HEC focused on the following primary programs.

The Home Safe Home childhood injury prevention program was first implemented in 1995 in collaboration with Family Foundations. Since that time, partnerships have expanded to also include the following home visitation agencies: Families Facing the Future, Pittsburgh Family Center for Child Development, Family Care Connection, Clairton Family Center and Mercy Hospital's Prenatal Outreach Program. Over 525 families have participated.

The Program is based on collaboration with local home visitation agencies that utilize in-home visitors, called Family Advocates, to deliver services to low-income families. Family Advocates and parents or other caregivers tour the home and assess potential dangers according to a 50-item, home safety checklist. The following detriments to child safety are addressed: fires, scald burns, electrical burns, domestic violence, firearms, drowning, falls, poisons (including lead and carbon monoxide), suffocation and motor vehicle related injuries. Based on their findings, Family Advocates alert parents about safety hazards, and provide options for their prevention. The home visitor then assists parents in making adjustments to the home or installing safety devices. A follow-up inspection is provided three months after the initial assessment to determine if safety practices are still in place, and whether any further improvements have been made to the home.

Home Safe Home is the only comprehensive, home-based injury prevention program in Allegheny County that addresses all major injury risks to children. The Program has received numerous acknowledgments from participants and Family Advocates regarding the benefits of the program.

The Health Education Scholarship Program was established in October 1997. Scholarships are provided for Lifestyle Improvement classes, including StartSMART Smoking Cessation, Diabetes Self-Management, Dr. Dean Ornish Program for Reversing Heart Disease, Eat Well for Life, Yoga, Tai Chi, and Nutrition Counseling. In addition to classes offered previously at

HealthPLACE centers, StartSMART smoking cessation programs has been offered in the community for groups of ten or more individuals.

Scholarships will continue to be offered through the Community Health Division of Caring Foundation to eligible participants for the above programs. Plans include raising awareness of the scholarship program, increasing access to scholarships (and therefore increasing the number of scholarship participants), and securing additional funding.

It is also anticipated that more scholarships will be awarded to Healthy Families program participants, as described below. The Healthy Families program will experience an increase in referrals as partnerships are developed with other organizations, such as Gateway Health Plan, the Allegheny County Bar Association and the Greater Pittsburgh Community Food Bank. Referrals will also increase from physicians through *Prescriptions for Wellness* and recruitment through area churches.

Realizing that there have been barriers to accessing these programs, such as a lack of transportation, and convenience of times and location, relationships will be identified and developed with other community resources that can provide similar programming. The Community Health Division and these agencies will work together to ensure access to health promotion and disease prevention programs for those who otherwise cannot afford these services.

The Healthy Families Program began in 1986 as a community-based parenting initiative to address the needs of low-income parents in Allegheny County. In 1998 the Healthy Families curriculum was updated to reflect a more holistic wellness model and to address the needs of the parent as well as the child based on participant feedback. The goal of Healthy Families is to improve health by empowering parents/caregivers to make positive changes in their health behaviors and thereby improve the health futures of families.

The Healthy Families program offers a comprehensive curriculum that includes an introduction to wellness and covers topics such as physical, environmental, emotional, intellectual, social, and spiritual growth and development. Participants attend six hours of workshops and complete home-based activities to reinforce skills learned. A Community Health Coach (CHC) facilitates workshops and contacts participants throughout the program to provide assistance, support and individual consultation. Each person completes a health risk assessment and lab work for health screenings at the first session. A personal wellness plan is then designed and discussed with each individual. Each plan recommends lifestyle improvement programs based on the results of the health risk assessment, screenings and participant interest. Through scholarships, as described above, lifestyle improvement courses such as stress, weight and diabetes management, smoking cessation and health counseling are available at no cost to the participant. In addition, referrals are made to community-based agencies and organizations when necessary.

The Health Literacy Program initially began as the Health Advocacy Program in April 1999. The purpose of the Health Advocacy Program was to promote the health of individuals and communities by improving their access to health information, services and preventive interventions. After assessing the program, it was revised to increase the effectiveness of service

delivery. Based upon the needs of the community, the Health Literacy Program was developed to provide individuals with the necessary skills to understand medical instruction, follow physician's instructions, and interpret health-related information and forms. A curriculum was developed that includes six one-hour health education sessions and home-based assignments. Agency partnerships were developed to ensure community awareness and for recruitment purposes.

Participants in the Health Literacy Program attend six one-hour health education sessions. Participants may request personalized health-counseling sessions. Participants who successfully complete the program are awarded a gift voucher that can be redeemed for health-related items (such as exercise videos, exercise equipment, etc.). In addition, health education materials are distributed to partner agencies, as requested, for dissemination to their clients.

The Men's Health Program was created in 2001-2002 to address the health needs of men. The purpose of the program is to assist men with developing positive attitudes toward health through education, ultimately promoting health and holistic lifestyles. The program collaborates with communities, behavioral health and social service agencies and churches to promote health and education, thereby enhancing existing programs and services.

There are workshops (10) that can be delivered as group-based sessions in their entirety or as separate presentations upon request. The sessions include an introduction to wellness, and topics relating to chronic diseases, developing healthy lifestyles and establishing positive relationships. Health Coaches facilitate the sessions and work with participants to provide assistance, support and referrals. Each participant completes a Health Risk Assessment and receives biometric screenings (lipid panel). Participants are also referred to other community-based programs should they have a need.

Highmark Foundation

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Description

Highmark Foundation

Mission

The mission of the Highmark Foundation is to improve the health, well-being and quality of life of the individuals who reside in the communities served by Highmark Inc.

Grants and Funding Priorities

The Highmark Foundation is an organization described in section 501(c)(3) of the Internal Revenue Code, a private foundation and nonprofit corporation dedicated to helping people live longer, better lives. The Foundation awards grants to nonprofit organizations for initiatives aimed at improving community health. Competitive grants are awarded to address certain health issues through Requests for Proposals (RFPs). To be eligible for funding by the Highmark Foundation, grants must be:

- Related to health, which may be broadly defined to include social, behavioral, and other dimensions beyond the absence of illness
- For a program in the Foundation's service area
- Sponsored by a nonprofit organization, exempt under section 501(c)(3) as a public charity

The Foundation makes grants within four priority areas that include: chronic disease (such as diabetes, cardiovascular disease, cancer and osteoporosis, along with nutrition, weight management and physical activity); family health (such as adolescent health, dental health, and senior care); service delivery systems (such as long term care, coordination of services, availability and access to primary care and dental care); and communicable disease (such as immunizations, pneumonia/influenza, and sexually transmitted diseases).

In some cases, the Foundation provides grants to health-related projects that fall outside of these areas. These other health-related grants may be deemed to be playing an important role in the Foundation's efforts to improve the health status of Pennsylvania and other communities served by Highmark.

Western Pennsylvania Caring Foundation

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Officers & Positions

Caring Foundation

The following individuals were elected as officers of the Caring Foundation and served as such from May 15, 2001 until the next annual meeting which was held on June 4, 2002:

Merril Hoge	Chairman of the Board
Charles P. LaVallee	Executive Director
Aaron A. Walton	Vice President
Melissa M. Anderson	Treasurer
Elaine B. Krasik	Secretary

The following individuals were elected as officers of the Caring Foundation and served as such from June 4, 2002 until the next annual meeting which was held on June 3, 2003:

Merril Hoge	Chairman of the Board
Aaron A. Walton	Vice Chairman
Charles P. LaVallee	Executive Director
Melissa M. Anderson	Treasurer
Elaine B. Krasik	Secretary

The following individuals were elected as officers of the Caring Foundation and served as such from June 3, 2003 until the next annual meeting which will be held on May 13, 2004:

Merril Hoge	Chairman of the Board
Aaron A. Walton	Vice Chairman
Charles P. LaVallee	Executive Director
Melissa M. Anderson	Treasurer
Elaine B. Krasik	*Secretary*

Positions of Officers in the Parent Corporation, Highmark Inc. and its subsidiaries.

Aaron A. Walton - Senior Vice President, Corporate Affairs, Highmark Inc.

Charles P. LaVallee - Vice President, Highmark Inc.

Melissa M. Anderson - Vice President, Controller, Highmark Inc.

Elaine B. Krasik - Associate Counsel, Highmark Inc.

Health Education Center, Inc

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Officers & Positions

Health Education Center, Inc.

The following individuals were elected as officers of Health Education Center, Inc., and served as such from October 18, 2001 until the next annual meeting which was held on October 16, 2002. The same officers served as such until the merger of Health Education Center, Inc., with and into Caring Foundation effective August 1, 2003:

Aaron A. Walton	Chairman of the Board
W. Bradley Pifalo, M.D.	Executive Director
Nanette P. DeTurk	Treasurer
Janine Colinear	Assistant Treasurer
Elaine B. Krasik	Secretary

Positions of Officers in the Parent Corporation, Highmark Inc. and its subsidiaries.

Aaron A. Walton - Senior Vice President, Corporate Affairs, Highmark Inc.

W. Bradley Pifalo, M.D. - Vice President, Corporate and Community Wellness Highmark Inc.

Nanette P. DeTurk - Sr. Vice President, Finance and Corporate Controller, Highmark Inc.

Janine Colinear - Director, Financial Accounting and Reporting, Highmark Inc.

Elaine B. Krasik - Associate Counsel, Highmark Inc.

Highmark Foundation

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Officers & Positions

Highmark Foundation

The following individuals were elected as officers of Highmark Foundation on February 28, 2001 and served as such until the next annual meeting which was held on May 15, 2002:

George F. Grode	Chairperson of the Board
Doris Carson Williams	Vice Chairperson of the Board
Aaron A. Walton	President
Melissa M. Anderson	Treasurer
Elaine B. Krasik	Secretary

The following individuals were elected as officers of Highmark Foundation on May 15, 2002 and served as such until the next annual meeting which was held on May 28, 2003:

Aaron A. Walton	Chairperson of the Board
Doris Carson Williams	Vice Chairperson of the Board
Yvonne C. Cook	President
Melissa M. Anderson	Treasurer
Elaine B. Krasik	Secretary

The following individuals were elected as officers of Highmark Foundation on May 28, 2003 and will serve as such until the next annual meeting which will be held on May 24, 2004:

Aaron A. Walton	Chairperson of the Board
Doris Carson Williams	Vice Chairperson of the Board
Yvonne C. Cook	President
Melissa M. Anderson	Treasurer
Elaine B. Krasik	Secretary

Positions of Officers in the Parent Corporation, Highmark Inc. and its subsidiaries.

George F. Grode - Executive Vice President, Highmark Inc., Retired March 2003

Aaron A. Walton - Senior Vice President, Corporate Affairs, Highmark Inc.

Yvonne C. Cook - Vice President, Community and Health Initiatives, Highmark Inc.

Melissa M. Anderson - Vice President, Controller, Highmark Inc.

Elaine B. Krasik - Associate Counsel, Highmark Inc.

Western Pennsylvania Caring Foundation

-

Charter Documents

2003032-1422

PENNSYLVANIA DEPARTMENT OF STATE
CORPORATION BUREAU

Articles of Amendment-Domestic Corporation

(15 Pa.C.S.)

Entity Number
871224

___ Business Corporation (§ 1915)
__x__ Nonprofit Corporation (§ 5915)

Name
Sara M. Malara, Paralegal

Address
120 Fifth Avenue, Fifth Avenue Place, Suite 2189

City: Pittsburgh | State: PA | Zip Code: 15222-3099

Document will be returned to the name and address you enter to the left. ⇐

Fee: $52

Filed in the Department of State on APR 11 2003

Secretary of the Commonwealth

ACTING

In compliance with the requirements of the applicable provisions (relating to articles of amendment), the undersigned, desiring to amend its articles, hereby states that:

1. The name of the corporation is:
Western Pennsylvania Caring Foundation

2. The (a) address of this corporation's current registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is (the Department is hereby authorized to correct the following information to conform to the records of the Department):

(a) Number and Street	City	State	Zip	County
120 Fifth Avenue	Pittsburgh	PA	15222-3099	Allegheny

(b) Name of Commercial Registered Office Provider — County

c/o

3. The statute by or under which it was incorporated: Non-profit Corporation Law of 1972

4. The date of its incorporation: June 3, 1985

5. *Check, and if appropriate complete, one of the following:*

__xx__ The amendment shall be effective upon filing these Articles of Amendment in the Department of State.

___ The amendment shall be effective on: _____ (Date) at _____ (Hour)

2003032-1423

DSCB:15-1915/5915–2

6. *Check one of the following:*

XX The amendment was adopted by the shareholders or members pursuant to 15 Pa.C.S. § 1914(a) and (b) or § 5914(a).

____ The amendment was adopted by the board of directors pursuant to 15 Pa. C.S. § 1914(c) or § 5914(b).

7. *Check, and if appropriate, complete one of the following:*

____ The amendment adopted by the corporation, set forth in full, is as follows

XX The amendment adopted by the corporation is set forth in full in Exhibit A attached hereto and made a part hereof.

8. *Check if the amendment restates the Articles:*

XX The restated Articles of Incorporation supersede the original articles and all amendments thereto.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer thereof this

7th day of Apri.,

2003.

Western Pennsylvania Caring Foundation
Name of Corporation

Elaine B. Krasik
Signature

Elaine B. Krasik, Secretary
Title

2003032-1424

Western Pennsylvania Caring Foundation
Consent to the Taking of Corporate Action
by the Sole Member

Highmark Inc., being the sole Member of Western Pennsylvania Caring Foundation., a non-profit corporation (the "Foundation"), in accordance with Section 5763 of the Pennsylvania Non-Profit Corporation Law, does hereby adopt the following resolutions, with the same force and effect as though such resolutions had been adopted at a duly convened special meeting of the members held on the date hereof, and hereby waives all notice requirements in connection with said special meeting:

WHEREAS, Highmark Inc. ("Highmark") is the sole member of the Foundation, which was established exclusively for charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code"), including, without limitation, to do the following: to promote health and wellbeing in western Pennsylvania and elsewhere by providing services in connection with, and sponsoring programs related to, children, elderly and economically disadvantaged persons in the community; and

WHEREAS, Highmark is also the sole member of Health Education Center, Inc., an affiliate of the Foundation ("HEC"), which was established exclusively for charitable, religious, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, including, all purposes and privileges conferred upon HEC by the Nonprofit Corporation Law of 1988, as amended from time to time, or any successor statute governing Pennsylvania nonprofit corporations; and

WHEREAS, in light of the similarities in purpose of the Foundation and HEC, the Board of Directors of the Foundation has determined that it is in the best interest of the Foundation that HEC be merged with and into the Foundation, with the Foundation being the surviving corporation; and

WHEREAS, to effectuate the foregoing, the Board of Directors has recommended that the Agreement and Plan of Merger (the "Plan"), attached hereto as Attachment A, be submitted to a vote of the sole Member of the Foundation; and

WHEREAS, in furtherance of the foregoing, it is deemed to be in the best interest and in furtherance of the purposes of the Foundation that its Articles of Incorporation be amended to change, among other things, the name of the Foundation;

NOW, THEREFORE, BE IT RESOLVED, that the merger of HEC with and into the Foundation, with the Foundation being the surviving Corporation, be and is hereby approved, substantially upon the terms and conditions set forth in the Plan; and

RESOLVED FURTHER, that the Plan be and is hereby approved, authorized and adopted; and

RESOLVED FURTHER, that the Articles of Incorporation be and are hereby amended and restated in their entirety, as set forth in Attachment B hereto; and

RESOLVED FURTHER, that the Amended and Restated Bylaws of the Foundation be and are hereby amended so as to provide, among other things, for a corporate name change, a change in geographic scope, and certain operational changes, including specifically: (i) Sections 1.1 and 1.2 of Article I; (ii) Section 2.1 of Article II; (iii) Sections 3.1 and 3.13 of Article III; and (iv) Section 5.2 of Article V, as more fully set forth in Attachment C hereto; and

RESOLVED FURTHER, that the Foundation, and its Board of Directors and officers, be and are hereby authorized, directed and empowered, in the name and on behalf of the Foundation and under its corporate seal where required, to execute and deliver any and all documents, certificates, writings and other instruments (including, without limitation, causing the filing of articles of merger or similar instruments with the Commonwealth of Pennsylvania), as such officers, in their sole discretion, deem necessary, appropriate or desirable in order to carry out the intent and accomplish the purposes of the foregoing resolutions, their execution and delivery thereof to be conclusive evidence of their approval thereof, and

RESOLVED FURTHER, that all actions heretofore taken by the Foundation, and its Board of Directors, officers, employees and agents, with respect to the matters referred to in the foregoing resolutions be, and they are hereby, approved, ratified and confirmed.

EXECUTED, as of the 7th day of April, 2003, by the undersigned President and Chief Executive Officer of Highmark Inc., who has been duly authorized by said Corporation to act for and on its behalf as the sole Member of the Foundation upon matters contained in the above Resolutions.

Highmark Inc.

by _____
Kenneth R. Melani, M.D.
President and
Chief Executive Officer

200303 2-1426

Exhibit B

AMENDED AND RESTATED
ARTICLES OF INCORPORATION
of
CARING FOUNDATION

1. Name. The name of the Corporation is Caring Foundation.

2. Registered Office. The location and post office address of the registered office of the Corporation in this Commonwealth is Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Allegheny County, Pennsylvania 15222.

3. Organization. The Corporation was incorporated under the provisions of the Nonprofit Corporation Law of 1972.

4. Purpose. The Corporation is formed exclusively for charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code"), including, without limitation, to do the following: to promote health and wellbeing in Pennsylvania and elsewhere by providing services in connection with, and sponsoring programs related to, children, elderly and economically disadvantaged persons in the community.

5. Pecuniary Gain or Profit. The Corporation does not contemplate pecuniary gain or profit, incidental or otherwise.

6. Non-Stock Basis. The Corporation is organized on a non-stock basis.

7. Members. The sole member of the corporation is Highmark Inc.

8. Management. The business and affairs of the Corporation shall be managed by or under the direction of a Board of Directors of the Corporation. The number, term of office, method of selection and manner of removal of the Board of Directors shall be as set forth in the Bylaws of the Corporation.

9. Exempt Organization. Notwithstanding any other provision of these Articles, the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a corporation described in Section 501(c)(3) of the Code (hereinafter referred to in these Articles as an "exempt organization"), or as a corporation contributions to which are deductible under Section 170(c)(2) of the Code. No substantial part of the activities of the Corporation shall be devoted to carrying on of propaganda, or otherwise attempting to influence legislation (except as otherwise provided in Section 501(h) of the Code), and the Corporation shall not participate in or intervene in (including the publishing or distributing of statements) any political campaign on behalf of or in opposition to any candidate for public office.

10. Earnings. Notwithstanding any other provision of these Articles; no part of the net earnings of the Corporation shall inure to the benefit of or be distributable to its members, directors, trustees, officers or any other private individual; provided, however, the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to the extent that such payments do not prevent it from qualifying, and continuing to qualify, as an exempt organization, and to make such lawful payments and distributions in furtherance of the purposes set forth in Article 4 hereof as may from time to time be either required or permitted by Section 501(c)(3) of the Code.

11. Foundation Status. In the event that the Corporation fails to qualify as an organization described in Section 509(a)(1), (2) or (3) of the Code, then, notwithstanding any other provision of these Articles, the Corporation shall be prohibited from engaging in any act of self-dealing (as defined in Section 4941(d) of the Code); from retaining any excess business holdings (as defined in Section 4943(c) of the Code); from making any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code; and from making any taxable expenditures (as defined in Section 4945(d) of the Code), to the extent any action therewith would subject the Corporation to tax under one or more of the cited sections of the Code. To the extent required, the Corporation shall make qualifying distributions at such time and in such manner as do not subject the Corporation to tax under Section 4942 of the Code.

12. Dissolution. In the event that the Corporation shall be dissolved or liquidated, the Board of Directors, after paying or making provision for payment of all of the known liabilities of the Corporation, may transfer or dispose of the Corporation's property and assets to (a) such one or more corporations, trusts, funds or other organizations which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and, in the sole judgment of the Corporation's Board of Directors, have purposes similar to those of the Corporation or (b) the federal government, or to state or local government for such purposes. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more of such corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations describe in Section 501(c)(3) of the Code, and which are organized and operated for such purposes; or to the federal government or to a state or local government for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

13. Personal Liability of Directors.

(a) Elimination of Liability. To the fullest extent that the laws of the Commonwealth of Pennsylvania, as now in effect or as hereafter amended, permit elimination or limitation of the liability of directors, no director of the Corporation shall be personally liable for monetary damages as such for any action taken, or any failure to take any action, as a director.

(b) Applicability. The provisions of this Article shall be deemed to be a contract with each director of the Corporation who serves as such at any time while this Article is in effect and each such director shall be deemed to be so serving in reliance on the provisions of this Article. Any amendment or repeal of this Article or adoption of any bylaw or provision of these Articles which has the effect of increasing director liability shall operate prospectively only and shall not

affect any action taken, or any failure to act, prior to the adoption of such amendment, repeal, bylaw or provision.

14. Indemnification.

(a) Right to Indemnification. (1) As used herein, the word "Action" shall mean any action, suit or proceeding, administrative, investigative or other, (i) to which such person is a party (other than an action by the Corporation) or (ii) in connection with which such person is not a party but is a witness, subject to investigation or otherwise involved, in either case by reason of such person being or having been a director or officer of the Corporation.

(2) Unless in a particular case indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, and except as prohibited by law, each director and officer of the Corporation shall be entitled as of right to be indemnified by the Corporation against expenses and any liability paid or incurred by such person (i) in the defense of any Action to which such person is a party or (ii) in connection with any other Action.

(3) A person who is not a director or officer of the Corporation may be similarly indemnified in respect of service to the Corporation to the extent the Board at any time designates such person as entitled to the benefits of this Article.

(4) As used in this Article, "indemnitee" shall include each director and each officer of the Corporation and each other person designated by the Board as entitled to the benefits of this Article; "liability" shall include amounts of judgments, excise taxes, fines, penalties and amounts paid in settlement; and "expenses" shall include fees and expenses of counsel, accountants and experts incurred by the indemnitee only (i) if the Corporation has not at its expense assumed the defense of the Action on behalf of the indemnitee with reputable and experienced counsel selected by the Corporation, or (ii) if it shall have been determined pursuant to Section (c) hereof that the indemnitee was entitled to indemnification for expenses in respect of an action brought under that Section.

(b) Right to Advancement of Expenses. Unless in a particular case advancement of expenses would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, every indemnitee shall be entitled as of right to have his expenses in defending any Action paid in advance by the Corporation, as incurred, provided that the Corporation receives a written undertaking by or on behalf of the indemnitee to repay the amount advanced if it should ultimately be determined that the indemnitee is not entitled to be indemnified for such expenses.

(c) Right of Indemnitee to Initiate Action; Defenses.

(1) If a written claim under Section (a) or Section (b) of this Article is not paid in full by the Corporation within thirty days after such claim has been received by the Corporation, the indemnitee may at any time thereafter initiate an action to recover the unpaid amount of the

claim and, and if successful in whole or in part, the indemnitee shall also be entitled to be paid the expense of prosecuting such action.

(2) The only defenses to an action to recover a claim for indemnification otherwise properly asserted under Section (a) shall be (i) that the indemnitee's conduct was such that under applicable law the Corporation is prohibited from indemnifying the indemnitee for the amount claimed, or (ii) that indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, but the burden of proving any such defense shall be on the Corporation.

(3) The only defenses to an action to recover a claim for advancement of expenses otherwise properly asserted under Section (b) shall be (i) that advancement of expenses would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or (ii) that the indemnitee failed to provide the undertaking required by Section (b), but the burden of proving any such defense shall be on the Corporation.

(d) Non-Exclusivity; Nature and Extent of Rights. The rights to indemnification and advancement of expenses provided for in this Article shall (i) not be deemed exclusive of any other rights to which any indemnitee may be entitled, (ii) be deemed to create contractual rights in favor of each indemnitee who serves the Corporation at any time while this Article is in effect (and each such indemnitee shall be deemed to be so serving in reliance on the provisions of this Article), and (iii) continue as to each indemnitee who has ceased to have the status pursuant to which he was entitled or was designated as entitled to indemnification under this Article and shall inure to the benefit of the heirs and legal representatives of each indemnitee.

15. Code. References in these Articles to a section of the Code shall be construed to refer both to such section and to the regulations promulgated thereunder, as they now exist or may hereafter be amended, and to the corresponding provisions of any future federal tax code and the regulations thereunder.

200202 3-1485

PENNSYLVANIA DEPARTMENT OF STATE
CORPORATION BUREAU

Articles of Amendment-Domestic Corporation
(15 Pa.C.S.)

Entity Number
871224

___ Business Corporation (§ 1915)
_X_ Nonprofit Corporation (§ 5915)

Name
Sara M. Malara

Address
120 Fifth Avenue, Fifth Avenue Place, Suite 2180

City | State | Zip Code
Pittsburgh, PA 15222-3099

Document will be returned to the name and address you enter to the left.
⇐

Fee: $52

Filed in the Department of State on MAR 08 2002

C. Michael Pfautz
Secretary of the Commonwealth

SCTWG

In compliance with the requirements of the applicable provisions (relating to articles of amendment), the undersigned, desiring to amend its articles, hereby states that:

1. The name of the corporation is:
Western Pennsylvania Caring Foundation for Children

2. The (a) address of this corporation's current registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is (the Department is hereby authorized to correct the following information to conform to the records of the Department):

(a) Number and Street | City | State | Zip | County
120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, Pennsylvania 15222-3099, Allegheny

(b) Name of Commercial Registered Office Provider | County
c/o

3. The statute by or under which it was incorporated: Non-profit Corporation Law of 1972

4. The date of its incorporation: June 3, 1985

5. *Check, and if appropriate complete, one of the following:*

_X_ The amendment shall be effective upon filing these Articles of Amendment in the Department of State.

___ The amendment shall be effective on: _____ (Date) at _____ (Hour)

PA DEPT. OF STATE
2002 MAR 25 PM 2:54

2002029-1486

DSCB:15-1915/5915–2

6. *Check one of the following:*

X The amendment was adopted by the shareholders or members pursuant to 15 Pa.C.S. § 1914(a) and (b) or § 5914(a).

___ The amendment was adopted by the board of directors pursuant to 15 Pa. C.S. § 1914(c) or § 5914(b).

7. *Check, and if appropriate, complete one of the following:*

___ The amendment adopted by the corporation, set forth in full, is as follows

X The amendment adopted by the corporation is set forth in full in Exhibit A attached hereto and made a part hereof.

8. *Check if the amendment restates the Articles:*

___ The restated Articles of Incorporation supersede the original articles and all amendments thereto.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer thereof this

7th day of March, 2002.

Western Pennsylvania Caring Foundation for Children

Name of Corporation

Elaine B. Krasik

Elaine B. Krasik Signature

Secretary

Title

2002029-1487

Western Pennsylvania Caring Foundation for Children

Action By Written Consent
of Sole Member

Highmark Inc., being the sole Member of Western Pennsylvania Caring Foundation for Children, a non-profit corporation (the "Corporation"), in accordance with Section 5763 of the Pennsylvania Non-Profit Corporation Law, with the same effect as if such action had been taken at a duly called meeting of the members of the Corporation, hereby approves the following Resolutions:

WHEREAS, as contemplated by Section 5911 of the Pennsylvania Business Corporation Law of 1988, as amended, the Corporation wishes to amend its Articles of Incorporation to change the name of the Corporation; and

WHEREAS, it is deemed to be in the best interest of the Corporation and in furtherance of the purposes of the Corporation, and more consistent with the Corporation's present business activities that its Articles of Incorporation be amended to change the name of the Corporation;

NOW, THEREFORE, BE IT RESOLVED, that Section 1 of the Articles of Incorporation be and hereby is deleted in its entirety and the following substituted therefor: 1. Name. "The name of the Corporation is Western Pennsylvania Caring Foundation"; and

RESOLVED FURTHER, that Article 1, Section 1.01 of the Bylaws of the Corporation be and hereby is amended by deleting the words "Western Pennsylvania Caring Foundation for Children", and in place thereof inserting the words, "Western Pennsylvania Caring Foundation"; and

RESOLVED FURTHER, that the officers of the Corporation be and hereby are authorized to take or cause to be taken all such additional or other actions, including without limitation, filing Articles of Amendment with the Department of State of the Commonwealth of Pennsylvania, and to execute or cause to be executed such additional or other documents certificates, writings or other instruments as may be deemed necessary, desirable or appropriate in order to carry out the intent and accomplish the purpose of the foregoing Resolutions.

200202 9-1488

EXECUTED, as of the 7th day of March, 2002, by the undersigned Chief Executive Officer of Highmark Inc., who has been duly authorized by said Corporation to act for and on its behalf as the sole Member of Western Pennsylvania Caring Foundation for Children, upon matters contained in the above Resolutions.

Highmark Inc.

By: _____
John S. Brouse, President
and Chief Executive Officer

DSCB: 15-5915 (Rev. 90)
P. O. NALY COMPANY, PGH., PA 16219

Microfilm Number_____

Entity Number 871224

Filed with the Department of State on MAR 04 1997

Secretary of the Commonwealth

ARTICLES OF AMENDMENT-DOMESTIC NONPROFIT CORPORATION

In compliance with the requirements of 15 Pa.C.S. § 5915 (relating to articles of amendment), the undersigned nonprofit corporation, desiring to amend its articles, hereby states that:

1. The name of the corporation is: Western Pennsylvania Caring Foundation, Inc.

2. The (a) address of this corporation's current registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is (the Department is hereby authorized to correct the following information to conform to the records of the Department):

   (a) 120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222, Allegheny
   Number and Street | City | State | Zip | County

   (b) c/o:_____
   Name of Commercial Registered Office Provider | County

   For a corporation represented by a commercial registered office provider, the county in (b) shall be deemed the county in which the corporation is located for venue and official publication purposes.

3. The statute by or under which it was incorporated is: Non-profit Corporation Law of 1972

4. The date of its incorporation is: June 3, 1985

5. (Check, and if appropriate complete, one of the following):

   XX The amendment shall be effective upon filing these Articles of Amendment in the Department of State.

   ___ The amendment shall be effective on:_____ at_____
   Date | Hour

6. (Check one of the following):

   XX The amendment was adopted by the members (or shareholders) pursuant to 15 Pa.C.S. § 5914(a).

   ___ The amendment was adopted by the board of directors pursuant to 15 Pa.C.S. § 5914(b).

7. (Check, and if appropriate complete, one of the following):

   ___ The amendment adopted by the corporation, set forth in full, is as follows:

   XX The amendment adopted by the corporation is set forth in full in Exhibit A attached hereto and made a part hereof.

9719- 794

DSCB:15-5915 (Rev 90)-2

8. (Check, if the amendment restates the Articles):

___The restated Articles of Incorporation supersede the original Articles and all amendments thereto.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer thereof this 26th day of February, 19 97.

WESTERN PENNSYLVANIA CARING FOUNDATION, INC.
(Name of Corporation)

BY: Elaine B. Krasik
(Signature)

Elaine B. Krasik

TITLE: Assistant Secretary

9/19- 795

WESTERN PENNSYLVANIA CARING FOUNDATION, INC.

Consent to the Taking of Corporate Action by the Sole Member

Highmark Inc., being the sole Member, as a result of the consolidation of Veritus Inc. and Medical Services Association of Pennsylvania, of Western Pennsylvania Caring Foundation, Inc., a non-profit corporation (the "Corporation"), in accordance with Section 5763 of the Pennsylvania Non-Profit Corporation Law, with the same effect as if such action had been taken at a duly called meeting of the members of the Corporation, hereby approves the following Resolutions:

WHEREAS, as contemplated by Section 5911 of the Pennsylvania Business Corporation Law of 1988, as amended, the Corporation wishes to amend its Articles of Incorporation to change the name of the Corporation; and

WHEREAS, it is deemed to be in the best interest and in furtherance of the purposes of the Corporation that its Articles of Incorporation be amended to change the name of the Corporation;

NOW, THEREFORE, BE IT RESOLVED, that Section 1 of the Articles of Incorporation be and hereby is amended so as to read in full as follows: 1. Name. "The name of the Corporation is Western Pennsylvania Caring Foundation for Children"; and

RESOLVED FURTHER, that Section 7. be and hereby is amended so as to read in full as follows: 7. Members. The sole member of the Corporation is Highmark Inc.; and

RESOLVED FURTHER, that Article 1, Section 1.01 of the Bylaws of the Corporation be and hereby is amended by deleting the words "Western Pennsylvania Caring Foundation, Inc.", and in place thereof inserting the words, "Western Pennsylvania Caring Foundation for Children"; and

9719- 796

RESOLVED FURTHER, that Article 2 Section 2.01 of the Bylaws of the Corporation be and hereby is amended by deleting the second sentence in its entirety and substituting therefor the following: "The sole member of the Corporation shall be Highmark Inc."; and

RESOLVED FURTHER, that the officers of the Corporation be and hereby are authorized to take or cause to be taken all such additional or other actions and to execute or cause to be executed such additional or other documents, including without limitation, filing Articles of Amendment with the Department of State of the Commonwealth of Pennsylvania, certificates, writings or other instruments as may be deemed necessary, desirable or appropriate in order to carry out the intent and accomplish the purpose of the foregoing Resolutions.

EXECUTED, as of the 26th day of February, 1997, by the undersigned Chief Executive Officer of Highmark Inc., who has been duly authorized by said Corporation to act for and on its behalf as the sole Member of Western Pennsylvania Caring Foundation, Inc., upon matters contained in the above Resolutions.

Highmark Inc.

William M. Lowry
Chief Executive Officer

9653- 697

Microfilm Number_____

Entity Number 871224

Filed with the Department of State on AUG 01 1996

Secretary of the Commonwealth

ARTICLES OF AMENDMENT-DOMESTIC NONPROFIT CORPORATION

DSCB:15-5915 (Rev 90)

In compliance with the requirements of 15 Pa.C.S. § 5915 (relating to articles of amendment), the undersigned nonprofit corporation, desiring to amend its articles, hereby states that:

1. The name of the corporation is: Western Pennsylvania Caring Foundation, Inc.

2. The (a) address of this corporation's current registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is (the Department is hereby authorized to correct the following information to conform to the records of the Department):

(a) 301 Fifth Avenue (Number and Street) | Pittsburgh (City) | PA (State) | 15222 (Zip) | Allegheny (County)

(b) c/o: _____ (Name of Commercial Registered Office Provider) _____ (County)

For a corporation represented by a commercial registered office provider, the county in (b) shall be deemed the county in which the corporation is located for venue and official publication purposes.

3. The statute by or under which it was incorporated is: Nonprofit Corporation Law of 1972

4. The date of its incorporation is: May 28, 1985

5. (Check, and if appropriate complete, one of the following):

X The amendment shall be effective upon filing these Articles of Amendment in the Department of State.

___ The amendment shall be effective on: _____ (Date) at _____ (Hour)

6. (Check one of the following):

X The amendment was adopted by the members (or shareholders) pursuant to 15 Pa.C.S. § 5914(a).

___ The amendment was adopted by the board of directors pursuant to 15 Pa.C.S. § 5914(b).

7. (Check, and if appropriate complete, one of the following):

___ The amendment adopted by the corporation, set forth in full, is as follows:

X The amendment adopted by the corporation is set forth in full in Exhibit A attached hereto and made a part hereof.

AUG -1 96

PA Dept. of State

9653- 698

DSCB:15-5915 (Rev 90)-2

8. (Check, if the amendment restates the Articles):

X The restated Articles of Incorporation supersede the original Articles and all amendments thereto.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer thereof this 30th day of July, 1996.

WESTERN PENNSYLVANIA CARING FOUNDATION, INC.

(Name of Corporation)

BY: _____

(Signature)

TITLE: Chairman of the Board

9653- 699

EXHIBIT A

AMENDED AND RESTATED
ARTICLES OF INCORPORATION
of
WESTERN PENNSYLVANIA CARING FOUNDATION, INC.

1. Name. The name of the Corporation is Western Pennsylvania Caring Foundation, Inc.

2. Registered Office. The location and post office address of the registered office of the Corporation in this Commonwealth is Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Allegheny County, Pennsylvania 15222.

3. Organization. The Corporation was incorporated under the provisions of the Nonprofit Corporation Law of 1972.

4. Purpose. The Corporation is formed exclusively for charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code"), including, without limitation, to do the following: to promote health and wellbeing in western Pennsylvania and elsewhere by providing services in connection with, and sponsoring programs related to, children, elderly and economically disadvantaged persons in the community.

5. Pecuniary Gain or Profit. The Corporation does not contemplate pecuniary gain or profit, incidental or otherwise.

6. Non-Stock Basis. The Corporation is organized on a non-stock basis.

7. Members. The sole member of the Corporation is Veritus Inc., doing business as Blue Cross of Western Pennsylvania.

8. Management. The business and affairs of the Corporation shall be managed by or under the direction of a Board of Directors of the Corporation. The number, term of office, method of selection and manner of removal of the Board of Directors shall be as set forth in the Bylaws of the Corporation.

9. Exempt Organization. Notwithstanding any other provision of these Articles, the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a corporation described in Section 501(c)(3) of the Code (hereinafter referred to in these Articles as an "exempt organization"), or as a corporation contributions to which are deductible under Section 170(c)(2) of the Code. No substantial part of the activities of the Corporation shall be devoted to carrying on of propaganda, or otherwise attempting to influence legislation (except as otherwise provided in Section 501(h) of the Code), and the Corporation shall not participate in or intervene in (including the publishing or distributing of statements) any political campaign on behalf of or in opposition to any candidate for public office.

10. Earnings. Notwithstanding any other provision of these Articles, no part of the net earnings of the Corporation shall inure to the benefit of or be distributable to its members, directors, trustees, officers or any other private individual; provided, however, the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to the extent that such payments do not prevent it from qualifying, and continuing to qualify, as an exempt organization and to make such lawful payments and distributions in furtherance of the purposes set forth in Article 4 hereof as may from time to time be either required or permitted by Section 501(c)(3) of the Code.

11. Foundation Status. In the event that the Corporation fails to qualify as an organization described in Section 509(a)(1), (2) or (3) of the Code, then, notwithstanding any other provision of these Articles, the Corporation shall be prohibited from engaging in any act of self-dealing (as defined in Section 4941(d) of the Code); from retaining any excess business holdings (as defined in Section 4943(c) of the Code); from making any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code; and from making any taxable expenditures (as defined in Section 4945(d) of the Code), to the extent any action therewith would subject the Corporation to tax under one or more of the cited sections of the Code. To the extent required, the Corporation shall make qualifying distributions at such time and in such manner as do not subject the Corporation to tax under Section 4942 of the Code.

12. Dissolution. In the event that the Corporation shall be dissolved or liquidated, the Board of Directors, after paying or making provision for payment of all of the known liabilities of the Corporation, may transfer or dispose of the Corporation's property and assets to (a) such one or more corporations, trusts, funds or other organizations which at the time are exempt from federal income tax as organizations described

in Section 501(c)(3) of the Code and, in the sole judgment of the Corporation's Board of Directors, have purposes similar to those of the Corporation or (b) the federal government, or to a state or local government for such purposes. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more of such corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, and which are organized and operated for such purposes, or to the federal government or to a state or local government for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

13. Personal Liability of Directors.

(a) Elimination of Liability. To the fullest extent that the laws of the Commonwealth of Pennsylvania, as now in effect or as hereafter amended, permit elimination or limitation of the liability of directors, no director of the Corporation shall be personally liable for monetary damages as such for any action taken, or any failure to take any action, as a director.

(b) Applicability. The provisions of this Article shall be deemed to be a contract with each director of the Corporation who serves as such at any time while this Article is in effect and each such director shall be deemed to be so serving in reliance on the provisions of this Article. Any amendment or repeal of this Article or adoption of any bylaw or provision of these Articles which has the effect of increasing director liability shall operate prospectively only and shall not affect any action taken, or any failure to act, prior to the adoption of such amendment, repeal, bylaw or provision.

14. Indemnification

(a) Right to Indemnification. (1) As used herein, the word "Action" shall mean any action, suit or proceeding, administrative, investigative or other, (i) to which such person is a party (other than an action by the Corporation) or (ii) in connection with which such person is not a party but is a witness, subject to investigation or otherwise involved, in either case by reason of such person being or having been a director or officer of the Corporation.

(2) Unless in a particular case indemnification would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, and except as prohibited by law, each director and officer of the Corporation shall be entitled as of right to be indemnified by the Corporation

against expenses and any liability paid or incurred by such person (i) in the defense of any Action to which such person is a party or (ii) in connection with any other Action.

(3) A person who is not a director or officer of the Corporation may be similarly indemnified in respect of service to the Corporation to the extent the Board at any time designates such person as entitled to the benefits of this Article.

(4) As used in this Article, "indemnitee" shall include each director and each officer of the Corporation and each other person designated by the Board as entitled to the benefits of this Article; "liability" shall include amounts of judgments, excise taxes, fines, penalties and amounts paid in settlement; and "expenses" shall include fees and expenses of counsel, accountants, and experts incurred by the indemnitee only (i) if the Corporation has not at its expense assumed the defense of the Action on behalf of the indemnitee with reputable and experienced counsel selected by the Corporation, or (ii) if it shall have been determined pursuant to Section (c) hereof that the indemnitee was entitled to indemnification for expenses in respect of an action brought under that Section.

(b) Right to Advancement of Expenses. Unless in a particular case advancement of expenses would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, every indemnitee shall be entitled as of right to have his expenses in defending any Action paid in advance by the Corporation, as incurred, provided that the Corporation receives a written undertaking by or on behalf of the indemnitee to repay the amount advanced if it should ultimately be determined that the indemnitee is not entitled to be indemnified for such expenses.

(c) Right of Indemnitee to Initiate Action; Defenses. (1) If a written claim under Section (a) or Section (b) of this Article is not paid in full by the Corporation within thirty days after such claim has been received by the Corporation, the indemnitee may at any time thereafter initiate an action to recover the unpaid amount of the claim and, if successful in whole or in part, the indemnitee shall also be entitled to be paid the expense of prosecuting such action.

(2) The only defenses to an action to recover a claim for indemnification otherwise properly asserted under Section (a) shall be (i) that the indemnitee's conduct was such that under applicable law the Corporation is prohibited from indemnifying the indemnitee for the amount claimed, or (ii) that indemnification would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, but the burden of proving any such defense shall be on the Corporation.

(3) The only defenses to an action to recover a claim for advancement of expenses otherwise properly asserted under Section (b) shall be (i) that advancement of expenses would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or (ii) that the indemnitee failed to provide the undertaking required by Section (b), but the burden of proving any such defense shall be on the Corporation.

(d) Non-Exclusivity; Nature and Extent of Rights. The rights to indemnification and advancement of expenses provided for in this Article shall (i) not be deemed exclusive of any other rights to which any indemnitee may be entitled, (ii) be deemed to create contractual rights in favor of each indemnitee who serves the Corporation at any time while this Article is in effect (and each such indemnitee shall be deemed to be so serving in reliance on the provisions of this Article), and (iii) continue as to each indemnitee who has ceased to have the status pursuant to which he was entitled or was designated as entitled to indemnification under this Article and shall inure to the benefit of the heirs and legal representatives of each indemnitee.

15. Code. References in these Articles to a section of the Code shall be construed to refer both to such section and to the regulations promulgated thereunder, as they now exist or may hereafter be amended, and to the corresponding provisions of any future federal tax code and the regulations thereunder.

Composite Copy: April 11, 2003

AMENDED AND RESTATED BYLAWS of CARING FOUNDATION

(a Pennsylvania nonprofit corporation)
Amended and Restated: July 25, 1996
Amended: February 27, 1997
Amended: April 11, 2003

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CARING FOUNDATION

Bylaws

ARTICLE I

NAME AND PURPOSE

Section 1.1. Name. The name of the Corporation is Caring Foundation (hereinafter referred to as the "Corporation"), incorporated under the Pennsylvania Nonprofit Corporation Law of 1972 on May 24, 1985. (Amended: February 27, 1997; April 11, 2003)

Section 1.2. Purpose. The Corporation is formed exclusively for charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code"), including, without limitation, to do the following: to promote health and well-being in Pennsylvania and elsewhere by providing services in connection with, and sponsoring programs related to, children, elderly and economically disadvantaged persons in the community.

ARTICLE 2

MEMBERS

Section 2.1 Members. The Corporation shall have members as contemplated by the Pennsylvania Nonprofit Corporation Law of 1988. The sole member of the Corporation shall be Highmark Inc. **(Amended: February 27, 1997)**

Section 2.2. Voting Rights. Members shall be entitled to vote on any matters submitted to the members for a vote or as required by law or these bylaws.

Section 2.3. Transfer of Membership Interest. A member may transfer its membership in the Corporation upon the consent of a majority of the members, provided the transferring member receives no compensation for such transfer unless the transferring member is described in section 501(c)(3) of the Code, and provided further that no transfer may occur if such transfer would adversely affect the status of the Corporation as an organization described in section 501(c)(3) of the Code.

Section 2.4. Additional Members. Additional members may be admitted by the members at a meeting duly held for such purpose.

Section 2.5. Annual Meeting. An annual meeting of the members shall be held each year during May or June on a date and at an hour fixed by the Board for the purpose of electing Directors and for the transaction of such other business as may come before the meeting. If the election of Directors shall not be held at such annual meeting, or at any adjournment thereof, the members or the Board shall cause the election to be held at a special meeting of the members as soon thereafter as convenient.

Section 2.6. Special Meetings. Special meetings of the members may be called by the Chairman, Executive Director, the Board of Directors, or not less than one-tenth of the members having voting rights.

Section 2.7. Place of Meeting. The place of all meetings of the members shall be at the principal office of the Corporation, or at such place as shall be determined from time to time by the Board. If no designation is made or if a special meeting be otherwise called, the place of meeting shall be the principal office of the Corporation.

Section 2.8. Notice of Meetings. Written notice stating the place, day and hour of any meeting of members shall be delivered by mail, delivery service, or facsimile, to each member entitled to vote at such meeting, not less

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than five days unless otherwise required by law before the date of such meeting, by or at the direction of the Executive Director, or the Secretary acting for the Board of Directors, or the persons calling the meeting as provided under Section 2.7. In case of a special meeting or when required by statute or by these Bylaws, the purpose or purposes for which the meeting is called shall be stated in the notice. If mailed, the notice of a meeting shall be deemed to be delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the Corporation, with postage thereon prepaid.

Section 2.9. Quorum. A quorum at any annual or special meeting shall consist of a majority of the then existing members. If a quorum is not present at any meeting of members, a majority of the members present may adjourn the meeting from time to time without further notice.

Section 2.10. Proxies. At any meeting of members, a member entitled to vote may vote by proxy executed in writing by the member or by his duly authorized attorney-in-fact. No proxy shall be valid after three (3)

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months from the date of its execution, unless otherwise provided in the proxy.

Section 2.11. Manner of Acting. A majority of the votes entitled to be cast on a matter to be voted upon by the members present or represented by proxy at a meeting at which a quorum is present shall be necessary for the adoption thereof unless a greater proportion is required by law or by these Bylaws.

Section 2.12. Unanimous Action. Any action required or permitted to be taken by the members may be taken without a meeting if all members consent in writing to the adoption of a resolution authorizing the action. The resolution and written consents thereto by the members shall be filed with the minutes of the proceedings of the members.

ARTICLE 3

DIRECTORS

Section 3.1. Number, Election and Term of Office. The number of Directors which shall constitute the full Board of Directors shall be fixed by the members from time to time. A full Board of Directors shall be elected at each annual meeting of the members. Each Director shall hold office from the time

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of his election, but shall be responsible as a Director from such time only if he consents to his election; otherwise from the time he accepts office or attends his first meeting of the Board. Each Director shall serve until the next annual meeting of the members, and thereafter until his successor is duly elected, or until his earlier death, resignation or removal. **(Amended: April 11, 2003)**

Section 3.2. Regular Meetings; Notice. Regular meetings of the Board of Directors shall be held at such time and place as shall be designated by the Board of Directors from time to time. Notice of such regular meetings shall not be required, except as otherwise expressly required herein or by law, and except that whenever the time or place of regular meetings shall be initially fixed and then changed, notice of such action shall be given promptly by telephone or otherwise to each Director not participating in such action. Any business may be transacted at any regular meeting.

Section 3.3. Annual Meeting of the Board. A regular meeting of the Board of Directors shall be held immediately after the annual meeting of the members or after the last adjournment thereof. Such regular meeting shall be the annual organization meeting at which the Board shall organize itself

and elect the Executive Officers of the Corporation for the ensuing year and may transact any other business.

Section 3.4. Special Meetings; Notice. Special meetings of the Board of Directors may be called at any time by the Board itself, or by the Chairman or the Executive Director, or by at least one-fourth of the Directors, to be held at such place and day and hour as shall be specified by the person or persons calling the meeting. Notice of every special meeting of the Board of Directors shall be given by the Secretary to each Director at least two days before the meeting. Any business may be transacted at any special meeting regardless of whether the notice calling such meeting contains a reference thereto, except as otherwise required by law.

Section 3.5. Organization. At all meetings of the Board of Directors, the presence of at least a majority of the Directors in office shall be necessary and sufficient to constitute a quorum for the transaction of business. If a quorum is not present at any meeting, the meeting may be adjourned from time to time by a majority of the Directors present until a quorum as aforesaid shall be present, but notice of the time and place to which such meeting is adjourned shall be given to any Directors not present either by being sent by facsimile or given personally or by telephone at least eight

hours prior to the hour of reconvening. Resolutions of the Board shall be adopted, and any action of the Board upon any matter shall be valid and effective, with the affirmative vote of a majority of the Directors present at a meeting duly convened and at which a quorum is present. The Chairman of the Board, if one has been elected and is present, or if not, the Executive Director, if he is a Director and is present, or if not, a Director designated by the Board, shall preside at each meeting of the Board. The Secretary, or in his absence any Assistant Secretary, shall take the minutes at all meetings of the Board of Directors. In the absence of the Secretary and an Assistant Secretary, the presiding officer shall designate any person to take the minutes of the meeting.

Section 3.6. Meetings by Telephone. One or more Directors may participate in any regular or special meeting of the Board of Directors or of a committee of the Board of Directors by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in a meeting in this manner by a Director will be considered to be attendance in person for all purposes under these Bylaws.

Section 3.7. Presumption of Assent. Minutes of each meeting of the Board shall be made available to each Director at

or before the next succeeding meeting. Each Director shall be presumed to have assented to such minutes unless his objection thereto shall be made to the Secretary at or within two days after such succeeding meeting.

Section 3.8. Unanimous Action. Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if all directors consent in writing to the adoption of a resolution authorizing the action. The resolution and written consents thereto by the directors shall be filed with the minutes of the proceedings of the Board.

Section 3.9. Catastrophe. Notwithstanding any other provisions of the Pennsylvania Nonprofit Corporation Law of 1988, the Articles or these Bylaws, if any emergency resulting from warlike damage or an attack on the United States or any nuclear or atomic disaster, or any other national or local disaster, causes a majority of the Board to be incapable of acting as such because of death or other physical disability or difficulties of communication or transportation, the other Director or Directors shall constitute a quorum for the sole purpose of electing Directors to replace the Directors so incapable of acting. The Directors so elected shall serve until such replaced Directors are able to attend meetings of the Board or until the Board acts to elect Directors for such purpose.

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Questions as to the existence of such an emergency or disaster or as to the fact of such incapacity shall be conclusively determined by such other Director or Directors.

Section 3.10. Resignations. Any Director may resign by submitting his resignation to the Secretary. Such resignation shall become effective upon its receipt by the Secretary or as otherwise specified therein.

Section 3.11. Removal. A Director may be removed from office by the members, without cause, at any meeting called for such purpose.

Section 3.12. Committees. By resolution adopted by a majority of the whole Board, standing or temporary committees, including an Executive Committee, may be appointed by the Board of Directors from time to time, with each such Committee consisting of such persons as the Board shall then appoint. Each such committee shall have and exercise such authority of the Board of Directors in the management of the business and affairs of the Corporation as the Board may specify from time to time, which may include any action which the Pennsylvania Nonprofit Corporation Law of 1988 provides shall or may be taken by the Board of Directors. The Board may designate one or more Directors as alternate members of any committee to replace any absent or disqualified member at any meeting of the committee,

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and in the event of such absence or disqualification, the member or members of such committee present at any meeting and not disqualified from voting, whether or not such member or members constitute a quorum, may unanimously appoint another Director to act at the meeting in the place of any such absent or disqualified member. Any action taken by any committee shall be subject to alteration or revocation by the Board of Directors; provided, however, that third parties shall not be prejudiced by such alteration or revocation.

Section 3.13. Advisory Committees. By resolution adopted by a majority of the whole Board, advisory committees may be appointed by the Board of Directors from time to time, with each such Committee consisting of such persons as the Board shall then appoint, to act as a resource to the Corporation in connection with the development and implementation of programs. An Advisory Committee shall have such duties and authorities as shall be designated by the Board of Directors in the resolution authorizing the Advisory Committee. The Executive Director shall develop operating guidelines for each Advisory Committee, and the Executive Director shall report on the operations, activities and recommendations of the Advisory Committees to the Board of Directors. **(Amended: April 11, 2003)**

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Section 3.14. Vacancies. Any vacancy that shall occur in the Board of Directors by reason of death, resignation, removal, increase in the number of Directors or any other cause whatever shall be filled by a majority of the then serving Directors, whether or not a quorum, and each person so elected shall be a Director until he or his successor is elected at the next annual meeting of the members or until his prior death, resignation or removal.

ARTICLE 4

ELIMINATION OF LIABILITY; INDEMNIFICATION

Section 4.1. Personal Liability of Directors.

(a) Elimination of Liability. To the fullest extent that the laws of the Commonwealth of Pennsylvania, as now in effect or as hereafter amended, permit elimination or limitation of the liability of directors, no Director of the Corporation shall be personally liable for monetary damages as such for any action taken, or any failure to take any action, as a Director.

(b) Nature and Extent of Rights. The provisions of this Section shall be deemed to be a contract with each Director of the Corporation who serves as such at any time while this Section is in effect and each such Director shall be deemed to be so serving in reliance on the provisions of this Section. Any amendment or repeal of this Section or adoption of any Bylaw

or provision of the Articles of the Corporation which has the effect of increasing director liability shall operate prospectively only and shall not affect any action taken, or any failure to act, prior to the adoption of such amendment, repeal, Bylaw or provision.

Section 4.2. Indemnification.

(a) Right to Indemnification.

(1) As used herein, the word "Action" shall mean any action, suit or proceeding, administrative, investigative or other, (i) to which such person is a party (other than an action by the Corporation) or (ii) in connection with which such person is not a party but is a witness, subject to investigation or otherwise involved, in either case by reason of such person being or having been a director or officer of the Corporation.

(2) Unless in a particular case indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, and except as prohibited by law, each director and officer of the Corporation shall be entitled as of right to be indemnified by the Corporation against expenses and any liability paid or incurred by such person (i) in the

defense of any Action to which such person is a party or (ii) in connection with any other Action.

(3) A person who is not a director or officer of the Corporation may be similarly indemnified in respect of service to the Corporation to the extent the Board at any time designates such person as entitled to the benefits of this Section.

(4) As used in this Section, "indemnitee" shall include each director and each officer of the Corporation and each other person designated by the Board as entitled to the benefits of this Section; "liability" shall include amounts of judgments, excise taxes, fines, penalties and amounts paid in settlement; and "expenses" shall include fees and expenses of counsel incurred by the indemnitee only (i) if the Corporation has not at its expense assumed the defense of the Action on behalf of the indemnitee with reputable and experienced counsel selected by the Corporation, or (ii) if it shall have been determined pursuant to Section (c) hereof that the indemnitee was entitled to indemnification for expenses in respect of an action brought under that Section.

(b) Right to Advancement of Expenses. Unless in a particular case advancement of expenses would jeopardize the

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Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, every indemnitee shall be entitled as of right to have his expenses in defending any Action paid in advance by the Corporation, as incurred, provided that the Corporation receives a written undertaking by or on behalf of the indemnitee to repay the amount advanced if it should ultimately be determined that the indemnitee is not entitled to be indemnified for such expenses.

(c) Right of Indemnitee to Initiate Action; Defenses.

(1) If a written claim under paragraph (a) or paragraph (b) of this Section is not paid in full by the Corporation within thirty days after such claim has been received by the Corporation, the indemnitee may at any time thereafter initiate an action to recover the unpaid amount of the claim and, if successful in whole or in part, the indemnitee shall also be entitled to be paid the expense of prosecuting such action.

(2) The only defenses to an action to recover a claim for indemnification otherwise properly asserted under paragraph (a) shall be (i) that the indemnitee's conduct was such that under applicable law the Corporation is prohibited from indemnifying the indemnitee for the amount

claimed, or (ii) that indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code or result in the Corporation's failure to be described in Section 501(c)(3) of the Code, but the burden of proving any such defense shall be on the Corporation.

(3) The only defense to an action to recover a claim for advancement of expenses otherwise properly asserted under paragraph (b) shall be that the indemnitee failed to provide the undertaking required by paragraph (b).

(d) Non-Exclusivity; Nature and Extent of Rights. The rights to indemnification and advancement of expenses provided for in this Section shall (i) not be deemed exclusive of any other rights to which any indemnitee may be entitled, (ii) be deemed to create contractual rights in favor of each indemnitee who serves the Corporation at any time while this Section is in effect (and each such indemnitee shall be deemed to be so serving in reliance on the provisions of this Section), and (iii) continue as to each indemnitee who has ceased to have the status pursuant to which he was entitled or was designated as entitled to indemnification under this Section and shall inure to the benefit of the heirs and legal representatives of each indemnitee.

ARTICLE 5

OFFICERS AND EMPLOYEES

Section 5.1. Executive Officers. The Executive Officers of the Corporation shall be the Chairman of the Board, the Executive Director, the Secretary and the Treasurer, and such other officers as may be designated as Executive Officers by the Board of Directors in accordance with the provisions of this Article. All of the Executive Officers shall be elected by the Board of Directors and shall hold office until their successors are chosen and qualified provided that any officer may be removed at any time by the Board of Directors without cause. Any two or more offices may be held by the same person except that of the offices of Executive Director and Secretary. The office of Treasurer may be held by a bank.

Section 5.2 Additional Officers; Other Agents and Employees. The Board of Directors may from time to time appoint or employ such additional officers, including Vice Chairperson, Vice Presidents, assistant officers, agents, employees and independent contractors as the Board deems advisable; the Board or the Executive Director shall prescribe their duties, conditions of employment and compensation; and the Board shall have the right to dismiss them at any time, without prejudice to their contract rights, if any. The Executive Director may

employ from time to time such other agents, employees and independent contractors as he may deem advisable for the prompt and orderly transaction of the business of the Corporation, and he may prescribe their duties and the conditions of their employment, fix their compensation and dismiss them at any time, without prejudice to their contract rights, if any. **(Amended: April 11, 2003)**

Section 5.2. The Chairman of the Board. The Chairman of the Board shall be a Director of the Corporation and shall preside at all meetings of the Board of Directors, and shall be responsible for having all orders and resolutions of the Board of Directors carried into effect. As authorized by the Board of Directors, the Chairman shall execute on behalf of the Corporation and may affix, or cause to be affixed, the corporate seal to all instruments requiring such execution, except to the extent that signing and execution thereof are expressly delegated to some other person. The Chairman shall perform such other duties as are prescribed by the Board of Directors.

Section 5.3. The Executive Director. The Executive Director shall be the chief executive officer of the Corporation and shall act as its President. He may appoint standing and special staff committees to assist him in carrying out his executive duties. He shall have the authority to assign

specific and general administrative duties and functions to the Corporation's officers and to determine the duties of its employees. He shall have authority to delegate his executive duties to such committees and officers to the extent permissible under the laws of the Commonwealth of Pennsylvania. He shall be ex-officio a member of all standing committees appointed by the Board of Directors. He shall make reports of the Corporation's business to the Board of Directors and to the members at such times as the Board shall require. He shall sign, execute and acknowledge in the name of the Corporation debts, mortgages, bonds, contracts and other instruments authorized by the Board except in cases where the signing and execution thereof shall be expressly delegated by the Board to some other officer or agent of the Corporation, and he shall perform all the usual duties incident to the office of President and such other duties as from time to time may be assigned to him by the Board.

Section 5.4. The Secretary. It shall be the duty of the Secretary (a) to keep an original or duplicate record of the proceedings of the Board of Directors and the members, and a copy of the Articles and of the Bylaws; (b) to give such notices as may be required by law or these Bylaws; (c) to be custodian of the corporate records and of the seal of the Corporation and see that the seal is affixed to such documents as may be

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necessary or advisable; and (d) to exercise all powers and duties incident to the office of Secretary; and such further powers and duties as from time to time may be prescribed in these Bylaws or by the Board of Directors or the Executive Director.

Section 5.5. The Treasurer. It shall be the duty of the Treasurer or his designee (a) to keep the Corporation's contracts, insurance policies, leases, deeds and other business records; (b) to see that the Corporation's lists, books, reports, statements, tax returns, certificates and other documents and records required by law are properly prepared, kept and filed; (c) to be the principal officer in charge of tax and financial matters, budgeting and accounting of the Corporation; (d) to have charge and custody of and be responsible for the Corporation's funds, securities and investments; (e) to receive and give receipts for checks, notes, obligations, funds and securities of the Corporation, and deposit monies and other valuable effects in the name and to the credit of the Corporation, in such depositories as shall be designated by the Board of Directors; (f) to cause the funds of the Corporation to be disbursed by payment in cash or by checks or drafts upon the authorized depositories of the Corporation, and to cause to be taken and preserved proper vouchers for such

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disbursements; (g) to render to the Executive Director and the Board of Directors whenever they may require it an account of all his transactions as Treasurer, and reports as to the financial position and operations of the Corporation; (h) to keep appropriate, complete and accurate books and records of account of all the Corporation's business and transactions; and (i) to exercise all powers and duties incident to the office of Treasurer; and such further duties from time to time as may be prescribed in these Bylaws or by the Board of Directors or the Executive Director.

Section 5.6. Vacancies. Any vacancy in any office or position by reason of death, resignation, removal, disqualification, disability or other cause shall be filled by the Board of Directors at any meeting called for such purpose. Any person so elected shall hold office only until the annual meeting of the Board of Directors and until his successor is chosen and qualified.

Section 5.7. Delegation of Duties. The Board of Directors may in its discretion delegate for the time being the powers and duties, or any of them, of any officer to any other person whom it may select.

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ARTICLE 6

MISCELLANEOUS CORPORATE TRANSACTIONS AND DOCUMENTS

Section 6.1. Execution of Notes, Checks, Contracts and Other Instruments. All notes, bonds, drafts, acceptances, checks, endorsements (other than for deposit), guarantees and all evidences of indebtedness of the Corporation whatsoever, and all deeds, mortgages, contracts and other instruments requiring execution by the Corporation, may be signed by the Chairman, Executive Director or the Treasurer, and authority to sign any of the foregoing, which may be general or confined to specific instances, may be conferred by the Board of Directors upon any other person or persons. Any person having authority to sign on behalf of the Corporation may delegate, from time to time, by instrument in writing, all or any part of such authority to any other person or persons if authorized to do so by the Board of Directors, which authority may be general or confined to specific instances. Facsimile signatures on checks may be used if authorized by the Board of Directors.

Section 6.2. Voting Securities Owned by Corporation. Securities owned by the Corporation and having voting power in any other corporation shall be voted by the Chairman, Executive Director or Treasurer, or their designee, unless the Board confers authority to vote with respect thereto, which may be

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general or confined to specific investments, upon some other person. Any person authorized to vote such securities shall have the power to appoint proxies, with general power of substitution.

Section 6.3. Borrowing. No officer, agent or employee of the Corporation shall have any power or authority to borrow money on its behalf, to pledge its credit, or to mortgage or pledge its real property, except to the extent of the authority delegated to such officer, agent or employee by a resolution of the Board.

Section 6.4. Deposits. All funds of the Corporation shall be deposited each day to the credit of the Corporation in such banks, trust companies or other depositaries as the Board may approve or designate, and all such funds shall be withdrawn only by checks signed as authorized in Section 6.1 hereof.

ARTICLE 7

GENERAL PROVISIONS

Section 7.1. Offices. The principal business office of the Corporation shall be at Fifth Avenue Place, Pittsburgh, Allegheny County, Pennsylvania 15222. The Corporation may also have offices at such other places within or without the

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Commonwealth of Pennsylvania as the business of the Corporation may require.

Section 7.2. Corporate Seal. The Board of Directors shall prescribe the form of a suitable corporate seal, which shall contain the full name of the Corporation and the year and state of incorporation.

Section 7.3. Fiscal Year. The fiscal year of the Corporation shall end on such day as shall be fixed by the Board of Directors. Unless changed by resolution of the Board, the fiscal year of the Corporation shall commence on January 1 and end on December 31.

Section 7.4. Annual Report. To the extent required, the Executive Director and Treasurer shall present an annual report to the Board of Directors in accordance with Section 5553 of the Pennsylvania Nonprofit Corporation Law of 1988.

Section 7.5. No Vested Rights. Except as otherwise specifically provided herein, no provision of these Bylaws shall vest any property or contract right in any person.

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ARTICLE 8

AMENDMENTS

Section 8.1. Amendments. Except as otherwise provided by law, these Bylaws may be amended, altered or repealed, and new bylaws may be adopted, by the Board of Directors or by the members at any regular or special meeting, provided the notice for such meeting sets forth the nature of the proposal.

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Health Education Center, Inc

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Charter Documents

80-13 1586

Filed in the Department of State o
the 19th day of February 1980
William R. Davis.
Secretary of the Commonwealth

703287

ARTICLES OF INCORPORATION

DOMESTIC NONPROFIT CORPORATION

In compliance with the requirements of 15 Pa. S. §7316 (relating to articles of incorporation) the undersigned, desiring to be incorporated as a nonprofit corporation, hereby certify that:

1. The name of the corporation is Health Education Center, Inc.

2. The location and post office address of the initial registered office of the corporation in this Commonwealth is: 200, Ross Street, Pittsburgh, Pennsylvania 15219.

3. The corporation is incorporated under the Nonprofit Corporation Law of the Commonwealth of Pennsylvania for the following purpose or purposes: to encourage, assist, support and promote health and the prevention of disease and disability primarily in the Western Pennsylvania region; to provide for and carry on such other charitable work in connection therewith as may be consistent with the history and purposes of the Corporation. The Corporation does not contemplate pecuniary gain or profit, incidental or otherwise.

4. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in or intervene in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to its trustees, officers or other private persons.

Notwithstanding any other provisions set forth herein, the Corporation shall not carry on any other activities not permitted to be carried on (i) by a corporation exempt from Federal Income Tax under Section 501(c) (3) of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent Federal tax laws, or (ii) by a corporation contributions to which are deductible for Federal Income Tax purposes.

5. Upon the dissolution of the Corporation, the board of directors shall, after paying or making provision for the payment of all of the liabilities of the Corporation, distribute all assets of the Corporation exclusively for the purposes of the Corporation in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational, religious, or scientific purposes as shall at the time qualify as an organization or organizations described in Section 501(c) (3) of the Internal Revenue Code of 1954, as the board of directors shall determine.

6. The term for which the corporation is to exist is perpetual.

7. The corporation is organized upon a nonstock basis.

8. The corporation shall have no members.

9. The names and post office addresses of each of the incorporators are:

NAME	ADDRESS
William J. Copeland	22 Mission Drive Pittsburgh, Pennsylvania 15228
William L. Colbert	7525 Graymore Road Pittsburgh, Pennsylvania 15221
Dominic F. Dornetto	166 North Sprague Avenue Pittsburgh, Pennsylvania 15202
Lawrence D. Ellis, M.D.	1270 Beechwood Boulevard Pittsburgh, Pennsylvania 15206
Lois G. Michaels	618 Ellsworth Place Pittsburgh, Pennsylvania 15232
Milton Porter	Gateway Towers, Apartment 9-E Pittsburgh, Pennsylvania 15222
George H. Taber	704 Amberson Avenue Pittsburgh, Pennsylvania 15232

IN TESTIMONY WHEREOF, the incorporators have signed and sealed these Articles of Incorporation this 15th day of February, 1980.

William J. Copeland (SEAL)

Lois G. Michaels (SEAL)

William L. Colbert (SEAL)

Milton Porter (SEAL)

Dominic F. Dornetto (SEAL)

George H. Taber (SEAL)

Lawrence D. Ellis (SEAL)

COMPOSITE COPY
(October 23, 1996)

AMENDED AND RESTATED
BY-LAWS
of
HEALTH EDUCATION CENTER, INC.

ARTICLE I
Name

Section 1. This Corporation shall be named and known as HEALTH EDUCATION CENTER, INC.

ARTICLE II
Purposes

Section 1. The purposes for which the Corporation is organized are exclusively charitable, religious, scientific or educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, including all purposes, powers and privileges conferred upon the Corporation by the Nonprofit Corporation Law of 1988, as amended from time to time, or any successor statute governing Pennsylvania nonprofit corporations (the "Act").

ARTICLE III
Offices

Section 1. Registered Office. The registered office of the Corporation shall be at Fifth Avenue Place, Pittsburgh, Pennsylvania 15222.

Section 2. Additional Offices. The Corporation may have additional offices at such other places as the Board of Directors may from time to time appoint or as the affairs of the Corporation may require.

ARTICLE IV
Seal

Section 1. The corporate seal of the Corporation shall have inscribed thereon the name of the Corporation, the year of its organization and the words "Nonprofit Corporation, Seal, Pennsylvania."

ARTICLE V
Members

Section 1. Blue Cross of Western Pennsylvania shall be the sole member of the Corporation and shall have the right to exercise all of the powers vested in members by the Act.

ARTICLE VI
Board of Directors

Section 1. General Powers. The management of the business and affairs of the Corporation shall be vested in the Board of Directors.

Section 2. Number and Selection of Directors. The Board of Directors shall consist of fifteen persons. Directors shall be elected by the member(s). Directors need not be nominated by a nominating committee or from the floor. Directors need not be residents of the Commonwealth of Pennsylvania, nor citizens of the United States of America.

Section 3. Term. Each director elected to office at the annual meeting in 1986 shall be elected for an initial term of two years. Upon the expiration of such initial terms, one-third of the directors shall be elected for a term of one year; one-third for a term of two years; and one-third for a term of three years. Upon the expiration of such one-year, two-year and three-year terms, the terms of all directorships shall be for a period of three years. If the number of directors is increased, such additional directors shall have such initial terms as shall be necessary to ensure that, following the initial two-year terms of all directors elected at the annual meeting in 1986, approximately one-third of the Board of Directors shall be elected annually. Subject to a director's entitlement to serve out the term for which he or she has been elected, no director may serve for more than twelve consecutive years unless he or she is also a regular employee on the payroll of Veritus Inc. (Blue Cross of Western Pennsylvania), provided, however, that such director's term shall immediately terminate whenever he or she ceases for any reason to be a regular employee of Veritus Inc. (Blue Cross of Western Pennsylvania). Following the serving of twelve consecutive years, a director may be eligible for re-election to the Board after a one-year interval.

Amended: October 23, 1996

Section 4. Election of Additional Directors. The member(s) of the Corporation as then constituted shall have the power to fill all vacancies in the Board of Directors, including vacancies resulting from an increase in the number of directors, and a person so elected as a director shall serve for the balance of the unexpired term of any directorship to which he or she has been elected which has become vacant prior to its expiration.

Section 5. Resignation. A director may resign at any time. The resignation shall be in writing (unless the requirement of a writing is waived by a majority of the remaining directors), but the acceptance thereof shall not be necessary to make it effective. A director elected to succeed a director who has resigned or died prior to the termination of his or her term shall serve for the remainder of the term of the director whom he or she has replaced.

Amended: October 23, 1996

Section 6. Annual Meeting. An annual meeting of the Board of Directors for the election of officers and for the transaction of such other business as may properly be brought before the Board shall be held at a place designated by the Board of Directors in October of each year or on such other date, time, and place as designated by the Board of Directors and stated in the notice of meeting. Written notice of each annual meeting shall be given to each director at least ten days before the day named for the meeting.

Amended: October 25, 1995

Section 7. Regular Meetings. Regular meetings of the Board of Directors may be held without notice at such times as are fixed by the Board of Directors.

Section 8. Special Meetings. Special meetings of the Board of Directors may be called by the Chairman of the Board and shall be called by the Chairman of the Board or the Secretary on the written request of any two of the directors then in office. Written notice of every special meeting, specifying the time and place of the meeting, and the general nature of the business to be transacted at such meeting, shall be given by the Secretary to each director. If the notice is given personally or sent by facsimile transmission (with confirmation of receipt), it shall be given at least 72 hours before the time named for the meeting. If the notice is given otherwise, it shall be given at least seven days before the day named for the meeting.

Amended: October 25, 1995

Section 9. Place of Meetings. The meetings of the Board of Directors may be held at such place or places within this Commonwealth, or elsewhere, as a majority of the directors may from time to time determine, or as may be designated in the notice calling the meeting.

Section 10. Use of Conference Telephone and Similar Equipment. One or more directors may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment, by which all

persons participating in the meeting can hear each other. Participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Quorum and Majority Vote. A quorum for the transaction of business at any meeting of the Board of Directors shall consist of a majority of the directors then in office. A majority of the directors at the meeting shall be required to pass any motion.

Section 12. Action by Unanimous Written Consent. Any action which may be taken at a meeting of the Board of Directors may be taken without a meeting, if a consent or consents in writing setting forth the action so taken shall be signed by all of the directors in office and shall be filed with the Secretary of the Corporation.

Section 13. Compensation. The directors shall receive no compensation for their services as such, but a director may also be a salaried officer of the Corporation. Directors may be reimbursed for reasonable expenses incurred to attend Board meetings.

Section 14. Power to Elect Officers. The Board of Directors shall elect a Chairman of the Board, one or more Vice Chairmen, an Executive Director, a Secretary, a Treasurer, and such other officers as the Board of Directors, from time to time deems advisable, including, but not limited to, one or more Assistant Secretaries and Assistant Treasurers. The officers need not be nominated by a nominating committee or from the floor. No officer except the Chairman of the Board and one Vice Chairman need be a member of the Board, but a Vice Chairman who is not a director shall not succeed to nor fill the office of Chairman of the Board. Any two or more offices may be held by the same person except the offices of Chairman of the Board and Secretary.

Amended: October 25, 1995

Section 15. Power to Appoint Other Officers and Agents. The Board of Directors shall have power to appoint such other officers and agents as the Board may deem necessary for transaction of the business of the Corporation.

Section 16. Director Emeritus. The Board of Directors shall have authority from time to time to elect Emeritus members of the Board without reference to the preceding provisions of Article VI. Directors Emeritus shall be elected in recognition and appreciation of long and valuable service to the Corporation and shall be entitled to such designation for life. Such Directors Emeritus shall not be directors of the Corporation or required to perform the duties of directors within the meaning of the Act.

Section 17. Power to Fill Other Vacancies. With the exception of vacancies in the Board of Directors, the Board shall have power to fill any vacancy in any corporate office occurring at any time for any reason whatsoever.

Section 18. Delegation of Powers. For any reason deemed sufficient by the Board of Directors, whether occasioned by absence or otherwise, the Board may delegate all or any of the powers and duties of any officer to any other officer or director, but no officer or director shall execute, acknowledge or verify any instrument in more than one capacity.

Section 19. Power to Appoint Executive and Other Committees. The Board of Directors in its discretion shall have power to appoint by resolution an Executive Committee or any other committee composed of two or more directors, who, to the extent provided in such resolution, shall have and exercise the authority of the Board of Directors in the management of the business of the Corporation between meetings of the Board in accordance with Section 5731 of the Act.

Section 20. Power to Require Bonds. The Board of Directors may require any officer or agent to file with the Corporation a satisfactory bond conditioned for faithful performance of his or her duties.

Amended October 23, 1996

Section 21. Compensation. The compensation of officers and agents may be fixed by the Board.

Section 22. Conflict of Interest. The Corporation shall not be precluded from conducting business with any partnership, firm or company with which one or more directors are associated, provided any business relationship is established and maintained on an arm's length basis and the subsequent provisions of this Section 22 are met. Each such director shall disclose any actual or potential conflict between the director's personal interests and his or her duty to the Corporation. Any director deemed by the Board to be disqualified because of an actual or apparent conflict of interest on any matter shall not vote or use his or her personal influence on the matter, and shall not be counted in determining the quorum for the meeting, even when permitted by law. The minutes of the meeting shall reflect that a disclosure was made, the abstention from voting and the effect on the quorum.

Section 23. Standard of Care and Justifiable Reliance. A director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a director, including duties as a member of any committee of the Board upon which the director may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would

use under similar circumstances. In performing his or her duties, a director shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the director reasonably believes to be reliable and competent in the matters presented.

b. Counsel, public accountants or other persons as to matters which the director reasonably believes to be within the professional or expert competence of such person.

c. A duly designated committee of the Board, upon which the director does not serve, as to matters within its designated authority, which committee the director reasonably believes to merit confidence.

A director shall not be considered to be acting in good faith if the director has knowledge concerning the matters in question that would cause his or her reliance to be unwarranted.

Section 24. Exercise of Powers Generally. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual directors may, in considering the best interests of the Corporation, consider to the extent they deem appropriate the factors more fully set forth in Section 5715 of the Act.

Section 25. Personal Liability of Directors. A director shall not be personally liable for monetary damages for any action taken, or any failure to take any action, unless:

a. the director has breached or failed to perform the duties of his or her office under this section; and

b. the breach or failure to perform constitutes self-dealing, willful misconduct or recklessness.

The above provisions of this section shall not apply to the responsibility or liability of a director pursuant to any criminal statute, or the liability of a director for the payment of taxes pursuant to local, state or federal law.

Section 26. Actions on Insolvency or Financial Difficulty. If the Corporation is insolvent or in financial difficulty, the Board of Directors shall take no action in connection therewith without the consent of the member(s).

ARTICLE VII
Officers

Section 1. Officers. The officers of the Corporation shall be a Chairman of the Board, one or more Vice Chairmen, an Executive Director, a Secretary, a Treasurer, and such other officers as the Board of Directors from time to time deems advisable, including, but not limited to, one or more Assistant Secretaries and Assistant Treasurers. The Board may refrain from filling any of such offices other than Chairman of the Board, Secretary and Treasurer. The Chairman of the Board, Secretary and Treasurer shall be elected by the Board of Directors at each of its annual meetings to hold office until the next annual meeting. Other officers shall be elected at such time, in such manner and for such terms as are determined by the Board. Except in the event of his or her earlier resignation or removal, each officer shall hold office until his or her successor has been duly elected and qualified.

Amended: October 25, 1995; October 23, 1996

Section 2. Chairman of the Board. The Chairman of the Board shall be a director of the Corporation. The Chairman of the Board shall preside at all meetings of the Board of Directors. The Chairman of the Board shall be responsible for having all orders and resolutions of the Board of Directors carried into effect. The Chairman of the Board shall perform such other duties as are prescribed by the Board of Directors.

Amended: October 25, 1995

Section 3. Vice Chairman. The Vice Chairman shall perform such duties and do such acts as are prescribed by the Board of Directors or the Chairman of the Board. Subject to the provisions of this section, the Vice Chairmen, in order of their seniority, unless designated by the Board of Directors, shall perform the duties and have the powers of the Chairman of the Board in the event of his or her absence or disability.

Amended: October 23, 1996

Section 4. Executive Director. The Executive Director shall have general and active management of the business of the Corporation, subject to supervision and oversight by the Chairman of the Board. The Executive Director shall make reports of the Corporation's business from time to time to the Board of Directors and its Committees, and to the member(s), and shall perform such other duties as from time to time may be assigned to him or her by the Board of Directors.

Amended: October 25, 1995; October 23, 1996

Section 5. Secretary. The Secretary shall act under the direction of the Chairman of the Board. Unless a designation to the contrary is made at a meeting, the Secretary shall attend all meetings of the Board of Directors and record the proceedings of such meetings in a minute book, and shall perform like duties for committees when required. The Secretary shall give, or cause to be given, notice of annual and special meetings of the Board of Directors. The Secretary shall keep in safe custody the corporate seal of the Corporation and, when authorized by the Chairman of the Board or the Board of Directors, cause it to be affixed to any instruments requiring it. The Secretary shall perform such other duties as are prescribed by the Board of Directors or the Chairman of the Board.

Section 6. Treasurer. The Treasurer shall act under the direction of the Chairman of the Board. The Treasurer shall keep full and accurate accounts of corporate receipts and disbursements in books belonging to the Corporation. The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board of Directors or by the Chairman of the Board, taking proper vouchers for such disbursements, and shall render to the Board of Directors and the Chairman of the Board at their regular meetings, or whenever they may require it, an account of all his or her transactions as Treasurer and of the financial condition of the Corporation. The Treasurer shall have custody of the corporate funds and securities and shall keep the moneys of the Corporation in accounts of the Corporation in such banks, trust companies, or other depositories as shall be selected by the Board of Directors. The Treasurer shall perform such other duties as are prescribed by the Board of Directors or the Chairman of the Board.

Amended: October 23, 1996

Section 7. Removal. Any officer or agent may be removed by the Board of Directors whenever in its judgment the best interests of the Corporation will be served thereby, but such removal shall be without prejudice to the contract rights of any person so removed.

Section 8. Vacancy. Pursuant to the authority granted in Article VI, Section 17, if the office of any officer or agent becomes vacant for any reason, the Board of Directors may choose a successor or successors, who shall hold office for the unexpired term in respect of which such vacancy occurred.

Section 9 General Powers. Subject always to the direction of the Board of Directors, the officers are authorized to do and perform all corporate acts appropriate to carry on the business of the Corporation.

ARTICLE VIII
Execution of Documents

Section 1. Checks, etc. All checks, drafts and orders for payment of money shall be signed in the name of the Corporation and shall be countersigned, by the Executive Director and the Treasurer, or by such officers or agents as the Board of Directors shall from time to time designate for that purpose.

Amended: October 25, 1995

Section 2. Contracts, Conveyances, etc. When the execution of any contract, conveyance or other instrument has been authorized without specification of the executing officers, the Chairman of the Board, any Vice Chairman, the Executive Director or any person designated by the Executive Director, and the Secretary, or Assistant Secretary, may execute the same in the name and on behalf of this Corporation and may affix the corporate seal thereto. The Board of Directors shall have the power to designate the officers and agents who shall have authority to execute any instrument on behalf of this Corporation.

Amended: October 25, 1995

ARTICLE IX
Advisory Committees

Section 1. Advisory Committees. The Corporation may form one or more Advisory Committees to make recommendations to the Board of Directors regarding, among other things, program development and implementation, the use of funds designated for health education and community service activities, and such other matters as shall be determined by the Chairman of the Board. An Advisory Committee shall have such Chairperson, duties and authorities as shall be designated by the Chairman of the Board, with the approval of the Board of Directors.

Section 2. Community Action Board. The Corporation shall have a Community Action Board ("CAB"). The CAB shall consist of a Chairperson, community representatives and such other persons as the Chairman of the Board shall determine with the advice of the Chairperson. The CAB shall advise the Corporation regarding program development and implementation, fundraising, volunteer recruitment, public/community education and evaluation with respect to the programs undertaken by the Corporation. The Chairperson shall report on the operations, activities and recommendations of the CAB to the Board of Directors. Any member of the CAB may resign by submitting a letter of resignation to the Chairperson. Such resignation shall be effective upon receipt by the Chairperson of the letter of resignation. A member of the CAB may be

removed by the Chairman of the Board, with the advice of the Chairperson. Standing or temporary committees may be formed by the Chairperson from time to time, with each such committee consisting of such persons as the Chairperson shall appoint. Each such committee shall have such duties and authorities as the Chairperson shall determine.

Amended: October 23, 1996

ARTICLE X
Transaction of Business

Section 1. Incidental Profits. Whenever the lawful activities of the Corporation involve among other things the charging of fees or prices for its services or products, it shall have the right to receive such income and, in so doing, may make an incidental profit. All such incidental profits shall be applied to the maintenance and operation of the lawful activities of the Corporation, and in no case shall be divided or distributed in any manner whatsoever among the directors or officers of the Corporation.

ARTICLE XI
Miscellaneous

Section 1. Indemnification. The Corporation shall, to the full extent permitted by the Act, indemnify each person whom it may lawfully indemnify pursuant thereto.

Section 2. Fiscal Year. The Corporation's fiscal year shall be determined by the Board of Directors.

Section 3. Annual Report. The Board of Directors shall present annually to the member(s) a report verified by the Executive Director and Treasurer in accordance with Section 5553 of the Act.

Amended: October 25, 1995

Section 4. Required Corporate Records. The Corporation shall keep complete and accurate books and records of account, minutes of the proceedings of the member(s) and the directors, and of any other body exercising power or performing duties authorized by these By-Laws, and the original or a copy of its By-Laws, including all amendments thereto to date, certified by the Secretary of the Corporation. All such records and documents shall be kept at the Corporation's principal place of business.

Section 5. Interpretation. Unless the context of these By-laws otherwise clearly requires, each gender shall include all genders.

Amended: October 25, 1995

ARTICLE XII
Termination, Dissolution or Winding Up

Section 1. In the event of the entire or partial termination, dissolution or winding up of this Corporation in any manner or for any reason whatsoever, the assets of the Corporation which remain after payment or making provision for payment of all liabilities of the Corporation shall be distributed to, and in accordance with, the lawful activities and purposes of the Corporation.

ARTICLE XIII
Adoption, Amendment and Repeal of By-Laws

Section 1. Adoption. These Amended and Restated By-Laws, which are supplemental to the Act, have been adopted as the By-Laws of the Corporation on the 2nd day of November, 1994, and shall be effective as of that date.

Section 2. Power to Adopt, Amend and Repeal By-Laws. The member(s) shall have the power to adopt, amend and repeal the By-Laws of the Corporation.

Section 3. Recording Amendments and Repeals. The text of each amendment to or repeal of these By-Laws, with a notation of the date of such amendment or repeal, shall be recorded in the minutes of the Corporation.

ARTICLE XIV
Emergency By-Laws

Section 1. When Operative. The emergency By-Laws provided by the following sections shall be operative during any emergency resulting from warlike damage or an attack on the United States or any nuclear or atomic disaster, notwithstanding any different provision in the preceding sections of the By-Laws or in the Articles of Incorporation of the Corporation or in the Act. To the extent not inconsistent with the emergency By-Laws, the By-Laws provided in the preceding sections shall remain in effect during such emergency, and upon its termination. The emergency By-Laws shall cease to be operative unless and until another such emergency shall occur.

Section 2. Meetings. During any such emergency:

(a) Any meeting of the Board of Directors may be called by any director. Whenever any officer of the Corporation who is not a director has reason to believe that no director is available to participate in a meeting, such officer may call a meeting to be held under the provisions of this section.

(b) Notice of each meeting called under the provisions of this section shall be given by the person calling the meeting or at his or her request by any officer of the Corporation. The notice shall specify the time and the place of the meeting, which shall be the head office of the Corporation at the time if feasible and otherwise any other place specified in the notice. Notice need be given only to such of the directors as it may be feasible to reach at the time and may be given by such means as may be feasible at the time, including publication or radio. If given by mail, messenger, telephone or telegram, the notice shall be addressed to the director at his or her residence or business address or such other place as the person giving the notice shall deem suitable. In the case of meetings called by an officer who is not a director, notice shall also be given similarly, to the extent feasible, to the persons named in the list referred to in part (c) of this section. Notice shall be given at least two days before the meeting if feasible in the judgment of the person giving the notice and otherwise the meeting may be held on any shorter notice he or she shall deem suitable.

(c) At any meeting called under the provision of this section, the director or directors present shall constitute a quorum for the transaction of business. If no director attends a meeting called by an officer who is not a director, and if there are present at least three of the persons named on a numbered list of personnel approved by the Board of Directors before the emergency, those present (but not more than the nine appearing highest in priority on such list) shall be deemed directors for such meeting and shall constitute a quorum for the transaction of business.

Amended: October 23, 1996

Section 3. Lines of Succession. The Board of Directors, during as well as before any such emergency, may provide, and from time to time modify, lines of succession in the event that during such an emergency any or all officers or agents of the Corporation shall for any reason be rendered incapable of discharging their duties.

Section 4. Offices. The Board of Directors, during as well as before any such emergency, may, effective in the emergency, change the head office or designate several alternative head offices or regional offices; or authorize the officers so to do.

Section 5. Liability. No officer, director or employee acting in accordance with these emergency By-Laws shall be liable except for self-dealing, willful misconduct or recklessness.

Section 6. Repeal or Change. The emergency By-Laws shall be subject to repeal or change by action of the member(s), except that no such repeal or change shall modify the provisions of the next preceding section with regard to action or inaction prior to the time of such repeal or change.

Highmark Foundation

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Charter Documents

200092-1214

Microfilm Number _____

Entity Number 2977826

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
CORPORATION BUREAU

Filed with the Department of State on _____

DEC 14 2000

Secretary of the Commonwealth

ARTICLES OF INCORPORATION
of
HIGHMARK FOUNDATION

In compliance with the requirements of the Nonprofit Corporation Law of 1988, 15 Pa. C.S.A. §§ 5301 et seq., as amended, the undersigned, desiring to incorporate a nonprofit corporation, hereby certifies that:

1. Name. The name of the Corporation is Highmark Foundation.

2. Registered Office. The location and post office address of the initial registered office of the Corporation in this Commonwealth is Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Allegheny County, Pennsylvania 15222-3099.

3. Organization. The Corporation is incorporated under the provisions of the Nonprofit Corporation Law of 1988.

4. Purpose. The Corporation is formed exclusively for charitable, scientific, and educational purposes, all within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code") and shall undertake charitable endeavors of Highmark Inc., including but not limited to, programs intended to promote the health and well-being of the communities served by Highmark, Inc., to the extent such endeavors further the foregoing purposes under section 501(c)(3) of the Code.

5. Pecuniary Gain or Profit. The Corporation does not contemplate pecuniary gain or profit, incidental or otherwise.

6. Non-Stock Basis. The Corporation is to be organized on a non-stock basis.

7. Members. The Corporation shall have members, and the initial sole member shall be Highmark Inc.

8. Incorporator. The name and post office address of the incorporator is Carol A. Soltes, 435 Sixth Avenue, Pittsburgh, Pennsylvania 15219.

9. Management. The business and affairs of the Corporation shall be managed by or under the direction of a Board of Directors of the Corporation. The number, term of office, method of selection and manner of removal of the Board of Directors shall be as set forth in the Bylaws of the Corporation.

200092-1215

10. Exempt Organization. Notwithstanding any other provision of these Articles, the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a corporation described in Section 501(c)(3) of the Code (hereinafter referred to in these Articles as an "exempt organization"), or as a corporation contributions to which are deductible under Section 170(c)(2) of the Code. No substantial part of the activities of the Corporation shall be devoted to carrying on of propaganda, or otherwise attempting to influence legislation (except as otherwise provided in Section 501(h) of the Code), and the Corporation shall not participate in or intervene in (including the publishing or distributing of statements) any political campaign on behalf of or in opposition to any candidate for public office.

11. Earnings. Notwithstanding any other provision of these Articles, no part of the net earnings or assets of the Corporation shall inure to the benefit of or be distributable to its members, directors, trustees, officers or any other private individual; provided, however, the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to the extent that such payments do not prevent it from qualifying, and continuing to qualify, as an exempt organization and to make such lawful payments and distributions in furtherance of the purposes set forth in Article 4 hereof as may from time to time be either required or permitted by Section 501(c)(3) of the Code.

12. Foundation Status. Notwithstanding any other provision of these Articles, the Corporation shall be prohibited from engaging in any act of self-dealing (as defined in Section 4941(d) of the Code); from retaining any excess business holdings (as defined in Section 4943(c) of the Code); from making any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code; and from making any taxable expenditures (as defined in Section 4945(d) of the Code), to the extent any action therewith would subject the Corporation to tax under one or more of the cited sections of the Code. To the extent required, the Corporation shall make qualifying distributions at such time and in such manner as do not subject the Corporation to tax under Section 4942 of the Code.

13. Dissolution. In the event that the Corporation shall be dissolved or liquidated, the Board of Directors, after paying or making provision for payment of all of the known liabilities of the Corporation, may transfer or dispose of the Corporation's property and assets to (a) such one or more corporations, trusts, funds or other organizations which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and, in the sole judgment of the Corporation's Board of Directors, have purposes similar to those of the Corporation or (b) the federal government, or to a state or local government for such purposes. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more of such corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, and which are organized and operated for such purposes, or to the federal government or to a state or local government for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution or sale of the assets of the Corporation.

14. Personal Liability of Directors.

(a) Elimination of Liability. To the fullest extent that the laws of the Commonwealth of Pennsylvania, as now in effect or as hereafter amended, permit elimination or limitation of the liability of directors, no Director of the Corporation shall be personally liable for monetary damages as such for any action taken, or any failure to take any action, as a Director.

(b) Applicability. The provisions of this Article shall be deemed to be a contract with each Director of the Corporation who serves as such at any time while this Article is in effect and each such Director shall be deemed to be so serving in reliance on the provisions of this Article. Any amendment or repeal of this Article or adoption of any bylaw or provision of these Articles which has the effect of increasing Director liability shall operate prospectively only and shall not affect any action taken, or any failure to act, prior to the adoption of such amendment, repeal, bylaw or provision.

200092-1216

15. Indemnification

(a) Right to Indemnification. (1) As used herein, the word "Action" shall mean any action, suit or proceeding, administrative, investigative or other, (i) to which such person is a party (other than an action by the Corporation) or (ii) in connection with which such person is not a party but is a witness, subject to investigation or otherwise involved, in either case by reason of such person being or having been a Director or officer of the Corporation.

(2) Unless in a particular case indemnification would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, and except as prohibited by law, each Director and officer of the Corporation shall be entitled as of right to be indemnified by the Corporation against expenses and any liability paid or incurred by such person (i) in the defense of any Action to which such person is a party or (ii) in connection with any other Action.

(3) A person who is not a Director or officer of the Corporation may be similarly indemnified in respect of service to the Corporation to the extent the Board at any time designates such person as entitled to the benefits of this Article.

(4) As used in this Article, "indemnitee" shall include each Director and each officer of the Corporation and each other person designated by the Board as entitled to the benefits of this Article; "liability" shall include amounts of judgments, excise taxes, fines, penalties and amounts paid in settlement; and "expenses" shall include fees and expenses of counsel incurred by the indemnitee only (i) if the Corporation has not at its expense assumed the defense of the Action on behalf of the indemnitee with reputable and experienced counsel selected by the Corporation, or (ii) if it shall have been determined pursuant to Section 3 hereof that the indemnitee was entitled to indemnification for expenses in respect of an action brought under that Section.

(b) Right to Advancement of Expenses. Unless in a particular case advancement of expenses would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, every indemnitee shall be entitled as of right to have his expenses in defending any Action paid in advance by the Corporation, as incurred, provided that the Corporation receives a written undertaking by or on behalf of the indemnitee to repay the amount advanced if it should ultimately be determined that the indemnitee is not entitled to be indemnified for such expenses.

(c) Right of Indemnitee to Initiate Action; Defenses. (1) If a written claim under Section (a) or Section (b) of this Article is not paid in full by the Corporation within thirty days after such claim has been received by the Corporation, the indemnitee may at any time thereafter initiate an action to recover the unpaid amount of the claim and, if successful in whole or in part, the indemnitee shall also be entitled to be paid the expense of prosecuting such action.

(2) The only defenses to an action to recover a claim for indemnification otherwise properly asserted under Section (a) shall be (i) that the indemnitee's conduct was such that under applicable law the Corporation is prohibited from indemnifying the indemnitee for the amount claimed, or (ii) that indemnification would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, but the burden of proving any such defense shall be on the Corporation.

(3) The only defense to an action to recover a claim for advancement of expenses otherwise properly asserted under Section (b) shall be (i) that advancement of expenses would jeopardize the Corporation's tax exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code or (ii) that the indemnitee failed to provide the undertaking required by Section (b), but the burden of proving any such defense shall be on the Corporation.

200092-1217

(d) Non-Exclusivity; Nature and Extent of Rights. The rights to indemnification and advancement of expenses provided for in this Article shall (i) not be deemed exclusive of any other rights to which any indemnitee may be entitled, (ii) be deemed to create contractual rights in favor of each indemnitee who serves the Corporation at any time while this Article is in effect (and each such indemnitee shall be deemed to be so serving in reliance on the provisions of this Article), and (iii) continue as to each indemnitee who has ceased to have the status pursuant to which he was entitled or was designated as entitled to indemnification under this Article and shall inure to the benefit of the heirs and legal representatives of each indemnitee.

16. Code. References in these Articles to a section of the Code shall be construed to refer both to such section and to the regulations promulgated thereunder, as they now exist or may hereafter be amended, and to the corresponding provisions of any future federal tax code and the regulations thereunder.

IN TESTIMONY WHEREOF, the Sole Incorporator has signed these Articles of Incorporation this 14th day of December, 2000.

Carol A. Salter
Sole Incorporator

BYLAWS

of

HIGHMARK FOUNDATION

(a Pennsylvania nonprofit corporation)

Adopted: February 28, 2001

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HIGHMARK FOUNDATION

Bylaws

ARTICLE I

NAME AND PURPOSE

Section 1.1. Name. The name of the Corporation is Highmark Foundation (hereinafter referred to as the "Corporation"), incorporated under the Pennsylvania Nonprofit Corporation Law of 1988 on December 14, 2000.

Section 1.2. Purpose. The Corporation is formed exclusively for charitable, scientific, and educational purposes, all within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended or modified or replaced by any future United States internal revenue law (the "Code") and shall undertake charitable endeavors of Highmark Inc., including but not limited to, programs intended to promote the health and well-being of the communities served by Highmark Inc., to the extent such endeavors further the foregoing purposes under section 501(c)(3) of the Code.

ARTICLE II

MEMBERS

Section 2.1. Members. The Corporation shall have members as contemplated by the Pennsylvania Nonprofit Corporation Law of 1988. Unless changed in accordance with the Articles of Incorporation and these Bylaws, the sole member of the Corporation shall be Highmark Inc.

Section 2.2. Voting Rights. Each member shall be entitled to one vote on any matters submitted to the members for a vote or as required by law or these Bylaws.

Section 2.3. Transfer of Membership Interest. A member may transfer all or any part of its interest in the Corporation upon an affirmative vote of all other members. No such transfer shall be permitted to the extent such transfer would adversely affect the Corporation's exempt status under section 501(c)(3) of the Code.

Section 2.4. Additional Members. Additional members may be admitted by an affirmative vote of all of the members, which vote shall be taken at a meeting duly held for such purpose.

Section 2.5. Annual Meeting. An annual meeting of the members shall be held each year on a date and at an hour fixed by the Board for the purpose of electing Directors and for the transaction of such other business as may come before the meeting. If the election of Directors shall not be held at such annual meeting, or at any adjournment thereof, the members or the Board shall cause the election to be held at a special meeting of the members as soon thereafter as convenient.

Section 2.6. Special Meetings. Special meetings of the members may be called by any member, by the Board of Directors, or by the President.

Section 2.7. Place of Meeting. The place of all meetings of the members shall be at the principal office of the Corporation, or at such place as shall be determined from time to time by the Board. If no designation is made

or if a special meeting be otherwise called, the place of meeting shall be the principal office of the Corporation.

Section 2.8. Notice of Meetings. Written notice stating the place, day and hour of any meeting of members shall be delivered by mail, delivery service, e-mail, or facsimile, to each member entitled to vote at such meeting, not less than five days unless otherwise required by law before the date of such meeting, by or at the direction of the Secretary acting for the Board of Directors, or the person calling the meeting as provided under Section 2.6. In case of a special meeting or when required by statute or by these Bylaws, the purpose or purposes for which the meeting is called shall be stated in the notice. If mailed, the notice of a meeting shall be deemed to be delivered when deposited in the United States mail addressed to the member at its address as it appears on the records of the Corporation, with postage thereon prepaid.

Section 2.9. Quorum. A quorum at any meeting shall consist of members holding a majority of the percentage interests of members. Unless stated otherwise in a transfer document, a member shall be deemed to hold a percentage interest equal to one divided by the number of members multiplied by 100. If a quorum is not present at any meeting of members, a majority of the members present may adjourn the meeting to a fixed date.

Section 2.10. Proxies. At any meeting of members, a member entitled to vote may vote by proxy executed in writing by the member or by his or her duly authorized attorney-in-fact. No proxy shall be valid after three (3) months from the date of its execution, unless otherwise provided in the proxy.

Section 2.11. Meetings by Telephone. One or more members may participate in any regular or special meeting of the members by means of

conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in a meeting in this manner by a member will be considered to be attendance in person for all purposes under these Bylaws.

Section 2.12. Manner of Acting. A majority of the votes entitled to be cast on a matter to be voted upon by the members present or represented by proxy at a meeting at which a quorum is present shall be necessary for the adoption thereof unless a greater proportion is required by law or by these Bylaws. Each corporate member shall designate a representative to vote on its behalf.

Section 2.13. Unanimous Action. Any action required or permitted to be taken by the members may be taken without a meeting if all members consent in writing to the adoption of a resolution authorizing the action. The resolution and written consents thereto by the members shall be filed with the minutes of the proceedings of the members.

ARTICLE III

DIRECTORS

Section 3.1. Number, Election and Term of Office. The number of Directors which shall constitute the full Board of Directors shall be determined from time to time by the member(s). The member(s) shall appoint the Directors of the Corporation. Each Director shall hold office from the time of his or her appointment, but shall be responsible as a Director from such time only if he or she consents to his or her appointment; otherwise from the time he or she accepts office or attends his or her first meeting of the Board. Directors shall

be appointed for a one-year term, and each Director may serve an unlimited number of terms at the discretion of the member(s). Each Director shall serve until his or her successor is duly appointed, or until his or her earlier death, resignation or removal.

Section 3.2. Regular Meetings; Notice. Regular meetings of the Board of Directors shall be held at such time and place as shall be designated by the Board of Directors from time to time. Notice of such regular meetings shall not be required, except as otherwise expressly required herein or by law, and except that whenever the time or place of regular meetings shall be initially fixed and then changed, notice of such action shall be given promptly by telephone, e-mail or otherwise to each Director not participating in such action. Any business may be transacted at any regular meeting.

Section 3.3. Annual Meeting of the Board. A regular meeting of the Board of Directors shall be held at such date, time and place as may be fixed by the Board of Directors. Such regular meeting shall be the annual organization meeting at which the Board shall organize itself and elect the Executive Officers of the Corporation for the ensuing year and may transact any other business.

Section 3.4. Special Meetings; Notice. Special meetings of the Board of Directors may be called at any time by a member or any Director, to be held at such place and day and hour as shall be specified by the person or persons calling the meeting. Notice of every special meeting of the Board of Directors shall be given by the Secretary to each Director at least two days before the meeting. Any business may be transacted at any special meeting

regardless of whether the notice calling such meeting contains a reference thereto, except as otherwise required by law.

Section 3.5. Organization. At all meetings of the Board of Directors, the presence of a majority of the Directors in office shall be necessary and sufficient to constitute a quorum for the transaction of business. If a quorum is not present at any meeting, the meeting may be adjourned from time to time by the Directors present until a quorum as aforesaid shall be present, but notice of the time and place to which such meeting is adjourned shall be given to any Directors not present either by being sent by e-mail or facsimile or given personally or by telephone at least eight hours prior to the hour of reconvening.

Resolutions of the Board shall be adopted, and any action of the Board upon any matter shall be valid and effective, with the affirmative vote of a majority of the Directors present at a meeting duly convened and at which a quorum is present. The Chairperson, the Vice Chairperson, if the Chairperson is unavailable, or the President, if neither the Chairperson nor the Vice Chairperson is available, shall preside at each meeting of the Board. The Secretary, or in his or her absence any Assistant Secretary, shall take the minutes at all meetings of the Board of Directors. In the absence of the Secretary and an Assistant Secretary, the presiding officer shall designate any person to take the minutes of the meeting.

Section 3.6. Meetings by Telephone. One or more Directors may participate in any regular or special meeting of the Board of Directors or of a committee of the Board of Directors by means of conference telephone or similar communications equipment by means of which all persons participating

in the meeting can hear each other. Participation in a meeting in this manner by a Director will be considered to be attendance in person for all purposes under these Bylaws.

Section 3.7. Presumption of Assent. Minutes of each meeting of the Board shall be made available to each Director at or before the next succeeding meeting. Each Director shall be presumed to have assented to such minutes unless his or her objection thereto shall be made to the Secretary at or within two days after such succeeding meeting.

Section 3.8. Resignations. Any Director may resign by submitting his or her resignation to the Secretary. Such resignation shall become effective upon its receipt by the Secretary or as otherwise specified therein. Upon the resignation of a Director, the member(s) shall appoint a successor Director.

Section 3.9. Committees. By resolution adopted by the Board, standing or temporary committees consisting of at least one Director may be appointed by the Board of Directors from time to time. Subject to any applicable restrictions under the Pennsylvania Nonprofit Corporation Law of 1988, each such committee shall have and exercise such authority of the Board of Directors in the management of the business and affairs of the Corporation as the Board may specify from time to time, which may include any action which the Pennsylvania Nonprofit Corporation Law provides shall or may be taken by the Board of Directors. The Board may designate one or more Directors as alternate members of any committee to replace any absent or disqualified member at any meeting of the committee, and in the event of such absence or disqualification, the member or members of such committee present

at any meeting and not disqualified from voting, whether or not such member or members constitute a quorum, may unanimously appoint another Director to act at the meeting in the place of any such absent or disqualified member. Any action taken by any committee shall be subject to alteration or revocation by the Board of Directors; provided, however, that third parties shall not be prejudiced by such alteration or revocation.

Section 3.10. Vacancies. Any vacancy that shall occur in the Board of Directors by reason of death, resignation, removal, or any other cause whatever shall be filled by the member(s) in a manner that complies with Section 3.1, and each person so appointed shall be a Director until he or she, or his or her successor, is appointed at the next meeting of the Board or until his or her prior death, resignation or removal.

Section 3.11. Removal. The member(s) may remove a Director for any or no reason.

Section 3.12. Personal Liability of Directors.

(a) Elimination of Liability. To the fullest extent that the laws of the Commonwealth of Pennsylvania, as now in effect or as hereafter amended, permit elimination or limitation of the liability of directors, no Director of the Corporation shall be personally liable for monetary damages as such for any action taken, or any failure to take any action, as a Director.

(b) Nature and Extent of Rights. The provisions of this Section shall be deemed to be a contract with each Director of the Corporation who serves as such at any time while this Section is in effect and each such Director shall be deemed to be so serving in reliance on the provisions of this

Section. Any amendment or repeal of this Section or adoption of any Bylaw or provision of the Articles of the Corporation which has the effect of increasing Director liability shall operate prospectively only and shall not affect any action taken, or any failure to act, prior to the adoption of such amendment, repeal, Bylaw or provision.

Section 3.13. Indemnification.

(a) Right to Indemnification.

(1) As used herein, the word "Action" shall mean any action, suit or proceeding, administrative, investigative or other, (i) to which such person is a party (other than an action by the Corporation) or (ii) in connection with which such person is not a party but is a witness, subject to investigation or otherwise involved, in either case by reason of such person being or having been a Director or officer of the Corporation.

(2) Unless in a particular case indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, and except as prohibited by law, each Director and officer of the Corporation shall be entitled as of right to be indemnified by the Corporation against expenses and any liability paid or incurred by such person (i) in the defense of any Action to which such person is a party or (ii) in connection with any other Action.

(3) A person who is not a Director or officer of the Corporation may be similarly indemnified in respect of service to the Corporation to

the extent the Board at any time designates such person as entitled to the benefits of this Section.

(4) As used in this Section, "indemnitee" shall include each Director and each officer of the Corporation and each other person designated by the Board as entitled to the benefits of this Section; "liability" shall include amounts of judgments, excise taxes, fines, penalties and amounts paid in settlement; and "expenses" shall include fees and expenses of counsel incurred by the indemnitee only (i) if the Corporation has not at its expense assumed the defense of the Action on behalf of the indemnitee with reputable and experienced counsel selected by the Corporation, or (ii) if it shall have been determined pursuant to Section (c) hereof that the indemnitee was entitled to indemnification for expenses in respect of an action brought under that Section.

(b) Right to Advancement of Expenses. Unless in a particular case advancement of expenses would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, every indemnitee shall be entitled as of right to have his or her expenses in defending any Action paid in advance by the Corporation, as incurred, provided that the Corporation receive a written undertaking by or on behalf of the indemnitee to repay the amount advanced if it should ultimately be determined that the indemnitee is not entitled to be indemnified for such expenses.

(c) Right of Indemnitee to Initiate Action; Defenses.

(1) If a written claim under paragraph (a) or paragraph (b) of this Section is not paid in full by the Corporation within thirty days after such claim has been received by the Corporation, the indemnitee may at any time thereafter initiate an action to recover the unpaid amount of the claim and, if successful in whole or in part, the indemnitee shall also be entitled to be paid the expense of prosecuting such action.

(2) The only defenses to an action to recover a claim for indemnification otherwise properly asserted under paragraph (a) shall be (i) that the indemnitee's conduct was such that under applicable law the Corporation is prohibited from indemnifying the indemnitee for the amount claimed, or (ii) that indemnification would jeopardize the Corporation's tax-exempt status under Section 501(a) of the Code, result in the Corporation's failure to be described in Section 501(c)(3) of the Code, or result in imposition of an excise tax under Chapter 42 of the Code, but the burden of proving any such defense shall be on the Corporation.

(3) The only defense to an action to recover a claim for advancement of expenses otherwise properly asserted under paragraph (b) shall be that the indemnitee failed to provide the undertaking required by paragraph (b).

(d) Non-Exclusivity; Nature and Extent of Rights. The rights to indemnification and advancement of expenses provided for in this Section shall (i) not be deemed exclusive of any other rights to which any indemnitee may be entitled, (ii) be deemed to create contractual rights in favor of each indemnitee

who serves the Corporation at any time while this Section is in effect (and each such indemnitee shall be deemed to be so serving in reliance on the provisions of this Section), and (iii) continue as to each indemnitee who has ceased to have the status pursuant to which he or she was entitled or was designated as entitled to indemnification under this Section and shall inure to the benefit of the heirs and legal representatives of each indemnitee.

ARTICLE IV

OFFICERS AND EMPLOYEES

Section 4.1. Executive Officers. The Executive Officers of the Corporation shall be the Chairperson, the Vice Chairperson, the President, the Secretary and the Treasurer, and may include one or more Vice Presidents as the Board may from time to time determine, all of whom shall be elected by the Board of Directors. Any two or more offices may be held by the same person. Each Executive Officer shall hold office at the pleasure of the Board of Directors, or until his or her death or resignation.

Section 4.2. Additional Officers; Other Agents and Employees. The Board of Directors may from time to time appoint or employ such additional officers, assistant officers, agents, employees and independent contractors as the Board deems advisable; the Board shall prescribe their duties, conditions of employment and compensation; and the Board shall have the right to dismiss them at any time, without prejudice to their contract rights, if any. The Board may employ from time to time such other agents, employees and independent contractors as it may deem advisable for the prompt and orderly transaction of the business of the Corporation, and it may prescribe their duties and the conditions of their employment, fix their

compensation and dismiss them at any time, without prejudice to their contract rights, if any.

Section 4.3. The Chairperson. The Chairperson of the Board shall be elected from among the Directors, shall preside at all meetings of the Board as provided herein, and shall have such other powers and duties as from time to time may be prescribed by the Board.

Section 4.4. The Vice Chairperson. The Vice Chairperson shall be elected from among the Directors, shall undertake the responsibilities of the Chairperson when he or she shall be unable to serve, and shall have such other powers and duties as from time to time may be prescribed by the Board.

Section 4.5. The President. The President shall be the chief executive officer of the Corporation. Subject to the control of the Board of Directors, the President shall have general supervision of and general management and executive powers over all the property, operations, business, affairs and employees of the Corporation, and shall see that the policies and programs adopted or approved by the Board are carried out. The President shall exercise such further powers and duties as from time to time may be prescribed in these Bylaws or by the Board of Directors.

Section 4.6. The Vice Presidents. The Vice Presidents may be given by resolution of the Board general executive powers, subject to the control of the Board, concerning one or more or all segments of the operations of the Corporation. The Vice Presidents shall exercise such further powers and duties as from time to time may be prescribed in these Bylaws or by the Board of Directors.

Section 4.7. The Secretary and Assistant Secretaries. It shall be the duty of the Secretary (a) to keep an original or duplicate record of the proceedings of the Board of Directors, and a copy of the Articles and of the Bylaws; (b) to give such notices as may be required by law or these Bylaws; (c) to be custodian of the corporate records and of the seal of the Corporation and see that the seal is affixed to such documents as may be necessary or advisable; and (d) to exercise all powers and duties incident to the office of Secretary; and such further powers and duties as from time to time may be prescribed in these Bylaws or by the Board of Directors or the President. The Secretary by virtue of his or her office shall be an Assistant Treasurer. Each officer of the Corporation by virtue of his or her office shall be an Assistant Secretary. The Assistant Secretaries shall assist the Secretary in the performance of his or her duties and shall also exercise such further powers and duties as from time to time may be prescribed by the Board of Directors, the President or the Secretary. At the direction of the Secretary or in his or her absence or disability, an Assistant Secretary shall exercise the powers and duties of the Secretary.

Section 4.8. The Treasurer and Assistant Treasurers. It shall be the duty of the Treasurer (a) to keep the Corporation's contracts, insurance policies, leases, deeds and other business records; (b) to see that the Corporation's lists, books, reports, statements, tax returns, certificates and other documents and records required by law are properly prepared, kept and filed; (c) to be the principal officer in charge of tax and financial matters, budgeting and accounting for the Corporation; (d) to have charge and custody of and be responsible for the Corporation's funds, securities and investments; (e) to receive and give receipts for checks, notes, obligations, funds and

securities of the Corporation, and deposit monies and other valuable effects in the name and to the credit of the Corporation, in such depositaries as shall be designated by the Board of Directors; (f) to cause the funds of the Corporation to be disbursed by payment in cash or by checks or drafts upon the authorized depositaries of the Corporation, and to cause to be taken and preserved proper vouchers for such disbursements; (g) to render to the President and the Board of Directors whenever they may require it an account of all his or her transactions as Treasurer, and reports as to the financial position and operations of the Corporation; (h) to keep appropriate, complete and accurate books and records of account of all the Corporation's business and transactions; and (i) to exercise all powers and duties incident to the office of Treasurer; and such further duties from time to time as may be prescribed in these Bylaws or by the Board of Directors or the President. The Assistant Treasurers shall assist the Treasurer in the performance of his or her duties and shall also exercise such further powers and duties as from time to time may be prescribed by the Board of Directors, the President or the Treasurer. At the direction of the Treasurer or in his or her absence or disability, an Assistant Treasurer shall exercise the powers and duties of the Treasurer.

Section 4.9. Vacancies. Any vacancy in any office or position by reason of death, resignation, removal, disqualification, disability or other cause shall be filled in the manner provided in this Article IV for regular election or appointment to such office. Pending such election or appointment, the President may temporarily fill such vacant office him or herself.

Section 4.10. Delegation of Duties. The Board of Directors may in its discretion delegate for the time being the powers and duties, or any of them, of any officer to any other person whom it may select.

ARTICLE V

MISCELLANEOUS CORPORATE TRANSACTIONS AND DOCUMENTS

Section 5.1. Execution of Notes, Checks, Contracts and Other Instruments. All notes, bonds, drafts, acceptances, checks, endorsements (other than for deposit), guarantees and all evidences of indebtedness of the Corporation whatsoever, and all deeds, mortgages, contracts and other instruments requiring execution by the Corporation, may be signed by the President, any Vice President or the Treasurer, and authority to sign any of the foregoing, which may be general or confined to specific instances, may be conferred by the Board of Directors upon any other person or persons. Any person having authority to sign on behalf of the Corporation may delegate, from time to time, by instrument in writing, all or any part of such authority to any other person or persons if authorized to do so by the Board of Directors, which authority may be general or confined to specific instances. Facsimile signatures on checks may be used if authorized by the Board of Directors.

Section 5.2. Voting Securities Owned by Corporation. Securities owned by the Corporation and having voting power in any other corporation shall be voted by the President or any Vice President, unless the Board confers authority to vote with respect thereto, which may be general or confined to specific investments, upon some other person. Any person authorized to vote such securities shall have the power to appoint proxies, with general power of substitution.

HIGHMARK 00519

ARTICLE VI

GENERAL PROVISIONS

Section 6.1. Offices. The principal business office of the Corporation shall be at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222-3099. The Corporation may also have offices at such other places within or without the Commonwealth of Pennsylvania as the business of the Corporation may require.

Section 6.2. Corporate Seal. The Board of Directors shall prescribe the form of a suitable corporate seal, which shall contain the full name of the Corporation and the year and state of incorporation.

Section 6.3. Fiscal Year. The fiscal year of the Corporation shall end on such day as shall be fixed by the Board of Directors.

Section 6.4. Annual Report. To the extent required, the President and Treasurer shall present an annual report to the Board of Directors in accordance with Section 5553 of the Pennsylvania Nonprofit Corporation Law of 1988.

ARTICLE VII

AMENDMENTS

Section 7.1. Amendments. These Bylaws may be amended, altered or repealed, and new bylaws may be adopted, by the members at any meeting by a majority vote of the members provided that all members shall have been given five days' written notice of the general nature of the proposed

Western Pennsylvania Caring Foundation

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Monthly Financial Report
December 2003

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Fast Fact Statistics

December 2003

Financial Results

(Year-to-date)	2003 Actual	2003 Financial Plan	2002 Actual
Contributions	$ 2,943,991	$ 2,400,000	$ 2,436,653
Healthcare Administration Fees	5,407,694	5,599,107	3,680,141
Net Investment Income, Program Fees & Other Income	703,537	630,000	716,439
Expenses & Losses	(9,057,720)	(8,589,207)	(6,681,969)
Change in Net Assets, excluding Net Unrealized Gains on Available-for-Sale Investments	$ (2,498)	$ 39,900	$ 151,264

BlueCHIP Program Enrollment

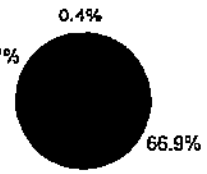
	December 2003	December 2002
Western Region:		
Indemnity		
Low Cost	30	27
Free	252	276
HMO		
Low Cost	3,122	3,195
Free	37,116	33,541
Total Western Region	40,520	37,039
Central Region:		
PPO		
Low Cost	11	-
Free	160	-
HMO		
Low Cost	118	-
Free	2,754	-
Total Central Region	3,043	-
Total BlueCHIP	43,563	37,039

adultBasic Program Enrollment

	December 2003	December 2002
Indemnity	127	123
HMO	21,345	19,673
Total adultBasic	21,472	19,796
adultBasic Waiting List	23,050	-

Investment Portfolio Profile

December 31, 03



■ Cash & Short-Term Investments
■ Fixed Income
■ Balanced Fund

(Year-to-date)

	Actual	Benchmark
Portfolio Return:		
Short-Term Investments	1.1%	1.2%
Available for Sale Investments		
Fixed Income	4.3%	4.1%
Balanced Fund	20.6%	18.8%

HIGHMARK 00523

Caring Foundation

Statements of Financial Position
December 2003 and December 2002

	Current Month				December 2002			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Assets:								
Cash & Short-Term Investments	$ 18,136,517	$ 172,544	$ 850,000	$ 19,159,061	$ 9,238,813	$ 133,130	$ 874,958	$ 10,246,901
Available-for-Sale Investments	8,103,787	-	77,381	8,181,168	8,379,185	-	95,592	8,474,777
Accounts Receivable:								
Due from Commonwealth of PA - CHIP	5,604,625	-	-	5,604,625	12,429,799	-	-	12,429,799
Due from Commonwealth of PA - adultBasic	4,383,654	-	-	4,383,654	7,868,118	-	-	7,868,118
Due from Highmark	242,107	-	-	242,107	40,271	-	-	40,271
Investment Income Receivable	39,413	-	-	39,413	69,273	33	-	69,306
Contributions Receivable	31,984	158,893	-	190,877	4,486	170,109	-	174,595
Furniture, Fixtures & Equipment, net	270,478	-	-	270,478	149,015	-	-	149,015
Prepaid Expenses & Other Assets	25,288	-	-	25,288	21,989	-	-	21,989
Total Assets	$ 36,837,853	$ 331,437	$ 927,381	$ 38,096,671	$ 38,200,949	$ 303,272	$ 970,550	$ 39,474,771
Liabilities & Net Assets:								
Due to Highmark	$ 18,711,654	$ -	$ -	$ 18,711,654	$ 20,019,269	$ -	$ -	$ 20,019,269
Other Payables & Accrued Expenses	464,991	-	-	464,991	321,211	-	-	321,211
Total Liabilities	19,176,645	-	-	19,176,645	20,340,480	-	-	20,340,480
Beginning Net Assets, excluding Net Unrealized Gains	17,345,328	303,272	970,550	18,619,150	17,338,604	158,732	970,550	18,467,886
Change in Net Assets, excluding Net Unrealized Gains	12,506	28,165	(43,169)	(2,498)	6,724	144,540	-	151,264
Net Assets, excluding Net Unrealized Gains	17,357,834	331,437	927,381	18,616,652	17,345,328	303,272	970,550	18,619,150
Net Unrealized Gains on Available-for-Sale Investments	303,374	-	-	303,374	515,141	-	-	515,141
Net Assets	17,661,208	331,437	927,381	18,920,026	17,860,469	303,272	970,550	19,134,291
Total Liabilities & Net Assets	$ 36,837,853	$ 331,437	$ 927,381	$ 38,096,671	$ 38,200,949	$ 303,272	$ 970,550	$ 39,474,771

HIGHMARK 00524

Caring Foundation

Statements of Activities

For the Periods Ended December 31, 2003 and 2002

	Current Year-to-date				Prior Year-to-date			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues, Gains & Other Support:								
Contributions:								
Community	$ 721,807	$ 199,654	$ -	$ 921,461	$ 522,533	$ 295,379	$ -	$ 817,912
Highmark	1,735,566	-	-	1,735,566	1,360,053	-		1,360,053
In-Kind Donations	105,359	-	-	105,359	111,047	-	-	111,047
Fundraising	181,605	-	-	181,605	147,641	-	-	147,641
Total Contributions	2,744,337	199,654	-	2,943,991	2,141,274	295,379	-	2,436,653
Healthcare Administration Fees:								
CHIP Administrative Revenue	2,906,819	-	-	2,906,819	1,954,814	-	-	1,954,814
adultBASIC Administrative Revenue	2,500,875	-	-	2,500,875	1,725,327	-	-	1,725,327
Total Healthcare Administration Fees	5,407,694	-	-	5,407,694	3,680,141	-	-	3,680,141
Net Investment Results	687,165	233	-	687,398	676,771	428	-	677,199
Program Fees	13,786	-	-	13,786	37,364	-	-	37,364
Other Income	2,353	-	-	2,353	1,876	-	-	1,876
Net Assets Released from Restrictions	214,891	(171,722)	(43,169)	-	151,267	(151,267)	-	-
Total Revenues, Gains & Other Support	9,070,226	28,165	(43,169)	9,055,222	6,688,693	144,540	-	6,833,233
Expenses & Losses:								
Healthcare Adminstration Expenses:								
CHIP Administrative Costs	2,906,819	-	-	2,906,819	1,954,814	-	-	1,954,814
adultBASIC Administrative Costs	2,500,875	-	-	2,500,875	1,725,327	-	-	1,725,327
Total Healthcare Administration Expenses	5,407,694	-	-	5,407,694	3,680,141	-	-	3,680,141
Foundation Expenses:								
Special Projects & Initiatives	165,920	-	-	165,920	1,126,979	-	-	1,126,979
Fundraising	64,835	-	-	64,835	63,861	-	-	63,861
CHIP Premium Costs	19,349	-	-	19,349	41,552	-	-	41,552
Total Foundation Expenses	250,104	-	-	250,104	1,232,392	-	-	1,232,392
Caring Place Expenses	2,870,700	-	-	2,870,700	1,291,494	-	-	1,291,494
Division of Community Health Expenses	529,222	-	-	529,222	477,942	-	-	477,942
Total Expenses & Losses	9,057,720	-	-	9,057,720	6,681,969	-	-	6,681,969
Change in Net Assets, excluding Net Unrealized Gains	12,506	28,165	(43,169)	(2,498)	6,724	144,540	-	151,264
Change in Net Unrealized Gains on Available-for-Sale Investments	(211,767)	-	-	(211,767)	258,739	-	-	258,739
Change in Net Assets	(199,261)	28,165	(43,169)	(214,265)	265,463	144,540	-	410,003
Beginning Net Assets	17,860,469	303,272	970,550	19,134,291	17,595,006	158,732	970,550	18,724,288
Net Assets	$ 17,661,208	$ 331,437	$ 927,381	$ 18,920,026	$ 17,860,469	$ 303,272	$ 970,550	$ 19,134,291

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Caring Foundation

Statements of Cash Flows

For the Periods Ended December 31, 2003 and 2002

	2003	2002
Cash Flows From Operating Activities:		
Changes in Net Assets	$ (214,265)	$ 410,003
Adjustments to reconcile change in net assets to net cash provided by (used by) operating activities:		
Depreciation	31,521	24,976
Increase (decrease) due to change in:		
Net Unrealized Gain on Available for Sale Securities	211,767	(258,739)
Realized Loss on Sale of Investments	14,716	-
Impairment of Investments	38,293	-
Accounts Receivable	10,107,802	(20,245,274)
Investment Income Receivable	29,893	16,978
Contributions Receivable	(16,282)	(90,661)
Prepaid Expenses & Other Assets	(3,299)	5,398
Due to Highmark	(1,307,615)	19,890,016
Other Payables & Accrued Expenses	143,780	172,389
Deferred revenue	-	(11,872)
Net Cash Used by Operating Activities	9,036,311	(86,786)
Cash Flows from Investing Activities:		
Purchases of Furniture, Fixtures & Equipment	(152,984)	(3,250)
Sale of Investments	28,833	-
Net Cash used by Investing Activities	(124,151)	(3,250)
Net Decrease in Cash & Short-Term Investments	8,912,160	(90,036)
Beginning Cash & Short-Term Investments	10,246,901	10,336,937
Ending Cash & Short-Term Investments	$ 19,159,061	$ 10,246,901

Western Pennsylvania Caring Foundation

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Western Pennsylvania Caring Foundation

Financial Statements
December 31, 2002 and 2001

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
600 Grant Street
Pittsburgh PA 15219
Telephone (412) 355 6000

Report of Independent Accountants

Board of Directors
Western Pennsylvania Caring Foundation

In our opinion, the accompanying statements of financial position and the related statements of activities and changes in net assets, statements of functional revenues and expenses and of cash flows present fairly, in all material respects, the financial position of the Western Pennsylvania Caring Foundation (the Foundation) at December 31, 2002 and 2001, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Foundation's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

April 4, 2003, except for note 14, as to which the date is April 7, 2003.

WESTERN PENNSYLVANIA CARING FOUNDATION

Statements of Financial Position

December 31, 2002 and 2001

ASSETS	2002	2001
Cash and cash equivalents	$ 8,752,978	$ 8,838,907
Investments:		
Bond fund	8,377,468	8,101,287
Balanced fund	65,762	79,355
Preferred stock – real estate investment trust	2,500	2,500
Accounts receivable:		
Commonwealth of Pennsylvania:		
Cash conduit for Highmark Inc.	19,303,064	-
Healthcare administration	994,853	-
Other	-	56,985
Investment income receivable	67,237	83,196
Contributions receivable	61,564	-
Furniture, fixtures and equipment, net	149,015	170,234
Prepaid expenses	14,135	14,427
Total assets	$ 37,788,576	$ 17,346,891
LIABILITIES AND NET ASSETS		
Due to Affiliate:		
Cash conduit for Highmark Inc. obligation	$ 19,303,064	$ -
Other	701,948	105,389
Accounts payable and accrued expenses	301,665	139,595
Deferred revenue	-	11,872
Total liabilities	20,306,677	256,856
Unrestricted net assets	17,290,815	16,980,655
Temporarily restricted net assets	91,084	9,380
Permanently restricted net assets	100,000	100,000
Total net assets	17,481,899	17,090,035
Total liabilities and net assets	$ 37,788,576	$ 17,346,891

See accompanying notes to financial statements.

WESTERN PENNSYLVANIA CARING FOUNDATION

Statements of Activities and Changes in Net Assets

For the Years Ended December 31, 2002 and 2001

	2002				2001			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenue and other support:								
Healthcare administration	$ 3,680,141	$ -	$ -	$ 3,680,141	$ 2,287,092	$ -	$ -	$ 2,287,092
Highmark Inc. contribution	1,161,375	-	-	1,161,375	861,385	-	-	861,385
Community contributions	733,820	104,574	-	838,494	689,587	10,000	-	699,587
Total contributions	1,895,195	104,574	-	1,999,869	1,550,972	10,000	-	1,560,972
CHIP income - low-cost program	-	-	-	-	907,019	-	-	907,019
Investment income	651,417	-	-	651,417	980,638	-	-	980,638
Other	1,876	-	-	1,876	-	-	-	-
Net assets released from donor restrictions	22,970	(22,970)	-	-	620	(620)	-	-
Total revenue and other support	6,251,599	81,704	-	6,333,303	5,726,341	9,380	-	5,735,721
Expenses:								
Healthcare administration	3,680,141	-	-	3,680,141	2,287,092	-	-	2,287,092
The Caring Places	1,291,494	-	-	1,291,494	1,708,862	-	-	1,708,862
Foundation and general	1,232,392	-	-	1,232,392	2,026,862	-	-	2,026,862
Total expenses	6,204,027	-	-	6,204,027	6,022,816	-	-	6,022,816
Excess of revenue over expenses/ (expenses over revenue)	47,572	81,704	-	129,276	(296,475)	9,380	-	(287,095)
Change in net unrealized gains on investments	262,588	-	-	262,588	21,824	-	-	21,824
Change in net assets	310,160	81,704	-	391,864	(274,651)	9,380	-	(265,271)
Net assets at beginning of year	16,980,655	9,380	100,000	17,090,035	17,255,306	-	100,000	17,355,306
Net assets at end of year	$ 17,290,815	$ 91,084	$ 100,000	$ 17,481,899	$ 16,980,655	$ 9,380	$ 100,000	$ 17,090,035

See accompanying notes to financial statements.

HIGHMARK 00531

WESTERN PENNSYLVANIA CARING FOUNDATION

Statements of Functional Revenues and Expenses

For the Years Ended December 31, 2002 and 2001

	2002				2001			
	Healthcare Administration	The Caring Places	Foundation and General	Total	Healthcare Administration	The Caring Places	Foundation and General	Total
Revenue and other support:								
CHIP administration fees	$ 1,954,814	$ -	$ -	$ 1,954,814	$ 2,287,092	$ -	$ -	$ 2,287,092
adultBasic administration fees	1,725,327	-	-	1,725,327	-	-	-	-
Total Healthcare administration	3,680,141	-	-	3,680,141	2,287,092	-	-	2,287,092
Highmark Inc. contribution	-	166,825	994,550	1,161,375	-	359,733	501,652	861,385
Community contributions	-	228,388	508,948	737,336	-	163,727	433,484	597,211
Community in-kind contributions	-	-	101,158	101,158	-	-	102,376	102,376
Total contributions	-	395,213	1,604,656	1,999,869	-	523,460	1,037,512	1,560,972
Investment income	-	325,709	325,708	651,417	-	490,319	490,319	980,638
Other	-	-	1,876	1,876	-	-	-	-
CHIP income - low-cost program	-	-	-	-	-	-	907,019	907,019
Total revenue and other support	3,680,141	720,922	1,932,240	6,333,303	2,287,092	1,013,779	2,434,850	5,735,721
Expenses:								
Salaries and related expenses	2,087,955	631,518	330,868	3,050,341	1,429,054	778,708	1,192	2,208,954
Printing, promotion and postage	605,082	152,170	56,940	814,192	244,459	243,824	49,156	537,439
Office and other expenses	337,091	112,893	340,928	790,912	181,681	214,256	56,775	452,712
Network support	408,672	30,384	65,574	504,630	267,310	90,612	-	357,922
Consulting/contracted services	119,583	2,569	253,175	375,327	33,770	52,004	2,400	88,174
Facilities and equipment	121,758	249,327	42,197	413,282	130,818	249,967	-	380,785
Program support	-	112,633	-	112,633	-	79,491	-	79,491
In-kind contributions	-	-	101,158	101,158	-	-	102,376	102,376
Healthcare benefits	-	-	41,552	41,552	-	-	1,814,963	1,814,963
Total expenses	3,680,141	1,291,494	1,232,392	6,204,027	2,287,092	1,708,862	2,026,862	6,022,816
Excess of revenue over expenses/ (expenses over revenue)	-	(570,572)	699,848	129,276	-	(695,083)	407,988	(287,095)
Change in net unrealized gains on investments	-	-	262,588	262,588	-	-	21,824	21,824
Change in net assets	$ -	$ (570,572)	$ 962,436	$ 391,864	$ -	$ (695,083)	$ 429,812	$ (265,271)

See accompanying notes to financial statements

HIGHMARK 00532

WESTERN PENNSYLVANIA CARING FOUNDATION

Statements of Cash Flows

For the Years Ended December 31, 2002 and 2001

	2002	2001
Cash flows from operating activities:		
Change in net assets	$ 391,864	$ (265,271)
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Depreciation	24,469	18,964
Increase (decrease) due to changes in:		
Net unrealized gains on investments	(262,588)	(21,824)
Accounts receivable	(20,240,932)	(8,227)
Investment income receivable	15,959	(18,454)
Contributions receivable	(61,564)	-
Prepaid expenses	292	(14,427)
Due to affiliate	19,899,623	(362,104)
Accounts payable and accrued expenses	162,070	122,743
Deferred revenue	(11,872)	(12,550)
Net cash used in operating activities	(82,679)	(561,150)
Cash flows from investing activities:		
Purchases of furniture, fixtures and equipment	(3,250)	(189,198)
Purchases of investments	-	(13,587)
Net cash used in investing activities	(3,250)	(202,785)
Net decrease in cash and cash equivalents	(85,929)	(763,935)
Cash and cash equivalents, January 1	8,838,907	9,602,842
Cash and cash equivalents, December 31	$ 8,752,978	$ 8,838,907

See accompanying notes to financial statements.

HIGHMARK 00533

WESTERN PENNSYLVANIA CARING FOUNDATION

Notes to Financial Statements

1. Organization

The Western Pennsylvania Caring Foundation (d/b/a The Western Pennsylvania Caring Foundation for Children) (the Foundation) is a not-for-profit affiliate of Highmark Inc. (d/b/a Highmark Blue Cross Blue Shield) (Highmark). The Foundation was incorporated on May 24, 1985, under the Nonprofit Corporation Law of the Commonwealth of Pennsylvania (the Commonwealth).

Highmark and the Foundation collaborate to administer the Children's Health Insurance Program (CHIP) and the adultBasic Program (adultBasic) in the 29 counties of Western Pennsylvania, with the Foundation providing the eligibility, enrollment, education, and outreach functions. Highmark, on its own, and through Keystone Health Plan West, Inc. (KHPW), a health maintenance organization and subsidiary of Highmark, provides all related insurance coverage and retains all insurance obligations.

Effective September 2002, a new three-year contract was awarded to Highmark and the Foundation by the Commonwealth to jointly administer CHIP. Under this new contract, the Foundation receives funding from the Commonwealth, retains certain funds in support of its administrative functions, and transfers the remainder to Highmark. Prior to September 2002, Highmark received payment from the Commonwealth and reimbursed the Foundation for its administrative costs. Funding for CHIP is appropriated through the state general fund, cigarette taxes and the state's share of funds allocated from the Federal Balanced Budget Act of 1997, through which CHIP began receiving federal monies from the United States Department of Health and Human Services to expand the provision of health care insurance coverage to children of low income families and related outreach efforts.

In March 2002, a three-year contract was awarded to Highmark and the Foundation by the Commonwealth to jointly administer adultBasic. The Foundation receives funding from the Commonwealth, retains certain funds in support of its administrative functions, and transfers the remainder to Highmark. Beginning July 1, 2002, adultBasic began affording low-cost health care insurance coverage to low income individuals between the ages of 19 and 64. Funding for adultBasic is allocated from the Commonwealth's Health Investment Insurance Act of 2001 Act 77 that directs a portion of the proceeds of the Commonwealth's tobacco settlement money received and yet to be received from the country's major tobacco companies to fund healthcare initiatives.

The Foundation also receives contributions from donors representing various segments of the community, including individuals, businesses, unions, foundations and religious and civic organizations.

1. Organization, continued

The Foundation administers the functions of The Caring Places located in Pittsburgh and Erie, the latter of which started providing services in May 2001. The Caring Places provide programs such as support groups, including specialized support groups, and volunteer recruitment and training.

Additionally, the Foundation plans to establish a Caring Place that will serve the Central Pennsylvania region in Lemoyne, Pennsylvania. The facility is expected to begin providing services in 2003.

The Foundation's New Caring Program supports initiatives involving the health and well being of children and adolescents. In 2002, the Foundation embarked on a childhood obesity initiative in conjunction with the Children's Health Fund. There were no New Caring Program initiatives in 2001.

2. Summary of Significant Accounting Policies

Basis of Financial Presentation

Net assets and revenues, expenses and gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Foundation and changes therein are classified and reported as follows:

Unrestricted net assets -	net assets that are not subject to donor-imposed restrictions.
Temporarily restricted net assets -	net assets subject to donor-imposed or legal restrictions that may or will be met either by actions of the Foundation and/or the passage of time.
Permanently restricted net assets -	net assets subject to donor-imposed stipulations that neither expire by passage of time nor can be fulfilled or otherwise removed by actions of the Foundation.

Revenues are reported as increases in unrestricted net assets unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Realized gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets.

2. Summary of Significant Accounting Policies, continued

Basis of Financial Presentation, continued

Receipt of unconditional promises for future cash contributions are reported as increases to temporarily restricted net assets. Expirations of temporary restrictions on net assets are reported as reclassifications between the applicable classes of net assets.

Contributions with donor-imposed restrictions that are received and entirely satisfied in the same reporting period are reported as unrestricted support. Funds not used within the same reporting period are recorded as restricted and reclassified to unrestricted as used, to reflect the satisfaction or expiration of the donor-imposed restrictions.

Investment income is reported as changes in permanently restricted net assets if so restricted by the donor; as changes in temporarily restricted net assets if the terms of the gift or relevant state law impose restrictions on the use of the income or gains or losses; and as changes in unrestricted net assets in all other cases.

Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities and changes therein, and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Reclassifications

Certain 2001 amounts have been reclassified to conform to the 2002 financial statement presentation.

2. Summary of Significant Accounting Policies, continued

Cash and Cash Equivalents

Cash and cash equivalents consist of checking account balances and shares in money market funds. The Foundation considers all financial instruments purchased with maturities of three months or less to be cash equivalents for purposes of the statements of cash flows. The carrying amount approximates fair value for these financial instruments. A substantial portion of cash and cash equivalents is held with one financial institution.

Investments

Bond funds, balanced funds and preferred stock are classified as available-for-sale investments and carried at fair value (based on quoted or estimated market prices).

Fair values presented in the financial statements are subject to various market fluctuations, which include changes in the interest rate environment, equity markets and general economic conditions.

Accounts receivable

The Foundation carries its accounts receivable at the estimated net realizable value.

Contributions receivable

Contributions receivable represent unconditional promises of cash and are measured at the present value of future cash flows.

Furniture, Fixtures and Equipment, net

Furniture, fixtures and equipment are carried at cost less accumulated depreciation. Maintenance, repairs and minor improvements are expensed as incurred. Depreciation is computed under the straight line method. The estimated useful lives of the various classes of furniture, fixtures and equipment are as follows: furniture and fixtures, 10 years; EDP equipment, 3 years; and office equipment, 5 years.

2. Summary of Significant Accounting Policies, continued

Cash Conduit for Highmark and Cash Conduit for Highmark Obligation

Cash conduit for Highmark represents amounts invoiced to the Commonwealth for CHIP and adultBasic on behalf of Highmark. Such amounts are not recorded as revenue by the Foundation and are due to Highmark upon receipt from the Commonwealth.

Income Taxes

The Foundation has been determined to be an organization which is exempt from federal income taxes under section 501(c)(3) of the Internal Revenue code of 1986 (the Code) and has further been determined to be an organization which is not a private foundation in accordance with sections 509(a)(1) and 170(b)(1)(A)(vi) of the Code.

3. Investments

The cost and fair values of investments classified as available-for-sale as of December 31, 2002 and 2001 are as follows:

	2002			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Bond fund	$ 7,800,000	$ 577,468	$ -	$ 8,377,468
Balanced fund	113,587	-	(47,825)	65,762
Preferred stock	2,500	-	-	2,500
Total Investments	$ 7,916,087	$ 577,468	$ (47,825)	$ 8,445,730

	2001			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Bond fund	$ 7,800,000	$ 301,287	$ -	$ 8,101,287
Balanced fund	113,587	-	(34,232)	79,355
Preferred stock	2,500	-	-	2,500
Total Investments	$ 7,916,087	$ 301,287	$ (34,232)	$ 8,183,142

As of December 31, 2002 and 2001, approximately 99% of the Foundation's investments were held in a single bond fund. There were no realized gains or losses on sales of investments in 2002 or 2001.

4. Contributions Receivable

Contributions receivable as of December 31, 2002 consists of the following:

	Due in:			
Donor	less than one year	one to five years	more than five years	Total
The Pittsburgh Foundation	$ 22,900	$ -	$ -	$ 22,900
Mellon Financial Corporation	5,000	18,150	15,514	38,664
	$ 27,900	$ 18,150	$ 15,514	$ 61,564

5. Furniture, Fixtures and Equipment, net

Furniture, fixtures and equipment, net as of December 31, 2002 and 2001 is comprised of the following:

	2002	2001
Furniture and fixtures	$ 169,382	$ 168,057
EDP equipment	11,405	11,405
Office equipment	11,661	9,736
	192,448	189,198
Less accumulated depreciation	(43,433)	(18,964)
Furniture, fixtures and equipment, net	$ 149,015	$ 170,234

Depreciation expense for 2002 and 2001 related to furniture, fixtures and equipment amounts to $24,469 and $18,964, respectively.

6. CHIP and adultBasic Administration Fees

As discussed in note 1, amounts received from the Commonwealth for CHIP are comprised of both federal and state funds. The federal reimbursement rate was 67.53% from January 2001 through September 2001, 68.26% from October 2001 through September 2002 and 68.28% from October 2002 through December 2002. The Foundation received CHIP revenue in the amount of $1,954,814 and $2,287,092 for 2002 and 2001, respectively. The federal and state portions of this award amounted to $1,334,476 and $620,338, respectively, in 2002, and $1,549,121 and $737,971, respectively, in 2001.

The Foundation received adultBasic revenue in the amount of $1,725,327 for 2002, solely comprised of state funding.

7. Leases

An operating lease for the building that houses the Caring Place in Erie is in effect as of December 31, 2002 for periods through 2007 and thereafter. Aggregate future rental commitments amount to $1,373,633, with commitments in each of the next five years and thereafter as shown in the following table:

	Operating Lease Commitments
2003	$ 168,200
2004	168,200
2005	168,200
2006	168,200
2007	168,200
Thereafter	532,633
Total	$ 1,373,633

Total rental expense is $168,200 and $130,758 in 2002 and 2001, respectively.

8. Contingencies

The Foundation receives financial assistance from governmental agencies in the form of contracts and grants. The disbursement of funds received under such programs generally requires compliance with terms and conditions specified in the contract/grant agreements and is subject to audit by the grantor agencies. Any disallowed costs resulting from such audits could become a liability of the Foundation.

9. Temporarily Restricted Assets

Temporarily restricted net assets are available as of December 31, 2002 and 2001 for the following:

	Donor	2002	2001
"Journey of Grief" initiative	The Pittsburgh Foundation	$ 45,800	$ -
The Caring Place in Central Pennsylvania	Mellon Financial Corporation	43,664	-
CHIP premium subsidization – McKean County	Philo and Sarah Blaisdell Foundation	1,620	-
CHIP premium subsidization – Elk County	Stackpole-Hall Foundation	-	9,380
		$ 91,084	$ 9,380

10. Permanently Restricted Assets

Permanently restricted net assets amounted to $100,000 as of December 31, 2002 and 2001. This amount represents an award to the Foundation from the Jewish Healthcare Foundation received in 1999 to establish an operating endowment fund for The Caring Place in Pittsburgh.

11. Net Assets Released from Donor Restrictions

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes or by the occurrence of other events specified by donors. Assets were released from donor restrictions for the years ended December 31, 2002 and 2001 as follows:

	2002	2001
CHIP premium subsidization – McKean County	$ 13,590	$ -
CHIP premium subsidization – Elk County	9,380	620
	$ 22,970	$ 620

HIGHMARK 00541

12. Transactions with an Affiliated Company

Highmark performs certain administrative and other services for the benefit of the Foundation and its programs. For the years ended December 31, 2002 and 2001, the Foundation recognized $541,375 and $359,733, respectively, in contributed services support from Highmark. These contributed services consist of salaries and benefits, facilities maintenance, and other office and administrative expenses incurred by Highmark in performing program and supporting services. Highmark's cost is the basis for the estimated fair value of these contributed services.

In addition, amounts due to Highmark are $20,005,012 and $105,389 as of December 31, 2002 and 2001, respectively.

13. Employee Benefit Plans

Certain employees of the Foundation are covered by a defined benefit pension plan sponsored by Highmark. The benefits are based upon years of service and the employee's final compensation. Accordingly, the Foundation has paid $134,396 and $69,172 for 2002 and 2001, respectively, to Highmark for its portion of the pension expense.

In addition, eligible employees of the Foundation are covered by a Highmark sponsored post-retirement health benefit plan. The Foundation's portion of post-retirement benefits expense allocated by Highmark was $40,189 and $25,669 in 2002 and 2001, respectively.

The Foundation's employees are also covered by a contribution savings plan sponsored by Highmark. The savings plan allows participating employees to contribute a percentage of their annual salary subject to current Internal Revenue Service limitations. Employee contributions are matched by the Foundation at various percentages. The Foundation's contributions to this plan totaled $34,676 and $25,014 for 2002 and 2001, respectively.

14. Subsequent Event

On April 7, 2003 and April 3, 2003, the Board of Directors of the Foundation and the Board of Directors of the Health Education Center, Inc. (HEC), respectively, authorized and approved the merger of HEC with and into the Foundation with the Foundation being the surviving corporation. Execution of the merger is in progress.

14. Subsequent Event, continued

All assets, liabilities and related unrestricted, temporarily restricted, and permanently restricted net assets will be merged in to the Foundation. Management believes the merger will not affect the statements of financial position as of December 31, 2002 or the statements of activities and changes in net assets for the year ended December 31, 2002.

The financial position of HEC as of December 31, 2002, the date of the most recent audited financial statements, is as follows:

Total assets	$ 1,686,195
Total liabilities	$ 33,803
Net assets:	
Unrestricted	569,654
Temporarily restricted	212,188
Permanently restricted	870,550
Total net assets	1,652,392
Total liabilities and net assets	$ 1,686,195

Health Education Center, Inc

-

Report of

Financial Condition

July 2003

HEALTH EDUCATION CENTER, INC.

Monthly Financial Report

July 2003

Attachments

cc: Aaron Walton
Nan Kline
Melissa Anderson
Janine Colinear
Susan Luden
Eric Hoffman
Mazrid Harper
Christina Wilds
Sue Bertenthal
Tom Disante
Beth Kairush

HEALTH EDUCATION CENTER, INC.
Financial Statements Summary
For the Period Ended July 31, 2003

Statement of Activities & Changes in Net Assets

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenue and other support	$ 184,408	$ 12,672	$ -	$ 197,080
Expenses and losses	191,368	-	-	191,368
(Deficiency) excess of revenue over expenses	(6,960)	12,672	-	5,712
Unrealized gain on investments	1,325	-	-	1,325
Change in net assets	(5,635)	12,672	-	7,037
Net assets @ beginning of year	569,654	212,188	870,550	1,652,392
Net assets @ end of period	$ 564,019	$ 224,860	$ 870,550	$ 1,659,429

Statement of Functional Revenue & Expenditures

	Social Services	Primary Prevention	Lifestyle Improvement	Management & General	Development & Fundraising	Total
Revenue and other support	$ 5,706	$ 11,749	$ 74,873	$ 91,414	$ 13,338	$ 197,080
Expenses and losses	39,065	4,482	42,123	87,833	17,865	191,368
(Deficiency) excess of revenue over expenses	(33,359)	7,267	32,750	3,581	(4,527)	5,712
Unrealized gain on investments	-	-	-	1,325	-	1,325
Change in net assets	$ (33,359)	$ 7,267	$ 32,750	$ 4,906	$ (4,527)	$ 7,037

PUBLIC CHARITY STATUS

Public Support Percentage*	37.80%
Program Service Revenue Percentage*	8.01%

* 2000 through July 2003

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HEALTH EDUCATION CENTER, INC.

Statements of Financial Position

July 31, 2003 and December 31, 2002

	July 2003	December 2002
Assets		
Cash and cash equivalents	$ 1,551,910	$ 1,493,923
Investments	30,372	29,047
Accounts receivable:		
Affiliates	33,176	40,271
Other	7,564	2,069
Contributions receivable	35,524	113,031
Investment income receivable	1,131	2,069
Other assets	15,608	5,785
Total assets	$ 1,675,285	$ 1,686,195
Liabilities and Net Assets		
Accounts payable:		
Affiliates	$ 6,767	$ 14,257
Other	434	1,718
Accrued expenses	8,655	17,828
Total liabilities	15,856	33,803
Net assets:		
Unrestricted net assets	564,019	569,654
Temporarily restricted net assets	224,860	212,188
Permanently restricted net assets	870,550	870,550
Total net assets	1,659,429	1,652,392
Total liabilities and net assets	$ 1,675,285	$ 1,686,195

HEALTH EDUCATION CENTER, INC.

Statements of Activities and Changes in Net Assets

For the periods ended July 31, 2003 and 2002

	2003				2002			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenue and other support:								
Public contributions	$ -	$ 62,220	$ -	$ 62,220	$ 3,809	$ 1,129	$ -	$ 4,938
Foundations and trusts	-	-	-	-	-	75,000	-	75,000
Highmark Inc.	112,988	-	-	112,988	129,641	-	-	129,641
United Way of Allegheny County	-	-	-	-	7,341	117,587	-	124,928
United Way of Centre County	-	-	-	-	-	1,567	-	1,567
Total contributions	112,988	62,220	-	175,208	140,791	195,283	-	336,074
Program fees	11,708	-	-	11,708	22,268	-	-	22,268
Net investment income	9,983	181	-	10,164	14,871	564	-	15,435
Net assets released from donor restrictions	49,729	(49,729)	-	-	46,763	(46,763)	-	-
Total revenue and other support	184,408	12,672	-	197,080	224,693	149,084	-	373,777
Expenses:								
Social services	39,065	-	-	39,065	75,644	-	-	75,644
Primary prevention	4,482	-	-	4,482	23,674	-	-	23,674
Lifestyle improvement	42,123	-	-	42,123	36,958	-	-	36,958
Management & general	87,833	-	-	87,833	99,355	-	-	99,355
Development & fundraising	17,865	-	-	17,865	29,225	-	-	29,225
Total expenses	191,368	-	-	191,368	264,856	-	-	264,856
(Deficiency) excess of revenue over expenses	(6,960)	12,672	-	5,712	(40,163)	149,084	-	108,921
Unrealized gain (loss) on investments	1,325	-	-	1,325	(2,136)	-	-	(2,136)
Change in net assets	(5,635)	12,672	-	7,037	(42,299)	149,084	-	106,785
Net assets at beginning of year	569,654	212,188	870,550	1,652,392	614,351	149,352	870,550	1,634,253
Net assets at end of period	$ 564,019	$ 224,860	$ 870,550	$ 1,659,429	$ 572,052	$ 298,436	$ 870,550	$ 1,741,038

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HEALTH EDUCATION CENTER, INC.

Statement of Functional Revenues and Expenses

For the period ended July 31, 2003

	Social Services	Primary Prevention	Lifestyle Improvement	Total Programs	Management & General	Development & Fund-Raising	Total
Revenue and other support:							
Public contributions	$ -	$ -	$ 62,220	$ 62,220	$ -	$ -	$ 62,220
Highmark Inc.	4,340	10,294	945	15,579	84,351	13,058	112,988
Total contributions	4,340	10,294	63,165	77,799	84,351	13,058	175,208
Program fees	-	-	11,708	11,708	-	-	11,708
Net investment income	1,366	1,455	-	2,821	7,063	280	10,164
Total revenue and other support	5,706	11,749	74,873	92,328	91,414	13,338	197,080
Expenses:							
Salaries and related employee expenses	11,858	-	8,293	20,151	14,024	-	34,175
Contract services	15,094	3,987	18,589	37,670	44,565	17,585	99,820
Equipment, software and processing	-	-	-	-	3,087	-	3,087
Facilities	12	-	4,945	4,957	15,924	-	20,881
Postage and express	136	-	105	241	419	-	660
Stationery, supplies and program materials	6,304	471	5,843	12,618	6,915	-	19,533
External training and business travel	484	24	-	508	593	280	1,381
Meetings and community programs	3,032	-	2,348	5,380	764	-	6,144
Promotion and community incentives	2,145	-	2,000	4,145	-	-	4,145
Other office expense	-	-	-	-	1,542	-	1,542
Total expenses	39,065	4,432	42,123	85,670	87,833	17,865	191,368
(Deficiency) excess of revenue over expenses	(33,359)	7,267	32,750	6,658	3,581	(4,527)	5,712
Unrealized gain on investments	-	-	-	-	1,325	-	1,325
Change in net assets	$ (33,359)	$ 7,267	$ 32,750	$ 6,658	$ 4,906	$ (4,527)	$ 7,037

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HEALTH EDUCATION CENTER, INC.

Statement of Functional Revenues and Expenses

For the period ended July 31, 2002

	Social Services	Primary Prevention	Lifestyle Improvement	Total Programs	Management & General	Development & Fund-Raising	Total
Revenue and other support:							
Public contributions	$ 2,960	$ -	$ 1,658	$ 4,618	$ -	$ 320	$ 4,938
Foundations & trusts	-	-	75,000	75,000	-	-	75,000
Highmark Inc.	19,223	1,226	3,763	24,212	87,158	18,271	129,641
United Way of Allegheny County	67,166	57,950	(188)	124,928	-	-	124,928
United Way of Centre County	1,567	-	-	1,567	-	-	1,567
Government grants	-	-	-	-	-	-	-
Total contributions	90,916	59,176	80,233	230,325	87,158	18,591	336,074
Program fees	-	-	22,268	22,268	-	-	22,268
Net investment income	2,403	4,548	687	7,638	7,797	-	15,435
Total revenue and other support	93,319	63,724	103,188	260,231	94,955	18,591	373,777
Expenses:							
Salaries and related expenses	23,759	(1)	16,946	40,704	384	961	42,049
Contract services	42,548	6,243	7,556	56,347	74,753	22,235	153,335
Equipment, software and processing	-	-	-	-	6,213	-	6,213
Facilities	251	-	4,820	5,071	14,789	4	19,864
Postage and express	668	3	480	1,151	393	17	1,561
Stationery, supplies and program materials	5,379	16,851	5,894	28,124	706	1,582	30,412
External training and business travel	228	78	1,130	1,436	-	2,039	3,475
Meetings and community programs	2,751	-	132	2,883	637	819	4,339
Promotion and community incentives	60	500	-	560	-	1,202	1,762
Other office expense	-	-	-	-	1,480	366	1,846
Total expenses	75,644	23,674	36,958	136,276	99,355	29,225	264,856
Excess (deficiency) of revenue over expenses	17,675	40,050	66,230	123,955	(4,400)	(10,634)	108,921
Unrealized loss on investments	-	-	-	-	(2,136)	-	(2,136)
Change in net assets	$ 17,675	$ 40,050	$ 66,230	$ 123,955	$ (6,536)	$ (10,634)	$ 106,785

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HEALTH EDUCATION CENTER, INC.

Statements of Cash Flows

For the periods ended July 31, 2003 and 2002

	2003	2002
Cash flows from operating activities:		
Change in net assets	$ 7,037	$ 106,785
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	-	507
Unrealized (gain) loss on investments	(1,325)	2,136
Increase (decrease) due to change in:		
Accounts receivable	1,600	10,742
Contributions receivable	77,507	(109,719)
Investment income receivable	938	632
Prepaid and deferred expenses	-	250
Other assets	(9,823)	2,662
Accounts payable and accrued expenses	(17,947)	(282)
Net cash provided by operating activities	57,987	13,713
Net increase in cash and cash equivalents	57,987	13,713
Cash and cash equivalents at beginning of year	1,493,923	1,498,030
Cash and cash equivalents at end of period	$ 1,551,910	$ 1,511,743

Health Education Center, Inc

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Annual Report of

Financial Condition

2002

Health Education Center, Inc.

Financial Statements
December 31, 2002 and 2001

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
600 Grant Street
Pittsburgh PA 15219
Telephone (412) 355 6000

Report of Independent Accountants

Board of Directors
Health Education Center, Inc.

In our opinion, the accompanying statements of financial position and the related statements of activities and changes in net assets, statements of functional revenues and expenses and of cash flows present fairly, in all material respects, the financial position of the Health Education Center, Inc. (the Center) at December 31, 2002 and 2001, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Center's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As explained in Note 10, the Board of Directors authorized and approved the merger of the Center with and into the Western Pennsylvania Caring Foundation (the Foundation) with the Foundation being the surviving corporation.

PricewaterhouseCoopers LLP

April 4, 2003, except for Note 10, as to which the date is April 7, 2003.

HEALTH EDUCATION CENTER, INC.

Statements of Financial Position

December 31, 2002 and 2001

	2002	2001
Assets		
Cash and cash equivalents	$ 623,373	$ 627,480
Permanently restricted assets whose use is limited	870,550	870,550
Investments	29,047	32,896
Accounts receivable:		
Affiliates	40,271	35,929
Other	2,069	4,119
Contributions receivable	113,031	83,934
Investment income receivable	2,069	3,088
Prepaid and deferred expenses	-	250
Equipment, net of accumulated depreciation of $27,682 and $27,175 at December 31, 2002 and 2001, respectively	-	507
Other assets	5,785	8,591
Total assets	$ 1,686,195	$ 1,667,344
Liabilities and Net Assets		
Accounts payable:		
Affiliates	$ 14,257	$ 23,864
Other	1,718	1,657
Accrued expenses	17,828	7,570
Total liabilities	33,803	33,091
Net assets:		
Unrestricted net assets	569,654	614,351
Temporarily restricted net assets	212,188	149,352
Permanently restricted net assets	870,550	870,550
Total net assets	1,652,392	1,634,253
Total liabilities and net assets	$ 1,686,195	$ 1,667,344

See accompanying notes to financial statements.

HIGHMARK 00555

Statements of Activities and Changes in Net Assets

For the Years Ended December 31, 2002 and 2001

	2002				2001			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenue and other support:								
Public contributions	$ 40,060	$ 5,590	$ -	$ 45,650	$ 7,650	$ 40,861	$ -	$ 48,511
Foundations and trusts	-	75,000	-	75,000	-	-	-	-
Highmark Inc.	198,678	-	-	198,678	255,420	-	-	255,420
United Way of Allegheny County	7,341	108,537	-	115,878	7,074	76,836	-	83,910
United Way of Centre County	-	1,578	-	1,578	-	5,434	-	5,434
Government grants	-	-	-	-	-	2,000	-	2,000
Total contributions	246,079	190,705	-	436,784	270,144	125,131	-	395,275
Program fees	37,364	-	-	37,364	34,989	-	-	34,989
Investment income	25,354	428	-	25,782	63,330	1,746	-	65,076
Net assets released from donor restrictions	128,297	(128,297)	-	-	135,615	(135,615)	-	-
Total revenue and other support	437,094	62,836	-	499,930	504,078	(8,738)	-	495,340
Expenses:								
Social services	137,903	-	-	137,903	182,318	-	-	182,318
Primary prevention	33,413	-	-	33,413	110,137	-	-	110,137
Lifestyle improvement	110,104	-	-	110,104	66,780	-	-	66,780
Management and general	157,610	-	-	157,610	145,890	-	-	145,890
Development and fundraising	38,912	-	-	38,912	102,952	-	-	102,952
Total expenses	477,942	-	-	477,942	608,077	-	-	608,077
Excess of (expenses over revenue)/ revenue over expenses	(40,848)	62,836	-	21,988	(103,999)	(8,738)	-	(112,737)
Change in unrealized loss on investments	(3,849)	-	-	(3,849)	(3,077)	-	-	(3,077)
Change in net assets	(44,697)	62,836		18,139	(107,076)	(8,738)	-	(115,814)
Net assets at beginning of year	614,351	149,352	870,550	1,634,253	721,427	158,090	870,550	1,750,067
Net assets at end of year	$ 569,654	$ 212,188	$ 870,550	$ 1,652,392	$ 614,351	$ 149,352	$ 870,550	$ 1,634,253

See accompanying notes to financial statements.

HIGHMARK 00556

Statement of Functional Revenues and Expenses

For the Year Ended December 31, 2002

	Social Services	Primary Prevention	Lifestyle Improvement	Total Programs	Management and General	Development and Fund-Raising	Total
Revenue and other support:							
Public contributions	$ 860	$ 500	$ 43,970	$ 45,330	$ -	$ 320	$ 45,650
Foundations and trusts	-	-	75,000	75,000	-	-	75,000
Highmark Inc.	33,649	840	4,724	39,213	135,122	24,343	198,678
United Way of Allegheny County	67,166	48,900	(188)	115,878	-	-	115,878
United Way of Centre County	1,578	-	-	1,578	-	-	1,578
Total contributions	103,253	50,240	123,506	276,999	135,122	24,663	436,784
Program fees	-	-	37,364	37,364	-	-	37,364
Investment income	8,612	6,301	1,461	16,374	9,319	89	25,782
Total revenue and other support	111,865	56,541	162,331	330,737	144,441	24,752	499,930
Expenses:							
Salaries and related expenses	40,641	122	29,969	70,732	1,674	1,186	73,592
Contract services	76,471	11,352	15,991	103,814	115,469	31,604	250,887
Equipment, software and processing	-	-	-	-	9,610	-	9,610
Facilities	501	1,238	9,279	11,018	23,289	7	34,314
Postage, office supplies and program materials	7,919	18,882	18,049	44,850	1,674	1,601	48,125
External training and business travel	415	290	1,743	2,448	490	2,129	5,067
Meetings and community programs	4,791	-	26,198	30,989	2,537	819	34,345
Promotion and community incentives	7,165	1,529	8,875	17,569	-	1,202	18,771
Other office expense	-	-	-	-	2,867	364	3,231
Total expenses	137,903	33,413	110,104	281,420	157,610	38,912	477,942
Excess of (expenses over revenue)/ revenue over expenses	(26,038)	23,128	52,227	49,317	(13,169)	(14,160)	21,988
Change in unrealized loss on investments	-	-	-	-	(3,849)	-	(3,849)
Change in net assets	$ (26,038)	$ 23,128	$ 52,227	$ 49,317	$ (17,018)	$ (14,160)	$ 18,139

See accompanying notes to financial statements.

HIGHMARK 00557

Statement of Functional Revenues and Expenses

For the Year Ended December 31, 2001

	Social Services	Primary Prevention	Lifestyle Improvement	Total Programs	Management and General	Development and Fund-Raising	Total
Revenue and other support:							
Public contributions	$ 5,260	$ 4,095	$ 36,766	$ 46,121	$ -	$ 2,390	$ 48,511
Foundations and trusts	-	-	-	-	-	-	-
Highmark Inc.	56,216	33,720	12,166	102,102	103,350	49,968	255,420
United Way of Allegheny County	69,516	12,394	2,000	83,910	-	-	83,910
United Way of Centre County	5,434	-	-	5,434	-	-	5,434
Government grants	-	2,000	-	2,000	-	-	2,000
Total contributions	136,426	52,209	50,932	239,567	103,350	52,358	395,275
Program fees	-	-	34,989	34,989	-	-	34,989
Investment income	4,672	32,845	4,017	41,534	23,542	-	65,076
Total revenue and other support	141,098	85,054	89,938	316,090	126,892	52,358	495,340
Expenses:							
Salaries and related expenses	37,854	4,205	24,304	66,363	311	1,162	67,836
Contract services	90,142	94,357	19,988	204,487	128,041	48,206	380,734
Equipment, software and processing	6,414	566	3,324	10,304	4,409	144	14,857
Facilities	21,433	1,950	8,969	32,352	394	507	33,253
Postage and express	1,081	392	519	1,992	22	78	2,092
Stationery, suppplies and program materials	10,307	7,715	2,544	20,566	5,152	4,514	30,232
External training and business travel	3,649	868	173	4,690	880	4,475	10,045
Meetings and community programs	2,389	30	6,959	9,378	1,389	12,930	23,697
Promotion and community incentives	9,000	-	-	9,000	385	30,522	39,907
Other office expense	49	54	-	103	4,907	414	5,424
Total expenses	182,318	110,137	66,780	359,235	145,890	102,952	608,077
Excess of (expenses over revenue)/ revenue over expenses	(41,220)	(25,083)	23,158	(43,145)	(18,998)	(50,594)	(112,737)
Change in unrealized loss on investments	-	-	-	-	(3,077)	-	(3,077)
Change in net assets	$ (41,220)	$ (25,083)	$ 23,158	$ (43,145)	$ (22,075)	$ (50,594)	$ (115,814)

See accompanying notes to financial statements.

HIGHMARK 00558

HEALTH EDUCATION CENTER, INC.

Statements of Cash Flows

For the Years Ended December 31, 2002 and 2001

	2002	2001
Cash flows from operating activities:		
Change in net assets	$ 18,139	$ (115,814)
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Depreciation	507	3,938
Increase (decrease) due to change in:		
Unrealized loss on investments	3,849	3,077
Accounts receivable	(2,292)	(19,741)
Contributions receivable	(29,097)	(43,149)
Investment income receivable	1,019	5,468
Prepaid and deferred expenses	250	7,000
Other assets	2,806	2,352
Accounts payable and accrued expenses	712	(30,402)
Net cash used in operating activities	(4,107)	(187,271)
Net decrease in cash and cash equivalents	(4,107)	(187,271)
Cash and cash equivalents at beginning of year	627,480	814,751
Cash and cash equivalents at end of year	$ 623,373	$ 627,480

See accompanying notes to financial statements.

HIGHMARK 00559

HEALTH EDUCATION CENTER, INC.

Notes to Financial Statements

1. Organization:

Health Education Center, Inc. (the Center) is incorporated in the Commonwealth of Pennsylvania as a not-for-profit organization with Highmark Inc. (Highmark) being the sole member of the organization. The Center offers health education programs to the public in Allegheny and surrounding counties.

2. Significant Accounting Policies:

Basis of Presentation:

Net assets and revenues, expenses and gains and losses are classified based on existence or absence of donor-imposed restrictions. Accordingly, net assets of the Center and changes therein are classified and reported as follows:

Unrestricted net assets - net assets that are not subject to donor-imposed restrictions.

Temporarily restricted net assets - net assets subject to donor-imposed or legal restrictions that may or will be met either by actions of the Center and/or the passage of time.

Permanently restricted net assets - net assets subject to donor-imposed restrictions that require the assets be maintained in perpetuity by the Center. Generally, the donors of these assets permit the Center to use all or part of the income earned on the related investments for general or specific purposes.

Revenues are reported as increases in unrestricted net assets unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Realized gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets unless their use is restricted by explicit donor restriction or by law. Expirations of temporary restrictions on net assets are reported as reclassifications between the applicable classes of net assets.

Contributions with donor-imposed restrictions that are received and satisfied in the same year are initially reported as an increase to temporarily restricted contributions at the time of receipt and as net assets released from donor restrictions upon satisfaction or expiration of the donor-imposed restriction.

Investment income is reported as changes in permanently restricted net assets if so restricted by the donor; as changes in temporarily restricted net assets if the terms of the gift or relevant state law impose restrictions on the use of the income or gains or losses; and as changes in unrestricted net assets in all other cases.

Basis of Accounting:

The financial statements have been prepared on the accrual basis of accounting.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities and changes therein, and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Cash and Cash Equivalents:

Cash and cash equivalents consist of checking account balances, money market and short-term bond mutual funds. All highly liquid instruments purchased for the investment portfolio with original maturities of three months or less are considered cash equivalents. Money market funds are carried at cost, which approximates fair value. Short-term bond mutual funds are carried at quoted market values. A substantial portion of cash and cash equivalents is held with one financial institution.

Assets Whose Use is Limited:

Assets whose use is limited consist of permanently restricted donor-imposed endowments.

Investments:

Investments include marketable equity securities, which are carried at fair value (based on quoted market values).

Contributions Receivable:

Contributions receivable represent unconditional promises to give made by donors, government agencies and the United Way. All contribution receivable amounts are expected to be received in less than one year and are recorded at net realizable value, which approximates the present value of estimated cash flows. Contributions receivable at December 31, 2002 and December 31, 2001 are $113,031 and $83,934, respectively.

Equipment, net:

Expenditures from unrestricted funds for equipment are capitalized. Depreciation is calculated on a straight-line basis over the estimated useful lives of three to five years for equipment. Maintenance, repairs and minor improvements are expensed as incurred.

Income Taxes:

The Center is exempt from federal income taxes under section 501(c)(3) of the Internal Revenue Code of 1986 (the Code) and has further been determined to be an organization that is not a private foundation in accordance with sections 509(a)(1) and 170(b)(1)(A)(vi) of the Code.

Reclassifications:

Certain 2001 amounts have been reclassified to conform to the 2002 financial statement presentation.

3. Investments:

The cost and quoted fair value of investments classified as available-for-sale at December 31, 2002 and 2001 are as follows:

	2002		
	Cost	Gross Unrealized Losses	Fair Value
Common Stock	$ 43,550	$ (14,503)	$ 29,047

	2001		
	Cost	Gross Unrealized Losses	Fair Value
Common Stock	$ 43,550	$ (10,654)	$ 32,896

4. Temporarily Restricted Net Assets:

Temporarily restricted net assets are restricted by donors at December 31, 2002 and 2001 for the following purposes:

	2002	2001
Lifestyle Improvement:		
HEC Scholarships	$ 93,551	$ 69,411
Social Services:		
Health education for families	22,787	16,275
Health education for literacy	44,789	36,942
Health education for men	2,689	-
Education for injury prevention	41,266	14,046
Primary Prevention:		
Porter Event	7,106	6,678
Disease prevention programs	-	6,000
	$ 212,188	$ 149,352

5. Permanently Restricted Net Assets:

Permanently restricted net assets are restricted by donors at December 31, 2002 and 2001:

	2002	2001
Revolving Fund Activity Restricted funds whose principal use is restricted to providing short-term financial support for new initiatives and existing programs in the form of a loan	$ 850,000	$ 850,000
Porter Event Investment in perpetuity, the income from which is expendable to support a health education event	20,550	20,550
	$ 870,550	$ 870,550

6. Net Assets Released from Donor Restrictions:

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes. Assets were released from donor restrictions for the years ended December 31, 2002 and 2001 as follows:

	2002	2001
Lifestyle Improvement expenses	56,450	6,763
Primary Prevention expenses	21,680	35,709
Social Services expenses	50,167	93,143
	$ 128,297	$ 135,615

7. Employee Benefit Plans:

Certain employees of the Center are covered by a defined benefit pension plan sponsored by Highmark. The benefits are based upon years of service and the employee's final compensation. Accordingly, the Center paid $4,284 and $2,572 during 2002 and 2001, respectively, to Highmark for its portion of the pension expense.

In addition, eligible employees of the Center are covered by a Highmark sponsored postretirement health benefit plan. The Center's portion of postretirement health benefits expense allocated by Highmark was $1,318 and $1,737 in 2002 and 2001, respectively.

The Center's employees are also covered by a contribution savings plan sponsored by Highmark. The savings plan allows participating employees to contribute a percentage of their annual salary subject to current Internal Revenue Service limitations. Employee contributions are matched by the Center at various percentages. The Center's contribution to this plan totaled $276 and $297 during 2002 and 2001, respectively.

8. Transactions with Affiliated Companies:

Highmark has assumed responsibility for the performance of certain administrative and program and other services for the benefit of the Center. The cost of such services amounted to $209,820 and $276,743 as of December 31, 2002 and 2001, respectively.

The Center received cash support of $198,678 and $255,420 as of December 31, 2002 and 2001, respectively, from Highmark to assist with administrative and development expenses, and to provide additional funding for various programs that the Center offers. Certain specialized skills provided by individuals possessing those skills have been donated by Highmark; if not

contributed, these services would typically need to be purchased. Contributed services at December 31, 2002 and 2001 amounted to $56,261 and $68,578, respectively.

Certain employees of the Center also perform services on behalf of Highmark HealthPLACE operations, a wholly owned subsidiary of Highmark, and the Center is reimbursed accordingly for the costs of these services. Program fees from all such activities amounted to $37,364 and $34,989 in 2002 and 2001, respectively.

At December 31, 2002 and 2001, amounts due to and from affiliated companies were as follows:

	2002	2001
Accounts Receivable from Affiliated Companies		
Highmark	$ 40,271	$ 35,929
Accounts Payable to Affiliated Companies		
Highmark	$ 14,257	$ 23,864

9. Contingencies:

The Center receives financial assistance from governmental agencies in the form of contracts and grants. The disbursement of funds received under such programs generally requires compliance with terms and conditions specified in the contract/grant agreements and is subject to audit by grantor agencies. Any disallowed costs resulting from such audits could become a liability of the Center. For 2002, there were no expenditures that were disallowed by granting agencies or amounts received from governmental agencies. For 2001, amounts received from governmental agencies were less than the minimum required for conduct of Office of Management and Budget Circular A-133 audits.

10. Subsequent Event:

On April 3, 2003 and April 7, 2003, respectively, the Board of Directors of the Center and the Board of Directors of the Western Pennsylvania Caring Foundation (the Foundation) authorized and approved the merger of the Center with and into the Foundation with the Foundation being the surviving corporation. Execution of the merger is in progress. All assets, liabilities, and related unrestricted, temporarily restricted, and permanently restricted net assets will be merged into the Foundation. Management believes the merger will not affect the statement of financial position at December 31, 2002 or the statement of activities and changes in net assets for the year ended December 31, 2002.

Highmark Foundation

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Annual Report of

Financial Condition

2003

HIGHMARK FOUNDATION

MONTHLY FINANCIAL REPORT

DECEMBER 2003

Attachments

cc: Aaron Walton
Yvonne Cook
Lynne Marchese
Melissa Anderson
Janine Colincar
Eric Hoffman
Tom DiSanto
Dave Glod
Elaine Krasik
Sara Malara

HIGHMARK FOUNDATION

Statements of Financial Position

December 31, 2003 and December 31, 2002

	December 2003	December 2002
Assets:		
Cash and cash equivalents	$ 6,841,683	$ 7,596,608
Interest receivable	4,982	8,371
Prepaid expenses	4,050	5,425
Total assets	$ 6,850,715	$ 7,610,404
Liabilities & Unrestricted Net Assets:		
Liabilities:		
Grants payable	$ 895,128	$ 714,682
Accrued expenses	-	73
Total liabilities	895,128	714,755
Unrestricted net assets	5,955,587	6,895,649
Total liabilities & unrestricted net assets	$ 6,850,715	$ 7,610,404

HIGHMARK FOUNDATION

Statements of Activities and Changes in Net Assets

For the periods ended December 31, 2003 and 2002

	Year-to-Date 2003	Year-to-Date 2002
Revenues and Gains:		
Interest income	$ 73,718	$ 134,360
Total Revenues and Gains	73,718	134,360
Expenses:		
Audit fees	8,400	-
Grants	1,002,946	772,182
Provision for excise taxes	1,375	1,344
Legal fees	944	653
Other	115	53
Total Expenses	1,013,780	774,232
Change in unrestricted net assets	(940,062)	(639,872)
Unrestricted net assets at beginning of year	6,895,649	7,535,521
Unrestricted net assets at end of period	$ 5,955,587	$ 6,895,649

HIGHMARK FOUNDATION

Statements of Cash Flows

For the periods ended December 31, 2003 and 2002

	2003	2002
Cash flows from operating activities:		
Change in unrestricted net assets	$ (940,062)	$ (639,872)
Adjustments to reconcile change in unrestricted net assets to net cash used in operating activities:		
Increase (decrease) due from changes in:		
Interest receivable	3,389	6,046
Prepaid expenses	1,375	1,344
Grants payable	180,446	114,682
Accrued expenses	(73)	(72)
Net cash used in operating activities	(754,925)	(517,872)
Net decrease in cash and cash equivalents	(754,925)	(517,872)
Cash and cash equivalents at beginning of year	7,596,608	8,114,480
Cash and cash equivalents at end of period	$ 6,841,683	$ 7,596,608

Highmark Foundation

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Annual Report of

Financial Condition

2002

HIGHMARK FOUNDATION

MONTHLY FINANCIAL REPORT

DECEMBER, 2002

Attachments

cc: Aaron Walton
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HIGHMARK FOUNDATION

Statements of Financial Position

December 31, 2002 and 2001

	2002	2001
Assets:		
Cash and cash equivalents	$ 7,596,608	$ 8,114,480
Interest receivable	8,371	14,417
Prepaid expenses	5,425	6,769
Total assets	$ 7,610,404	$ 8,135,666
Liabilities & Unrestricted Net Assets:		
Liabilities:		
Grants payable	$ 714,682	$ 600,000
Accrued expenses	73	145
Total liabilities	714,755	600,145
Unrestricted net assets	6,895,649	7,535,521
Total liabilities & unrestricted net assets	$ 7,610,404	$ 8,135,666

See accompanying notes to financial statments

HIGHMARK FOUNDATION

Statements of Activities and Changes in Net Assets

For the Years Ended December 31, 2002 and 2001

	2002	2001
Revenues and Gains:		
Interest income	$ 134,360	$ 329,306
Total revenues and gains	134,360	329,306
Expenses:		
Grants	772,182	750,000
Legal fees	653	8,388
Provision for excise taxes	1,344	3,545
Other	53	556
Total expenses	774,232	762,489
Change in unrestricted net assets	(639,872)	(433,183)
Unrestricted net assets at beginning of year	7,535,521	7,968,704
Unrestricted net assets at end of period	$ 6,895,649	$ 7,535,521

See accompanying notes to financial statements.

HIGHMARK FOUNDATION

Statements of Cash Flows

For the Years Ended December 31, 2002 and 2001

	2002	2001
Cash flows from operating activities:		
Change in unrestricted net assets	$ (639,872)	$ (433,183)
Adjustments to reconcile change in unrestricted net assets to net cash (used in) provided by operating activities:		
Increase (decrease) due from changes in:		
Due from broker for securities sold	-	7,666,214
Interest receivable	6,046	(14,417)
Dividend receivable	-	25,200
Prepaid expenses	1,344	(6,769)
Grants payable	114,682	600,000
Accrued expenses	(72)	(132,640)
Net cash (used in) provided by operating activities	(517,872)	7,704,405
Net (decrease) increase in cash and cash equivalents	(517,872)	7,704,405
Cash and cash equivalents at beginning of year	8,114,480	410,075
Cash and cash equivalents at end of year	$ 7,596,608	$ 8,114,480

See accompanying notes to financial statements.

Western Pennsylvania Caring Foundation

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Funding Report

2003

Caring Foundation
Funding Sources
12 Months Ended December 31, 2003

	Revenue		
	Caring Foundation (including Health Education Center, Inc.)	Merged In to Caring Foundation	Caring Foundation (excluding Health Education Center, Inc.)
Funding Sources - Cash (Received or Receivable)			
CHIP Administrative Fees			
Commonwealth of Pennsylvania	$ 2,906,819	$ -	$ 2,906,819
	2,906,819	-	2,906,819
adultBasic Administrative Fees			
Commonwealth of Pennsylvania	2,500,875	-	2,500,875
Contributions and Grants			
Government (Federal, County, State, Local)	104,111	19,527	84,584
Highmark match and other	857,552	4,214	853,338
Community	968,955	42,693	926,262
	1,930,618	66,434	1,864,184
Net Investment Results	687,398	10,164	677,234
HealthPlace Program Fees from Highmark	13,786	13,786	-
Other Income	2,353	-	2,353
	8,041,849	90,384	7,951,465
Funding Sources - Non-Cash			
Contributions - In Kind (Donated Items)			
Highmark	9,823	9,823	-
Community	95,536	-	95,536
	105,359	9,823	95,536
Highmark Donated Services	908,014	96,873	811,141
	1,013,373	106,696	906,677
Total	$ 9,055,222	$ 197,080	$ 8,858,142

Note: The Caring Foundation also received cash for 2003 CHIP and adultBasic premiums totalling $53,337,754 and $46,496,148, respectively, which were passed through to Highmark upon receipt and were not recorded as income by the Foundation

Note: Health Education Center, Inc. was merged with and into the Caring Foundation on August 1, 2003

Western Pennsylvania Caring Foundation

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Funding Report

2002

Caring Foundation
Funding Sources
12 Months Ended December 31, 2002

	Revenue
Funding Sources - Cash (Received or Receivable)	
CHIP Administrative Fees	
Pass through from Highmark	$ 1,354,854
Commonwealth of Pennsylvania	599,960
	1,954,814
adultBasic Administrative Fees	
Commonwealth of Pennsylvania	1,725,327
Contributions and Grants	
Highmark Match	620,000
Community	737,336
	1,357,336
Investment Income	651,417
Other Income	1,876
	5,690,770
Funding Sources - Non-Cash	
Contributions - In Kind (Donated Items)	
Community	101,158
	101,168
Highmark Donated Services	541,375
	642,533
Total	$ 6,333,303

Note: The Caring Foundation also received cash for 2002 CHIP and adultBasic premiums totalling $11,735,556 and $12,933,694, respectively, which were passed through to Highmark upon receipt and were not recorded as income by the Foundation

Health Education Center, Inc

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Funding Report

2003

Health Education Center, Inc.
Funding Sources
7 Months Ended July 31, 2003

	Revenue		
	Health Education Center, Inc.	Merger Adjustments	Merged in to Caring Foundation
Funding Sources - Cash (Received or Receivable)			
Contributions and Grants			
Government (Federal, County, State, Local)	$ 19,527	$ -	$ 19,527
Highmark	89,224	(85,010)	4,214
Community	42,693	-	42,693
	151,444	(85,010)	66,434
HealthPlace Program Fees from Highmark	11,708	2,078	13,786
Investment Income	10,164	-	10,164
	173,316	(82,932)	90,384
Funding Sources - Non-Cash			
Contributions - In Kind (Donated Items)			
Highmark	-	9,823	9,823
Highmark Donated Services	23,764	73,109	96,873
	23,764	82,932	106,696
Total	$ 197,080	$ -	$ 197,080

Note: Health Education Center, Inc. was merged with and into the Caring Foundation on August 1, 2003

Health Education Center, Inc

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Funding Report

2002

Health Education Center, Inc.
Funding Sources
12 Months Ended December 31, 2002

	Revenue
Funding Sources - Cash (Received or Receivable)	
Contributions and Grants	
Highmark	$ 142,417
Highmark Foundation	75,000
Community (all other)	153,217
	370,634
HealthPlace Program Fees from Highmark	37,364
Investment Income	25,782
	433,780
Funding Sources - Non-Cash	
Contributions - In Kind (Donated Items)	
Government (Federal, County, State, Local)	-
Highmark	-
Highmark Foundation	-
Community (all other)	9,889
	9,889
Highmark Donated Services	56,261
	66,150
Total	$ 499,930

Highmark Foundation

-

Funding Report

2003

Highmark Foundation
Funding Sources
12 Months Ended December 31, 2003

Funding Sources - Cash (Received or Receivable)	Revenue
Investment Income	$ 73,718
Total	$ 73,718

Highmark Foundation

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Funding Report

2002

Highmark Foundation
Funding Sources
12 Months Ended December 31, 2002

Funding Sources - Cash (Received or Receivable)	Revenue
Investment Income	$ 134,360
Total	$ 134,360

Western Pennsylvania Caring Foundation

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Certified Statements of

Federal Tax Exemption

Internal Revenue Service
District Director

Department of the Treasury
P.O. Box 2508 - Room 4508
Cincinnati, Ohio 45201

Date: NOV 12 1996

Employer Identification Number:
25-1494238
Person to Contact:
D. A. Downing
Contact Telephone Number:
513-684-3957
Date of Exemption:
June, 1985
Internal Revenue Code:
Section 501(c)(3)

Western Pennsylvania Caring
Foundation, Inc.
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

Dear Sir or Madam:

Thank you for submitting the information on September 16, 1996. We have made it a part of your file.

The changes as stated in your letter do not adversely affect your exempt status and the exemption letter issued to you continues in effect.

Please let us know about any future changes in the character, purpose, method of operation, name or address of your organization. This is a requirement for retaining your exempt status.

We have sent a copy of this letter to your representative as indicated in your power of attorney.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Thank you for your cooperation.

Sincerely yours,

C. Ashley Bullard
District Director

cc: Carolyn D. Duronio

INTERNAL REVENUE SERVICE
DISTRICT DIRECTOR
31 HOPKINS PLAZA
BALTIMORE, MD 21201

DEPARTMENT OF THE TREASURY

Date: MAY 13 1991

Employer Identification Number:
25-1474.[illegible]
Contact Person:
D JAMES
Contact Telephone Number:
(301) 962-7756

WESTERN PENNSYLVANIA CARING
FOUNDATION INC
P O BOX CARING
PITTSBURGH, PA 15230

Our Letter Dated:
June 3, 1985
Addendum Applies:
YES

Dear Applicant:

This modifies our letter of the above date in which we stated that you would be treated as an organization which is not a private foundation until the expiration of your advance ruling period.

Your exempt status under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3) is still in effect. Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the code because you are an organization of the type described in section 509(a)(1) and 170(b)(1)(a)(vi).

Grantors and contributors may rely on this determination unless the Internal Revenue Service publishes notice to the contrary. However, if you lose your section 509(a)(1) status, a grantor or contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act, or the substantial or material change on the part of the organization that resulted in your loss of such status, or if he or she acquired knowledge that the Internal Revenue Service had given notice that you would no longer be classified as a section 509(a)(1) organization.

If we have indicated in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,

H. J. Hightower

District Director

Letter 1050(DO/CG)

HIGHMARK 00590

[illegible]

[illegible]

Guidelines under which private foundations may rely on this determination for gifts, grants and contributions made after March [illegible], 1989, are liberalized and published in Rev. Proc. 89-[illegible] Cumulative Bulletin 1989-1, page 844.

HIGHMARK 00591

Internal Revenue Service
District Director

Depa .nent of the Treasury

Date: JUNE 3, 1985

Employer Identification Number:

Accounting Period Ending:
DECEMBER 31
Foundation Status Classification:
509(a)(1) AND 170(b)(1)(A)(vi)
Advance Ruling Period Ends:
DECEMBER 31, 1990
Person to Contact:
P.D. MEEKS
Contact Telephone Number:
281-0112

WESTERN PENNSYLVANIA CARING FOUNDATION, INC.
301 FIFTH AVENUE BUILDING
PITTSBURGH, PA. 15222

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably be expected to be a publicly supported organization described in sections 509(a)(1) AND 170(b)(1)(A)(vi)*

Accordingly, you will be treated as a publicly supported organization, and not as a private foundation, during an advance ruling period. This advance ruling period begins on the date of your inception and ends on the date shown above.

Within 90 days after the end of your advance ruling period, you must submit to us information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, you will be classified as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, you will be classified as a private foundation for future periods. Also, if you are classified as a private foundation, you will be treated as a private foundation from the date of your inception for purposes of sections 507(d) and 4940.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and donors may continue to rely on the advance determination until the Service makes a final determination of your foundation status. However, if notice that you will no longer be treated as a section * organization is published in the Internal Revenue Bulletin, grantors and donors may not rely on this determination after the date of such publication. Also, a grantor or donor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section * status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section * organization.

(over)

Letter 1045(DO) (Rev. 10-83)

If your sources of su ort, or your purposes, characte or method of operation change, please let us know so we can consider the effect of the change on your exempt status and foundation status. Also, you should inform us of all changes in your name or address.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have any questions about excise, employment, or other Federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

You are required to file Form 990, Return of Organization Exempt from Income Tax, only if your gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late, unless there is reasonable cause for the delay.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Eddy R. Kern

District Director

cc:
Gary R. Truitt Esq.
Blue Cross of Western Pennsylvania
One Smithfield St.
Pittsburgh, Pa. 15222

Joseph Greif Esq.
Whitney & Dempsey
2401 L. Street N.W. - Suite 501
Washington, D.C. 20037.

Letter 1045(DO) (Rev. 10-83)

HIGHMARK 00593

Health Education Center, Inc

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Certified Statements of

Federal Tax Exemption

Internal Revenue Service
District Director

Department of the Treasury

Date: July 9, 1986

Our Letter Dated: Oct. 28, 1980

Person to Contact: Ms. A. K. Wilds

Contact Telephone Number: 301-962-4777

Health Education Center, Inc.
200 Ross Street
Pittsburgh, PA 15219

Dear Sir or Madam:

This modifies our letter of the above date in which we stated that you would be treated as an organization which is not a private foundation until the expiration of your advance ruling period.

Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the Internal Revenue Code, because you are an organization of the type described in section _____*_____. Your exempt status under section 501(c)(3) of the code is still in effect.

Grantors and contributors may rely on this determination until the Internal Revenue Service publishes notice to the contrary. However, a grantor or a contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section _____*_____ status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section _____*_____ organization.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

*509(a)(1) & 170(b)(1)(A)(vi)

Sincerely yours,

Teddy R. Kern

Teddy R. Kern
District Director

See the attached notice of changes in FICA tax and filing requirements.

cc: Stanley J. Lehman
Berkman Ruslander Pohl Lieber & Engel
One Oxford Centre 40th Floor
Pittsburgh, PA 15219-6498

31 Hopkins Plaza, Baltimore, Md 21201

Letter 1050 (DO) (7-77)

For tax years ending before December 31, 1982, you must file Form 990, Return of Organization Exempt from Income tax, only if your gross receipts each year are normally more than $10,000. For tax years ending on and after December 31, 1982, you are required to file Form 990 only if your gross receipts are normally more than $25,000. For guidance in determining whether your gross receipts are "normally" more than $25,000, see the instructions for the 1982 Form 990. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $10.00 a day, up to a maximum of $5,000, when a return is filed late, unless there is reasonable cause for delay.

Beginning January 1, 1984, unless specifically excepted, you must pay taxes under the Federal Insurance Contributions Act (Social Security taxes) for each employee who is paid $100 or more in a calendar year.

Highmark Foundation

-

Certified Statements of

Federal Tax Exemption

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: JUN 15 2001

HIGHMARK FOUNDATION
120 FIFTH AVE FIFTH AVE PL
PITTSBURGH, PA 15222

RECEIVED
JUN 20 2001
MAIL CONTROL
SENT TO SUITE
-7905

Employer Identification Number:
25-1876666
DLN:
17053138025031
Contact Person:
RICHARD K DOLFI
Contact Telephone Number:
(877) 829-5500
Accounting Period Ending:
December 31
Addendum Applies:
No

RECEIVED
MAIL CONTROL
ID# 31363
JUN 2 0 2001
HIGHMARK
BLUE CROSS BLUE SHIELD

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3).

We have further determined that, as indicated in your application, you are a private foundation within the meaning of section 509(a) of the Code. In this letter we are not determining whether you are an operating foundation as defined in section 4942(j)(3).

If your sources of support, or your purposes, character, or method of operation change, please let us know so we can consider the effect of the change on your exempt status and foundation status. In the case of an amendment to your organizational document or bylaws, please send us a copy of the amended document or bylaws. Also, you should inform us of all changes in your name or address.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA). However, since you are a private foundation, you are subject to excise taxes under chapter 42 of the Code. You also may be subject to other Federal excise taxes. If you have any questions about excise, employment, or other Federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Contribution deductions are allowable to donors only to the extent that their contributions are gifts, with no consideration received. Ticket purchases and similar payments in conjunction with fundraising events may not necessarily qualify as deductible contributions, depending on the circum-

Letter 1076 (DO/CG)

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stances. See Revenue Ruling 67-246, published in Cumulative Bulletin 1967-2, on page 104, which sets forth guidelines regarding the deductibility, as charitable contributions, of payments made by taxpayers for admission to or other participation in fundraising activities for charity.

You are required to file Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Trust Treated as a Private Foundation. Form 990-PF must be filed by the 15th day of the fifth month after the end of your annual accounting period. A penalty of $20 a day is charged when a return is filed late, unless there is reasonable cause for the delay. However, the maximum penalty charged cannot exceed $10,000 or 5 percent of your gross receipts for the year, whichever is less. For organizations with gross receipts exceeding $1,000,000 in any year, the penalty is $100 per day per return, unless there is reasonable cause for the delay. The maximum penalty for an organization with gross receipts exceeding $1,000,000 shall not exceed $50,000. This penalty may also be charged if a return is not complete, so please be sure your return is complete before you file it.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You are required to make certain returns available for public inspection for three years after the later of the due date of the return or the date the return is filed. The returns required to be made available for public inspection are Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Nonexempt Charitable Trust Treated as a Private Foundation, and Form 4720, Return of Certain Excise Taxes on Charities and Other Persons Under Chapters 41 and 42 of the Internal Revenue Code. You are also required to make available for public inspection your exemption application, any supporting documents, and your exemption letter. Copies of these documents must be provided to any individual upon written or in person request without charge other than reasonable fees for copying and postage. You may fulfill this requirement by placing these documents on the Internet. Penalties may be imposed for failure to comply with these requirements. Additional information is available in Publication 557, Tax-Exempt Status for Your Organization, or you may call our toll free number shown above.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

This determination is based on evidence that your funds are dedicated to the purposes listed in section 501(c)(3) of the Code. To assure your continued exemption, you should maintain records to show that funds are expended only for those purposes. If you distribute funds to other

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INQUIRY CONTROL
HBCBS

organizations, your records should show whether they are exempt under section 501(c)(3). In cases where the recipient organization is not exempt under section 501(c)(3), there should be evidence that the funds will remain dedicated to the required purposes and that they will be used for those purposes by the recipient.

If distributions are made to individuals, case histories regarding the recipients should be kept showing names, addresses, purposes of awards, manner of selection, relationship (if any) to members, officers, trustees or donors of funds to you, so that any and all distributions made to individuals can be substantiated upon request by the Internal Revenue Service. (Revenue Ruling 56-304, C.B. 1956-2, page 306.)

If we have indicated in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

We have sent a copy of this letter to your representative as indicated in your power of attorney.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Steven T. Miller

Steven T. Miller
Director, Exempt Organizations

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Letter 1076 (DO/CG)

Charitable Contributions - Substantiation and Disclosure Requirements

UNDER THE NEW LAW, CHARITIES WILL NEED TO PROVIDE NEW KINDS OF INFORMATION TO DONORS. Failure to do so may result in denial of deductions to donors and the imposition of penalties on charities.

Legislation signed into law by the President on August 10, 1993, contains a number of significant provisions affecting tax-exempt charitable organizations described in section 501(c)(3) of the Internal Revenue Code. These provisions include: (1) new substantiation requirements for donors, and (2) new public disclosure requirements for charities (with potential penalties for failing to comply). Additionally, charities should note that donors could be penalized by loss of the deduction if they fail to substantiate. **THE SUBSTANTIATION AND DISCLOSURE PROVISIONS APPLY TO CONTRIBUTIONS MADE AFTER DECEMBER 31, 1993.**

Charities need to familiarize themselves with these tax law changes in order to bring themselves into compliance. This Publication alerts you to the new provisions affecting tax-exempt charitable organizations. Set forth below are brief descriptions of the new law's key provisions. The Internal Revenue Service plans to provide further guidance in the near future.

Donor's Substantiation Requirements

Documenting Certain Charitable Contributions. — Beginning January 1, 1994, no deduction will be allowed under section 170 of the Internal Revenue Code for any charitable contribution of $250 or more unless the donor has contemporaneous written substantiation from the charity. In cases where the charity has provided goods or services to the donor in exchange for making the contribution, this contemporaneous written acknowledgement must include a good faith estimate of the value of such goods or services. Thus, taxpayers may no longer rely solely on a cancelled check to substantiate a cash contribution of $250 or more.

The substantiation must be "contemporaneous." That is, it must be obtained by the donor no later than the date the donor actually files a return for the tax year in which the contribution was made. If the return is filed after the due date or extended due date, then the substantiation must have been obtained by the due date or extended due date.

The responsibility for obtaining this substantiation lies with the donor, who must request it from the charity. The charity is not required to record or report this information to the IRS on behalf of donors.

The legislation provides that substantiation will not be required if, in accordance with regulations prescribed by the Secretary, the charity reports directly to the IRS the information required to be provided in the written substantiation. At present, there are no regulations establishing procedures for direct reporting by charities to the IRS of charitable contributions made in 1994. Consequently, charities and donors should be prepared to provide/obtain the described substantiation for 1994 contributions of $250 or more.

There is no prescribed format for the written acknowledgement. For example, letters, postcards or computer-generated forms may be acceptable. The acknowledgement does not have to include the donor's social security or tax identification number. It must, however, provide sufficient information to substantiate the amount of the deductible contribution. The acknowledgement should note the amount of any cash contribution. However, if the donation is in the form of property, then the acknowledgement must describe, but need not value, such property. Valuation of the donated property is the responsibility of the donor.

The written substantiation should also note whether the donee organization provided any goods or services in consideration, in whole or in part, for the contribution and, if so, must provide a description and good-faith estimate of the value of the goods or services. In the new law these are referred to as "quid pro quo contributions."

Please note that there is a new law requiring charities to furnish disclosure statements to donors for such quid pro quo donations in excess of $75. This is addressed in the next section regarding Disclosure By Charity.

If the goods or services consist entirely of intangible religious benefits, the statement should indicate this, but the statement need not describe or provide an estimate of the value of these benefits. "Intangible religious benefits" are also discussed in the following section on Disclosure By Charity. If, on the other hand, the donor received nothing in return for the contribution, the written substantiation must so state.

The present law remains in effect that, generally, if the value of an item or group of like items exceeds $5,000, the donor must obtain a qualified appraisal and submit an appraisal summary with the return claiming the deduction.

The organization may either provide separate statements for each contribution of $250 or more from a taxpayer, or furnish periodic statements substantiating contributions of $250 or more.

Separate payments are regarded as independent contributions and are not aggregated for purposes of measuring the $250 threshold. However, the Service is authorized to establish anti-abuse rules to prevent avoidance of the substantiation requirement by taxpayers writing separate smaller checks on the same date.

If donations are made through payroll deductions, the deduction from each paycheck is regarded as a separate payment.

A charity that knowingly provides false written substantiation to a donor may be subject to the penalties for aiding and abetting an understatement of tax liability under section 6701 of the Code.

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Disclosure by Charity of Receipt of Quid Pro Quo Contribution

Beginning January 1, 1994, under new section 6115 of the Internal Revenue Code, a charitable organization must provide a written disclosure statement to donors who make a payment, described as a "quid pro quo contribution," in excess of $75. This requirement is separate from the written substantiation required for deductibility purposes as discussed above. While, in certain circumstances, an organization may be able to meet both requirements with the same written document, an organization must be careful to satisfy the section 6115 written disclosure statement requirement in a timely manner because of the penalties involved.

A quid pro quo contribution is a payment made partly as a contribution and partly for goods or services provided to the donor by the charity. An example of a quid pro quo contribution is where the donor gives a charity $100 in consideration for a concert ticket valued at $40. In this example, $60 would be deductible. Because the donor's payment (quid pro quo contribution) exceeds $75, the disclosure statement must be furnished, even though the deductible amount does not exceed $75.

Separate payments of $75 or less made at different times of the year for separate fundraising events will not be aggregated for purposes of the $75 threshold. However, the Service is authorized to develop anti-abuse rules to prevent avoidance of this disclosure requirement in situations such as the writing of multiple checks for the same transaction.

The required written disclosure statement must:

(1) inform the donor that the amount of the contribution that is de-

Item D

Highmark

And

Social Mission

Highmark's Corporate Mission – 2002 and 2003
Executive Summary

Highmark carries out its corporate mission – to provide access to affordable, quality health care coverage enabling individuals to live longer, healthier lives – in a variety of ways, including through our social mission activities. Some of the company's activities are routinely reported and recognized. For example, the attached reports summarize Highmark's 2002 and 2003 contributions to programs and products that help reduce the number of uninsured in the Commonwealth by providing access to health insurance for everyone in the community, regardless of medical condition, age or gender. The reports also summarize Highmark's contributions to community organizations and strategic, community-based health programs that help improve the health and well-being of people in the communities served by Highmark.

Some highlights regarding Highmark's **$96.1** million in contributions in 2003 include the following:

- In 2003, Highmark contributed **$66.3** million in rate subsidies to direct pay and senior products which helped make them more affordable to Pennsylvanians.
- In 2003, Highmark contributed **$15.3** million to the adultBasic, CHIP and Caring Programs in terms of direct contributions, administration and underwriting losses. Highmark serves over 43,000 children in CHIP, over 21,000 adults in adultBasic, and over 300,000 individuals in aggregate since these programs began.
- In 2003, Highmark contributed **$14.5** million in direct community contributions. In addition to direct contributions to non-profit organizations, this funding supported Highmark's strategic community health initiatives such as addressing childhood obesity and inactivity, minority health disparities, health prevention and education activities through HealthPLACE and the Center for Grieving Children. In 2003, Highmark made contributions to 1,017 non-profit organizations with the average contribution amount being about $7,250.

Other Highmark activities play an equally important role in sustaining the economic vitality of Pennsylvania and its localities, which in turn improves the health and quality of life for many Pennsylvanians. Highmark and Highmark's subsidiary companies contribute to the economic health of Pennsylvania through their spending on goods and services with Pennsylvania-based vendors, as well as through the spending and business volume generated by Pennsylvania-based companies that do business with Highmark (vendors, lodging establishments, restaurants, construction firms, temporary agencies, etc.). As a significant corporate presence, Highmark's direct and indirect economic impact sustains and expands the state's employment base.

As the largest health insurance plan headquartered in Pennsylvania, Highmark has more than 11,000 employees (including the parent company and its subsidiaries), located in the Commonwealth. Highmark employees are deeply involved in the communities the company

serves through their volunteerism (22,172 hours in 2003) and management representation on non-profit Board of Directors (172 individuals in 2003).

Highmark's subsidiaries also participated in activities that included direct contributions to non-profit organizations, employee volunteerism and management Board participation. These are outlined in detail in the attached reports.

Last, it is important to recognize some of Highmark's practices that also assist Pennsylvanians in securing access to health care coverage:

- Highmark offers guarantee issue direct pay products (generally not available through commercial insurers);
- Highmark offers continuous open enrollment in those guarantee issue direct pay products;
- Highmark's group programs include limited pre-existing condition waiting periods with conversion privileges;
- Highmark makes available the Special Care program to low-income Pennsylvanians;
- Highmark continues to be committed to small employers, in 2003 Highmark underwrote in excess of $900 million in small group business;
- Highmark, along with the other Blue plans in the state, serve as the HIPAA State Alternative Mechanism for individuals, assuring access to health insurance without a pre-existing condition waiting period to those leaving group health coverage, and;
- Highmark offers qualified health care coverage to individuals eligible for the HCTC (Health Care Tax Credit Program) of the Trade Adjustment Act.

Please refer to the following pages for more details regarding Highmark's charitable contributions and activities.

HIGHMARK INC.

Report on Condition #4 of the Commissioner's Decision and Order ($ in Millions)

February 28, 2003

	2002 Final
REQUIREMENT:	
Direct Written Premiums	$3,700*
1.25% of Direct Written Premiums	**$46.3**
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$0.8
BlueCHIP and Caring Program Administrative Expense Contributions	$8.4
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$36.4
Community Contributions	$13.0
TOTAL	**$60.8**

* Source is the IDR, Underwriting and Investment Exhibit part 1, line 9, column 1.

HIGHMARK INC.

Report on Condition #4 of the Commissioner's Decision and Order ($ in Millions)

February 27, 2004

	2003 Final
REQUIREMENT:	
Direct Written Premiums	$3,971*
1.25% of Direct Written Premiums	**$49.6**
CONTRIBUTIONS:	
Direct Contributions to Caring Program for Children	$0.8
CHIP, Caring Program and adultBasic Administrative Expense Contributions	$9.3
Special Care Rate Subsidy	$2.2
Group Conversion/Subsidy	$39.1
Community Contributions	$14.5
Medicare Choice Rate Subsidy	$25.0
CHIP and adultBasic Claim Losses	$5.2
TOTAL	**$96.1**

* Source is the IDR, Underwriting and Investment Exhibit part 1, line 9, column 1.

Condition 4 Report
Description of Contribution Categories

Direct Contributions to Caring Program for Children

Highmark Inc. matches dollar for dollar any community contributions made to the Caring Foundation. These funds support the Caring Program for Children, a broad umbrella of programs, which assist low-income families in obtaining access to, and utilization of, health care for their children. Initiatives include improving immunization rates with birthday card reminders and immunization record cards, along with healthy tips related to seeing the doctor, washing hands and wearing safety helmets. Additionally, these funds support The Caring Place, a Center for Grieving Children, Adolescents and Their Families, in the Pittsburgh, Erie and Harrisburg areas. The Caring Place serves children and families who have suffered the death of a parent or other loved one. The Caring Place assists the child and the family through caring, encouragement and support from trained professionals and volunteers in a friendly environment. In 2002, 95 Caring Team schools raised money in support of the Caring Foundation programs and in 2003, 131 Caring Team schools raised money in support of these programs.

Highmark, in conjunction with Independence Blue Cross (IBC), also matches dollar for dollar any community contributions raised by the Independence Blue Cross and Highmark Blue Shield Caring Foundation in the Southeastern region of the state. No funds are matched in the other regions of the state as these Caring Foundations do not conduct community fundraising activities.

CHIP, Caring Program, and adultBasic Administrative Expense Contributions

Highmark and its partner, the Caring Foundation, have been a contractor for both the Children's Health Insurance Program (CHIP) and adultBasic programs since their inception. In fact, Highmark's Caring Program for Children, started in 1985, has served as a model for both the state and federal CHIP programs. Additionally, Highmark's Special Care program, started in 1992, has served as a model for Pennsylvania's adultBasic program. For the CHIP and the adultBasic programs, Highmark donates administrative staff and resources that are far in excess of what a health insurer typically provides. For these programs, Highmark and the Caring Foundation not only incur the costs of processing claims and answering customer service calls, but also are required to receive, enter and process all applications for the programs including verification of income eligibility and enrollment of individuals.

In 2002, the Caring Foundation processed each month, on average, 4,200 applications for the CHIP and adultBasic programs and in 2003 processed an average 4,400 applications for these programs. The Caring Foundation refers over 1,000 children and adults to Medical Assistance each month. In 2003, total enrollment was over 43,000 children in CHIP and over 21,000 adults in adultBasic with over 28,000 adults on the adultBasic waiting list. In aggregate, over 300,000 children and adults have been enrolled in CHIP or adultBasic through the Caring Foundation.

Highmark and the Caring Foundation also provide staff and resources in conducting grass-roots outreach to find and enroll eligible uninsured individuals. In 2002, outreach staff conducted 84

events that touched over 40,000 individuals. In 2003, outreach staff conducted 102 events that touched over 87,000 individuals.

Key goals for the uninsured child and adult programs include:

1. Reaching uninsured children and adults who are eligible for CHIP and adultBasic, and providing a pathway for them to gain health care coverage, to receive health care services, and to improve their health.
2. Referring all eligible children and adults to Medical Assistance.
3. Empowering community partners to reach uninsured children and adults in their own communities.

For the CHIP and adultBasic programs, the administrative expense contribution reflects administrative expenses that are in excess of the 10% reimbursement by the Commonwealth to CHIP and adultBasic contractors.

Special Care Rate Subsidy

Special Care is a product that was developed in 1992 by the Blue Plans in Pennsylvania to help make health care coverage more available, accessible and affordable for low income Pennsylvanians whose incomes are at or below 185% of Federal poverty levels. Statewide there are 56,559 individuals enrolled in the Special Care program – making it one of the largest private initiatives to address the issue of the uninsured in the nation.

Highmark Inc. subsidizes the Special Care rates in its programs throughout the State. This $2.2 million rate subsidy is in addition to the direct pay rate subsidy applied through the group conversion subsidy, which is described below.

Group Conversion/ Subsidy

Highmark Inc. subsidizes the rates charged to direct pay programs with a subsidy collected from group customers. These rate subsidies are reflected in all rate filings presented and approved through the Pennsylvania Insurance Department. These subsidies help to make health care coverage more affordable to individuals who may otherwise be uninsured. In 2003, Highmark served over 500,000 individuals through all of our direct pay programs.

Attachment A shows a chart of the products which are subsidized and the amount of subsidy applied to each product.

Community Contributions

Highmark is a leader in working with the community to promote healthy lifestyles through education, training and prevention programs. We have long known that controllable behaviors -- overeating, smoking, poor nutrition and lack of exercise - are significant contributing factors to

devastating health problems such as heart disease, diabetes and many forms of cancer. Everyday choices add up over time to mean the difference between well being and disease.

Through support of strategic community and health initiatives and through our contributions to non-profit community organizations, Highmark is helping people safeguard their health and make choices that improve the quality of life in order that people can live longer, healthier lives.

Below is a chart providing detail on the community contributions, which Highmark made in 2002 and 2003. Following this is an explanation of each of these detailed categories.

Highmark
Detail of Community Contributions
Condition #4 of the Commissioner's Decision and Order
March 22, 2004

Community Contributions Detail	2002	2003
Community Program Administration	$2,053,741	$2,139,979
HealthPLACE and Van	$3,111,137	$2,960,717
Direct Community Contributions	$5,729,766	$7,378,826
Dr. Dean Ornish Heart Health Program	$935,325	$1,066,881
Center for Grieving Children	$732,765	$716,038
Division of Community Health	$0	$222,384
Influenza Campaign	$500,000	$0
TOTAL	**$13,062,734**	**$14,484,825**

Community Program Administration

This category reflects the staff and overhead costs necessary to administer the community programs offered by Highmark and includes administration of Highmark's employee volunteer efforts as well as donated administrative support to the Highmark Foundation and the Caring Foundation.

HealthPLACE and Van

This category reflects the costs associated with developing and delivering health promotion and health education services to the community through Highmark's HealthPLACE sites and the HealthPLACE on the MOVE mobile unit both in Western and Central Pennsylvania. In 2003, over 202,600 units of service to the community were offered through HealthPLACE including 57,192 screenings, 6,225 Health Awareness classes and 25,880 participants in Lifestyle Improvement classes. One of the many programs HealthPLACE offers is the H.O.P.E. (Highmark Osteoporosis Prevention & Education) program. This program focuses on protection and prevention for those at risk, and on bone-strengthening exercise, diet and medication counseling, and group support for those who have been diagnosed. Results show improvement in participants strength and flexibility and reduced risk for falls. Many also experience lower blood pressure, decreased pain, and a better sense of well being.

Direct Community Contributions

This category reflects Highmark's corporate giving to non-profit organizations in the community. Highmark contributes to programs that support the goal of health promotions, disease prevention and improving the health care delivery system. Highmark also supports a variety of programs targeted to addressing youth issues, improving health, building strong community resources and senior citizens and their health. While the majority of the funding goes to health and human services, Highmark also supports programs to strengthen communities, educational institutions and arts and culture.

One of the strategic health initiatives Highmark is involved with is childhood obesity and inactivity. Highmark annually spends $1.1 billion on illnesses closely associated with obesity and $300 million on costs directly attributed to obesity-related problems. Additionally, Highmark has seen a 164% increase in gastric surgery expenditures from $14.6 million in 2001 to $39.4 million in 2002. As a result, Highmark has undertaken a multi-pronged strategy to "create positive impact on health risk through advocacy and support of evidence-based approaches to better nutrition and increased physical activity." The company's *Fun to be Fit* program integrates two science-based programs, FRESH (Food Re-education for Elementary School Health) and SPARK (Sports, Play, and Active Recreation for Children), to combine both nutrition and physical education in elementary schools. In an initial pilot program, intervention schools showed significant improvements compared with control groups. For example, there was a 19%, 15%, and 18% decrease in the consumption of high sodium, high-sugar, and high-fat foods, respectively, through the FRESH component. Time spent in class being physically active increased as did the number of periods devoted to physical education and SPARK tenets. In the 2002-2003 school year the program was instituted throughout Pittsburgh's 58 elementary schools, affecting nearly 22,000 children.

The KidShape® program adopted by Highmark has shown similar success. Through nutrition, education, group support, and physical activity, the pediatric weight management program for overweight children emphasizes lifestyle change, not weight loss. In initial trials of KidShape®, the program's creator, the KidShape® Foundation, reports that 87% of the children lost weight, 80% maintained their weight or continued to lose at a two-year follow up, there was a 51% decrease in TV viewing per week, and a seven-fold increase in physical activity per week. Highmark currently supports six Pennsylvania sites and hopes to realize similar results.

Highmark is providing grant funding for two other initiatives. Working with the Children's Health Fund, Highmark is participating in activities to increase awareness and education regarding childhood obesity and health risks that includes a local forum for community leaders and national experts, physician training, and a forum convening state legislators and community leaders to discuss a state-wide strategy. In addition, the Challenge for Healthier Schools has invited educators to create an in-school nutrition or physical education program. Nine cash grants, totaling $125,000, have been awarded and will be implemented in the 2003-2004 school year. The Challenge encourages best practices and requires an evaluation component to determine the most successful programs.

In 2003, Highmark gave direct contributions to 1,017 non-profit organizations with the average contribution amount being $7,250. Some examples of the kinds of grants Highmark made in 2003 include the following:

- A grant to the American Lung Association of Pennsylvania to provide Asthma Care Packages to help educate families about asthma and help them effectively manage the disease with their newly diagnosed child;
- A grant to Nuestra Clinica for a pilot Hepatitis C Screening/Intervention program;
- A grant to the Laurel Foundation to provide defibrillators at various schools and community sites;
- Sponsorship of the Sisters Take Charge of Your Health Conference to inspire women of color to take charge of their health;
- A grant to Family Links to provide needed mental health services in area schools;
- Grants to nursing schools and the Health Occupations Students of America (HOSA) Foundation to provide scholarships to students pursuing nursing careers to assist in addressing the nursing shortage in Pennsylvania;
- A grant to St. Joseph Medical Center to fund an educator/interpreter/outreach position to work with Latino patients and their families to reduce language barriers and enhance their health and wellness;
- A grant to the Eastern Area Adult Services organization to set up Health Check Kiosks at local malls; and

- Grants to numerous organizations such as the United Way, the American Red Cross, the American Heart Association and the American Diabetes Association, just to mention a few.

Dr. Dean Ornish Health Program

This category reflects Highmark's contributions associated with supporting the Dr. Dean Ornish Program for Reversing Heart Disease. This program works with individuals who have met clinical criteria for heart disease to dramatically improve their quality of life and avoid costly and painful invasive treatment options. To date, over 2,500 individuals have benefited from this program. The program combines a low-fat vegetarian eating style, moderate aerobic exercise, stress management techniques and group support to improve blood flow to the heart and decrease cholesterol, blood pressure and chest pain.

Center for Grieving Children

This category reflects the costs associated with The Caring Place, A Center for Grieving Children, Adolescents and Their Families. Currently, there are Caring Place sites in Pittsburgh, Erie, and Central Pennsylvania. In 2002, The Caring Place served 1,024 families and in 2003, served 975 families. The Caring Place in Central Pennsylvania opened its doors in 2003. Since its inception, The Caring Place has helped more than 8,000 family members.

The Caring Place provides peer support services for children and their families who have experienced the death of a family member. The services are offered at no cost.

The Caring Place provides ongoing education, training and consultation to counselors, teachers, therapists and other professionals who serve children.

Key goals for Grieving Children, Adolescents and Their Families include:

1. Reaching grieving children, adolescents and their families to let them know of the services available to them.
2. Finding adult volunteers who would like to help make a difference in the lives of grieving children and adults.
3. Enabling providers and other professionals to help children cope with their grief.

Division of Community Health

In August 2003, Highmark moved the Health Education Center into the Caring Foundation and created the Division of Community Health.

The Division of Community Health is anticipated to serve as a conduit to improving community health, partnering with community organizations to enhancing their missions, helping them to leverage resources and empowering them with measurable and replicable strategies to effect lifestyle changes in the individuals they serve.

The Division of Community Health will be building strong partnerships with health providers, human-service agencies, educational and faith-based agencies and other key stakeholders for the purpose of improving community health. A key place to begin when serving those at risk or underserved is to listen to the needs and hopes, barriers and dreams of the communities as expressed by the community leadership. The Division of Community Health will listen to the community, assess its needs and work to dramatize those needs. In this way, the Division of Community Health will serve as a catalyst for change by establishing partnerships to create initiatives and programs addressing the problems voiced by the community.

Influenza Campaign

In 2002, Highmark contributed $500,000 to a flu immunization campaign targeted to providing flu shots to high-risk senior citizens. Highmark contributed to the cost of the immunizations, and the administration of the vaccinations specifically targeted to low-income senior care centers in order to try to get as many at-risk seniors vaccinated as possible. As a result of this campaign, 106,927 flu shots were provided to senior citizens.

Medicare Choice Rate Subsidy

In 2003, Highmark applied a $25 million rate subsidy to its Medicare + Choice HMO product (now Medicare Advantage). This subsidy helped mitigate rate increases to senior citizens at a time when federal reimbursement levels were inadequate in some areas.

CHIP and adultBasic Claim Losses

Highmark has a long history of commitment to children's health insurance programs beginning with the Caring Program for Children in 1985. Highmark, with its partner the Caring Foundation, is the only insurer providing CHIP coverage in 49 counties in Western and Central Pennsylvania, and has continued in the program since its inception in 1993 despite administrative and claim losses. Highmark is proud of its partnership role with the Commonwealth in the nationally recognized public/private CHIP program in Pennsylvania. Highmark, with its partner the Caring Foundation, is also the only insurer to administer the adultBasic program in the Western region of the state.

Highmark's Additional Contributions Employee Volunteerism and Non-Profit Board Participation

In addition to the contributions outlined previously, Highmark strongly encourages its employees to be active in the community. Highmark has staff which regularly let employees know of volunteer opportunities with local, non-profit organizations and encourages and supports employee participation. Highmark annually recognizes key employee volunteers through a volunteer luncheon and volunteer of the year ceremony.

In 2002, Highmark employees volunteered over 23,158 hours of their time, which equated in dollars to a contribution of about $383,033*. In 2003, Highmark employees volunteered over 22,172 hours of their time, which equated in dollars to a contribution of $366,725*.

Additionally, Highmark encourages all management level individuals to be involved in non-profit community organizations through Board of Director participation.

Based on a survey conducted in 2003, 172 management individuals actively served on the Board of Directors of non-profit community organizations.

*Value of volunteer time was $16.54/hour. Source: Independent Sector 2002.

Charitable Contributions of Highmark's Subsidiaries

Below is a summary of the charitable contributions made by each of Highmark's subsidiaries. These contributions reflect 3 categories: direct contributions to non-profit community organizations, employee volunteerism and management participation on Board of Directors for non-profit organizations.

Gateway Health Plan		
	2002	2003
Direct Contributions (dollars)	$257,635	$124,670
Employee Volunteerism (hours/dollar value)	2,179/$36,040	
Management Board Participation (number of individuals)	3	8

HealthGuard		
	2002	2003
Direct Contributions (dollars)	Not Available	$315,160
Employee Volunteerism (hours/dollar value)	Not Available	160/$2,646
Management Board Participation (number of individuals)	Not Available	3

Davis Vision		
	2002	2003
Direct Contributions (dollars)	$1,313,673	$472,386
Employee Volunteerism (hours/dollar value)	Not Available	521/$8,617
Management Board Participation (number of individuals)	Not Available	Not Available

United Concordia		
	2002	2003
Direct Contributions (dollars)	$36,626	$55,009
Employee Volunteerism (hours/dollar value)	9,980 /$165,069	
Management Board Participation (number of individuals)	29	

Alliance Ventures		
	2002	2003
Direct Contributions (dollars)	$2,711	

Highmark Life and Casualty		
	2002	2003
Direct Contributions (dollars)	$19,950	$12,550

Standard Property		
	2002	2003
Direct Contributions (dollars)	$8,255	$64,993
Employee Volunteerism (hours/dollar value)	323/$5,342	338/$5,590
Management Board Participation (number of individuals)	2	2

Attachment A

Rate Subsidy Amounts by Product ($ in millions)

Product	2002 Subsidy	2003 Subsidy
Preferred Hospital/Medical and Major Medical (Western Region)	$6.4	$6.7
Medical/Surgical** (Mid-Atlantic Region)	$0.6	$0.3
Comprehensive Major Medical** (Mid-Atlantic Region)	$0.9	$0.1
Classic Blue (Central Region)	$0	$1.2
Special Care* (Statewide)	$10.8	$11.9.
Security 65 (Statewide)	$17.2	$14.2
Medigap Blue (Central Region)	$2.6	$7.1
Medicare HMO	$0	$25.0
TOTAL* **	**$38.6**	**$66.3**

* Special Care subsidy includes the group conversion subsidy dollars plus the additional $2.2 million Special Care subsidy.

** Includes subsidy to old business with CBC as well as joint IBC and BCNEPA programs.

*** Totals include these categories from the "Condition 4 Report": Group Conversion/Subsidy, Special Care Rate Subsidy and Medicare Choice Rate Subsidy. Individual columns may not add exactly due to rounding.

Item E

Highmark

-

Role of Wholly Owned

For Profit Subs

Highmark Inc. - Role of For-Profit Subsidiaries

OVERVIEW

Highmark's wholly owned, for-profit subsidiaries are a vital component in helping the company meet its corporate mission. That mission is to provide access to affordable, quality health care enabling individuals to live longer, better lives. First and foremost, Highmark is a health plan corporation that provides health insurance – and its mission hasn't changed since Highmark's predecessors (Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield) were created 65 years ago.

Closely linked to the mission is a commitment to the communities in which its employees live and work. The company's community-based heritage remains a focal point today as Highmark carries out the mission in its core markets – Central Pennsylvania, Western Pennsylvania, and, to a different extent, throughout the rest of the Commonwealth where it works in partnership with other Blue Plans.

The subsidiaries reinforce Highmark's mission in several key ways. Some subsidiaries, including Keystone Health Plan West, Inc. (KHPW) and HealthGuard, provide managed care health insurance coverage to Pennsylvanians in different regions of the state, and thereby directly reinforce Highmark's core purpose. Other subsidiaries, including United Concordia Companies, Inc. (UCCI); HVHC Inc., the holding company for Davis Vision, Inc. and Clarity Vision, Inc.; and Highmark Life and Casualty Group, provide other insurance coverage to Pennsylvanians, and serve as investment vehicles to generate revenues that help Highmark meet its financial obligations and fulfill its mission. And finally, some subsidiaries manage administrative functions, such as Standard Property Corporation, which manages Highmark's downtown offices.

Highmark must maintain financial strength to carry out its mission. Unlike many of the health insurance companies with which it must compete for business in Pennsylvania and nationally, Highmark does not have access to capital from public stock offerings. As a non-profit health plan, Highmark must fulfill its corporate mission and other financial obligations from the revenues it generates from other means. The for-profit, wholly owned subsidiaries are not publicly traded. Their only shareholder is Highmark, and the subsidiary revenues roll up to Highmark's surplus, thus inuring to the benefit of the non-profit parent company so it can meet its obligations.

In 2003, alone, Highmark contributed over $96 million to charitable endeavors in support of its corporate mission. More than $80 million was provided to help hold down the cost or to expand access to individual health insurance programs for lower-income families, uninsured children and older adults. Among other things, Highmark contributed $9.3 million toward the administrative expense of operating the Children's Health Insurance Program (CHIP), the Caring Program for Children and adultBasic. In addition to these subsidies, Highmark absorbed an additional $5.2 million in CHIP and adultBasic claims losses.

HEALTH INSURANCE SUBSIDIARIES

Highmark's for-profit, wholly owned health care subsidiaries directly contribute to the health and well-being of hundreds of thousands of Pennsylvanians, representing all segments of the population. Keystone Health Plan West (KHPW) provides managed health insurance coverage to 450,000 people in the 29 counties of Western Pennsylvania. KHPW also administers the SecurityBlue HMO program, one of the largest Medicare+Choice (now renamed Medicare Advantage) HMO programs in the country.

To help its members live longer, healthier lives, KHPW has undertaken a broad range of clinical quality activities. For example, the incidence of diabetes in Pennsylvania is among the highest in the United States. Working closely with physicians, KHPW has undertaken a number of activities to help ensure that people with diabetes receive appropriate retinal screenings, foot exams and blood sugar tests. Through these efforts, many KHPW members with diabetes are much better able to manage their condition and lead more productive lives. Similar KHPW programs are helping people with other chronic conditions, such as asthma and congestive heart failure.

In addition to making managed health insurance available to young and old alike, KHPW helps Highmark fulfill its mission by administering programs that cover vulnerable segments of the community, low-income families and uninsured children. These programs include the Caring Program for Children, CHIP and the adultBasic program.

In Central Pennsylvania, HealthGuard of Lancaster, Inc. provides coverage to more than 95,000 people in 10 counties. Similar to KHPW, HealthGuard has enhanced the quality of many lives through clinical programs to help its members control their asthma, diabetes and heart conditions.

By meeting the health care needs of hundreds of thousands of Pennsylvanians, Highmark's health-related subsidiaries promote the company's mission and help to ensure the delivery of high-quality medical care in the state.

OTHER INSURANCE SUBSIDIARIES

Highmark's other insurance subsidiaries have an important and essential relationship to Highmark's corporate mission. They are vehicles designed principally to generate investment returns that Highmark can use to carry out its corporate mission activities. In a February 23, 2003 article in the *Pittsburgh Post-Gazette*, Highmark President and Chief Executive Officer Dr. Kenneth Melani clearly articulated the overriding goal of these subsidiaries: "Other businesses such as dental and vision insurance plans . . . will be treated as investments" to support the core health insurance business.

Highmark uses several criteria to measure the performance and value of its health insurance subsidiaries as investment vehicles. First, these subsidiaries are designed to bring "strategic value" to Highmark, meaning that they must improve or complement the offering of the company's core health insurance business. Second, the subsidiaries are

expected to generate cost effective ways to make health insurance more affordable, and therefore more accessible. Finally, and most significantly, these subsidiaries are expected to produce a return on investment to Highmark to help support its corporate mission.

The for-profit subsidiaries serve many other vital functions:

Diversification of income sources

Highmark's for-profit insurance subsidiaries help diversify the company's sources of income in the event of weak operating performance by the core health insurance business. Health insurance is subject to significant underwriting cycles. In some years, Highmark takes in more money in revenues than the total cost of payments to health care providers, plus operating expenses. In other years, our payments for medical services, plus operating expenses, exceed the revenues we take in.

In 2003, for example, Highmark posted negative operating results on its health insurance business. Highmark's dental and vision subsidiaries, however, produced positive operating results that offset losses in the health insurance business, helping the company achieve a gain in net income that can be used to support corporate mission activities.

As investments to support Highmark's corporate mission, the key wholly owned, for-profit insurance subsidiaries (UCCI, KHPW, HVHC, Highmark Life and Casualty and HealthGuard of Lancaster) have fulfilled their stated purpose. Collectively, these five subsidiaries produced a return on investment of nearly 34 percent over the life of the investments.

Several credit rating agencies, including A.M. Best, Moody's Investors Service and Standard & Poor's have repeatedly cited Highmark's subsidiaries as an important complement to the company's core health business. In a 2002 report, A.M. Best said, "Highmark's product and geographic diversification strengthen its existing customer relationships and the quality of its earnings stream."

Marketplace and product readiness

The health insurance industry has consolidated significantly in the past decade. As a result Highmark today competes with much larger, diversified publicly traded companies that have access to wider sources of capital and can offer entire portfolios of insurance products. Highmark's for-profit subsidiaries help it meet marketplace expectations.

Employers increasingly are looking for a one-stop source to meet all of their employee health benefit needs. The for-profit subsidiaries help Highmark compete for mid-sized and larger customers – Pennsylvania-based companies and those with operations in multiple states. And by bringing out-of-state revenues into Pennsylvania, Highmark's for-profit subsidiaries contribute to the economic vitality of the Commonwealth, and to the communities in which they operate.

Testing ground for innovation

Highmark's health insurance subsidiaries have served as testing grounds for programs to produce more cost-effective, high quality medical care. KHPW and HealthGuard have been industry leaders in developing quality improvement programs to treat chronic medical conditions. Other Highmark subsidiaries focus on programs or services complementing Highmark's mission.

Administrative services to the parent company

Some of Highmark's for-profit subsidiaries, such as Highmark Life and Casualty Group, have provided administrative services to the parent company, thereby creating greater operating efficiencies. Other subsidiaries have performed strategic functions to allow Highmark to continue to promote affordable, quality health insurance products. For example, subsidiaries Alliance Ventures, and Insurer Physician Services Organization, were developed at a time of provider consolidation in the market, as a means to assure that Highmark's members would have access to necessary, quality primary care physicians.

THE ECONOMIC IMPACT OF THE SUBSIDIARIES

Highmark's subsidiaries have a tangible impact on the economy of the state. They employ thousands of Pennsylvanians in the western and central regions of the Commonwealth. The growth of UCCI, for example, has added more than 1,000 jobs in the Harrisburg area alone.

These subsidiaries have increased the tax revenues in the communities in which they operate, and the insurance company subsidiaries have paid premium taxes that contribute to the Commonwealth's general fund. In the past three years the key health insurance subsidiaries have paid over $56 million in state and local taxes in Pennsylvania.

SUMMARY OF ROLE OF SUBSIDIARIES

Highmark is facing enormous challenges that will severely test its ability to fulfill its corporate mission moving forward. Demographic, economic, social and technological forces are reshaping the health insurance industry, at a time when consolidation of large health plans are producing fewer but better financed companies against which Highmark will compete. New forms of health insurance are emerging, as illustrated by the movement to consumer-directed health plans. The recently passed Medicare reform legislation will usher in a wave of new insurance programs for the senior population.

Notwithstanding these changes, Highmark remains committed to its mission, as it has for 65 years. Health insurance will remain Highmark's core business and the centerpiece of its mission. The company, however, will need substantial sums of capital for the requisite infrastructure improvements to compete in the health insurance market of tomorrow.

Highmark's for-profit, wholly owned subsidiaries can serve as a vital source of capital to compete in this changing marketplace. They are critical to Highmark's financial success in the future, making it possible for the company to continue to fulfill its corporate mission.

Contribution of For-Profit Subsidiaries

As noted previously, Highmark's wholly owned for-profit subsidiaries contribute to Highmark's financial health and soundness, generating capital through return on investments, or by providing administrative services.

Highmark's for-profit subsidiaries make the following contributions:

- They are investments;
- They provide for diversification of income sources;
- They position Highmark to compete with larger publicly-traded companies that are highly diversified;
- They position Highmark to respond to customers' requests and expectations for full-service insurance offerings;
- They serve as important testing grounds and innovators of quality initiatives;
- And some provide administrative services to the parent company.

Two of Highmark's key wholly owned subsidiary companies - Keystone Health Plan West (KHPW) and HealthGuard of Lancaster Inc. – provide managed care health care coverage to Pennsylvanians in the 29 counties of western Pennsylvania and 10 counties of central Pennsylvania respectively. Other key wholly owned insurance company subsidiaries offer products complementing our core health business in Pennsylvania - dental, vision, and life and casualty insurance product offerings. They also strategically position us as a strong, vital choice of large employers with multi-state employees and presence through national marketing.

Highmark's wholly owned insurance subsidiaries provide quality coverage to insured and self-funded customers. Their commitment to quality outcomes has led to important program savings through better medical management in both our customer's programs, as well as in the important public programs we administer: such as the state's Children's Health Insurance Program (CHIP) and the federal government's Medicare Advantage programs administered by KHPW, and the military family TRICARE Dental Program administered by UCCI.

Highmark's dental and vision subsidiaries also contribute to Pennsylvania through the robust network and access to affordable supplemental coverage made available to customers, as well as through their administration of such supplemental benefits in coverage for CHIP and HealthyChoices enrollees. Highmark's life subsidiary also provides administrative and COBRA services to customers, facilitating the important continuation of coverage that program provides. Some of Highmark's other subsidiaries provide information and management systems to foster improved outcomes and closer affiliations with the provider community.

Highmark's subsidiaries also contribute to their communities. In the past three years Highmark's key wholly owned insurance companies have contributed over $56 million in state and local taxes in Pennsylvania.

Highmark and its predecessor companies have been and continue to be strong, solvent companies. Highmark's for-profit insurance subsidiaries have contributed to its surplus, permitting Highmark to continue to focus on access to affordable quality health insurance, offering highly subsidized rates and coverage in guarantee issue direct pay programs, including the Special Care program to low-income Pennsylvanians, and the Caring Program for Children.

None of the subsidiary activity has taken our focus away from our commitments – and most of the subsidiary activity has been directly related to high quality administration and delivery of our programs (see ATTACHMENT on Historical Diversification). Our subsidiaries have provided opportunities to act as incubators of innovation and as testing grounds for pilot programs and functions that have often been adopted later by the parent company. For example Health Related Services was an early medical management company.

Highmark's diversification strategy has resulted in additional revenue streams. Additionally, attractive for-profit companies can also provide the option for obtaining necessary revenue through the sale of such subsidiaries if necessary. Thus, they can serve as an important "capital reserve" that contributes to the financial strength and stability of the parent company.

And finally, and most importantly, our subsidiaries contribute to Highmark by positioning Highmark to attract customers as a full service insurance company, and by contributing to the maintenance of necessary surplus that permits us to continue our mission of providing access to affordable, quality health care enabling individuals to live longer, healthier lives.

Historical Diversification

A Look Back At Highmark's For Profit Subsidiaries

These key historical milestones of Highmark operations (or its predecessor companies Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield) provide a helpful overview of the value of Highmark's diversification over the years. Some have argued that Highmark's subsidiary activities have occurred at the expense of the parent company subscribers. However, a review of the history of activity tells a different story.

The scope of innovative health programs and planning undertaken by Highmark over the changing years of health insurance market change and challenges is illustrative. The history shows that Highmark has engaged in a host of not-for-profit activities and ventures, as well as for-profit activities accruing to the benefit of the parent company. Key health related developments and investments were established through the following:

1982 Keystone Health Plans Inc.
1984 Health Related Services Inc.; Pen-Wel Inc.
1985 Western Pennsylvania Caring Foundation; Blue Cross Blue Shield Caring Program for Children; Penn Western Agency
1986 Keystone Health Plan West; Health Education Center
1987 Keystone Ventures Inc.
1988 Diversified Benefit Services Inc.; Fifth Avenue Place; Health Promotion Services
1989 Inter-County - Blair Mill Administrators and HealthGuard of Lancaster
1990 Alliance Ventures Inc.; Trans-General Life Insurance Company, Promises Kept, Inc.
1992 Gateway Health Plan
1993 National Institute for HealthCare Management; Keystone Health Plan Northwest
1994 Comp Services Inc.; United Concordia Companies, GroupAmerica Insurance Company; Insurer Physicians Service Organization; Green Spring Health Services Inc.
1995 Center for Health Care Quality and Pennsylvania Blue Shield Institute
1996 Pittsburgh Center for Grieving Children; Davis Vision; Trans-General Life Insurance Company of New York
1997 Sale of Eastern Pennsylvania managed care business netted $274 million
1998 Mountain State Blue Cross Blue Shield affiliation
1999 Preservation of Allegheny General Hospital
2000 Lifestyle Advantage, LLC
2002 Community and facility program grants and loans; new Children's Hospital of Pittsburgh
2003 Sale of Keystone Health Plan Central, new equity position in Fischers/Medmark specialty pharmacy business

HIGHMARK INC.

Need for Statutory Surplus
and
Development of Optimal Surplus Target Range

May 21, 2004

Richard A. Kipp, M.A.A.A. **Ronald G. Harris, F.S.A.**
Frank J. Cestare, F.S.A.

Milliman USA

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I. OVERVIEW

A. Background and Scope

General. Adequate surplus is central to the viability and sound operation of any insuring organization. It is needed to enable a company like Highmark[1] to ensure that the promises and commitments made in offering health care protection to its customers, directly and through its subsidiaries and affiliates, can continue to be met. It is also needed to ensure that its promises and obligations to hospitals, physicians, and other providers can be met. Further, surplus is needed by a company like Highmark to develop new products, maintain and operate complementary services and coverages, build infrastructure, respond to new business opportunities, develop and maintain service capabilities, and generally operate effectively as a viable ongoing business entity over time.

Highmark has committed itself to a corporate mission to "provide access to affordable, quality health care enabling individuals to live longer, healthier lives." This is an important factor with regard to the platform on which the company plans and builds for the future. It means that Highmark must always keep itself in a position to meet the promises and commitments it has made, under whatever circumstances (anticipated or unforeseen) may arise. It also means that Highmark must continue over time to offer health care coverage products that customers voluntarily choose to purchase.

In order to fulfill its corporate mission, Highmark must be stable and strong financially. It must systematically build and maintain sufficient statutory surplus to remain viable over time, while competing in a market against strong regional entities and very large national managed care companies. These national competitors, in particular, have enormous financial and technological resources, extremely large enrollment bases over which to spread overhead costs, and the ability to diminish participation or withdraw from Highmark's markets as they see fit. Highmark

[1] The term "Highmark," as used in this report, refers to Highmark Inc. and its subsidiaries, affiliates and related parties, as an overall enterprise, unless specifically indicated otherwise. For historical periods, this includes all predecessor companies, including Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield.

should never underestimate the difficulty of fulfilling the commitment made in the company's corporate mission.

Financial strength for Highmark, under these conditions, requires ever vigilant attention to the fundamental financial elements of the health insurance business. Principal among these elements are adequate rates, competitive costs (medical costs and administrative expenses), and strong statutory surplus. Inadequate performance over time with regard to any of these three elements is almost certain to lead to failure in meeting Highmark's corporate mission and commitments, and to failure to sustain itself as a viable business.

Pennsylvania Insurance Department Request Regarding Surplus Levels. In its Notice 2004-01 issued January 17, 2004, the Pennsylvania Insurance Department (PID) requested certain information from Highmark regarding its reserve and surplus levels. Certain aspects of this Notice were modified or clarified at a subsequent hearing on the Notice. Two of the items requested by the PID, with regard to which we were asked by Highmark to assist in formulating the company's response, were (i) a suggested maximum surplus range within which to operate, using Risk Based Capital (RBC) or another methodology, and (ii) a proposed business plan explaining how surplus maintained in excess of the suggested maximum range should be distributed.

The development of an optimal surplus target range within which to strive to operate under normal circumstances is an important undertaking for a company such as Highmark, as a matter of prudent business practice and planning. It should be updated periodically, to reflect fundamental changes in operations and the environment. Although perhaps not completely unprecedented in concept, the establishment of a maximum surplus level – beyond which a portion of Highmark's assets might be distributed by the company to other parties (not stock shareholders or mutual insurance company policyholders) – is an unusual action, in our experience. Such a step has legal, philosophical, and financial ramifications for the company. This report is not intended to explore these ramifications, other than to outline certain principles that we believe should be followed in addressing amounts above some predetermined threshold level for the company's surplus, in a manner to protect the financial soundness and ongoing viability of the company.

Scope of This Report. This report has been prepared by Milliman at the request of Highmark. The purpose is to address the need for statutory surplus for Highmark (including its subsidiaries and affiliates) and to quantify an optimal surplus target range within which we believe Highmark should strive to operate, under normal circumstances. We understand that the upper end of this range may be considered as constituting a level beyond which surplus amounts are potentially unnecessary to serve the risk-taking and business needs of the enterprise and, if so, that action may be taken to distribute such amounts.

In order to develop an optimal surplus target range, we used actuarial projection techniques. We characterize the output of this form of analysis as "pro forma projections." They show the financial results that could be expected if actual operations were to occur exactly as stated and assumed, with no deviations. These pro forma projections are intended to serve as demonstrations of the impact of the stated assumptions within a scenario, relative to alternative assumptions and scenarios, so as to enable an understanding of the actuarial implications of the scenario assumptions. The pro forma projections are not intended to be predictions or forecasts of what the future will hold as actual circumstances emerge and contingencies arise. Actual future financial outcomes will undoubtedly vary, potentially in a material way, from any particular pro forma projection scenario.

This report has been prepared for the exclusive use of Highmark, to help its management and Board of Directors formulate intermediate and long-term financial and business plans for the company. The material contained in it will not necessarily apply to any other situation or set of circumstances, and may not be appropriate for other than its stated purpose. To conduct our analysis, we relied on a variety of confidential and proprietary data and information provided by Highmark staff. We did not audit the material we received, although we did review the data for general reasonableness. However, if there are any substantial inaccuracies in the data, the results of our analysis may likewise be substantially inaccurate.

We understand that Highmark may wish to share this report with the PID and others. We hereby grant permission, so long as the entire 54 page report is provided.

B. Approach Taken by Milliman

As indicated above, the purposes of this report are to address the need for statutory surplus for the Highmark enterprise, and to quantify an optimal surplus target range within which we believe Highmark should strive to operate under normal circumstances. The need for surplus is addressed specifically in Section II, and throughout the remainder of this report.

The approach to developing an optimal target surplus range for Highmark is documented in Sections III-VI. It begins in Section III with a discussion of minimum surplus requirements, which create a floor for our analysis and development.

Sections IV and V describe alternative bases for establishing the amount of provision to be made against risk of loss and other contingencies. Section IV presents historical operating loss results for the industry as a whole, for Highmark, and for a comparison set of Blue Plans. This data provides an empirically-derived basis for making provision against future multi-year adverse loss periods. Section V addresses specific risks and contingencies, enabling their quantification and combination through Monte Carlo simulation. The result is an alternative approach to making provision for loss periods, based on risk assessment rather than actual historical operating results. Together, these two alternative approaches help to form a range of multi-year operating loss levels, against which Highmark's surplus needs to provide protection for the company. Section VI then applies the loss levels developed in the preceding two sections using pro forma financial projections, in order to determine the amount of surplus needed by Highmark to operate under normal circumstances as a viable company.

Section VII discusses briefly what we believe to be the key principles to consider if Highmark or others were to treat the upper end of the optimal surplus target range as an indicator of a potential maximum. These principles are particularly important if consideration should be given to reducing the company's surplus by distributing assets that are determined not to contribute to the well being of the company and those who rely on it.

II. SURPLUS NEEDS AND USES

A. Business Environment

Continued change has been, and will continue to be, a predominant characteristic of the U.S. health care industry at large. This is driven, at least in part, by the fact that today in most areas of the country the health insurance market is increasingly dominated by aggressive and highly competitive regional and national managed care companies. In order to remain viable, a health insurer must anticipate and respond to this ever-changing competitive environment. Doing so requires substantial capital resources and surplus.

The business environment of tomorrow is certain to differ markedly from that of today. Some directional changes – such as continued advances in technology and competitive pressures from consolidation and scale of operations – can be generally anticipated. Other fundamental environmental changes simply cannot be known at this time. The continued viability of a company like Highmark will require that it have the foresight, savvy, and resources to both anticipate and respond effectively to such changes.

Competitor Consolidation and Scale. Perhaps the most noticeable change in the health care industry over the past decade has been the unprecedented consolidation of even sizeable insurers and managed care plans into large and jumbo-sized companies. Most commercial life insurance carriers – stock and mutual companies – have withdrawn from the health insurance market, selling their sizeable blocks of business to the few remaining managed care companies. Likewise, a large proportion of HMOs have gone through mergers or acquisitions, producing an ever smaller number of increasingly larger surviving entities which operate regionally and nationally; and significant consolidation is occurring within the Blue Cross and Blue Shield system.

The capital resources of these new competitors tend to be enormous. Such resources enable them to invest in new, leading technologies and to aggressively build and contract with provider networks. It gives them negotiating clout, risk-spreading capacity, and funding for market acquisition. A large scale of operations also enables them to spread overhead costs more effectively.

Role of Technology. Virtually every segment of our economy is being bombarded with technological change. Not only is every aspect of the way business operates changing, but what businesses do as a result of new technology-driven capabilities continually changes as well.

The inherent natures of medical delivery and of health care financing place a high degree of importance on communication, data gathering and processing, testing and analysis, and information feedback among these activities. Health insurers must stay near the forefront in terms of the effective integration of communication, information processing, and computing technology. This requires capital investment, which has become virtually continuous with the rapid development and obsolescence of technology.

Care Management Evolution. Care management strategies and programs come in a number of forms today, but virtually all health care coverage is "managed" in some manner. This was initiated, at least in part, by the public acceptance of and dramatic growth in HMOs during the past 10-20 years. Today, care management can be considered more appropriately in terms of the nature, form, and extent of the clinical and financial management involved in whatever health care products are found in the local market, rather than in terms of the enrollment in any particular product type.

The clinical and financial management of care has not only expanded, it has evolved. This has been driven, at least in part, by a blend of consumer and provider pressures and advances in information technology. As technology has enabled the detailed analysis of financial and member information, the industry has begun to manage and evaluate the delivery of medical services against protocols and benchmarks derived from a combination of cost and quality factors. This new direction for the industry is also being driven by factors such as the rapid introduction of new drugs and therapies, including the use of member direct marketing strategies.

Simply keeping pace with these kinds of changes, let alone playing a leadership role in the market, is a daunting challenge for every major health insurer. Core competence, corporate capabilities, and support systems in the clinical and financial management of care must be re-established and overhauled every few years. This requires the maintenance of strong business and professional leadership, a depth and breadth of clinical management resources, and astute financial thinking. It also requires ongoing capital investment, which at times may be substantial.

Competitive Market, Small Operating Margins. With the exception of certain brief periods and certain atypical geographic areas, operating margins (i.e., the excess of premium over claims and expenses) for health insurers generally have been remarkably low over time. A notable exception historically was the early 1990s, when certain aggressive, publicly traded managed care companies achieved substantial gains for a number of consecutive years (at least in part through favorable risk selection). Even then, the primary source of sizeable profit growth for many publicly traded HMOs was through mergers and acquisitions.

The health care coverage market continues overall to be price sensitive. From time-to-time and from place-to-place, price and operating margin pressures ease somewhat for brief periods. However, the pervasive ongoing outlook is for strong competition, enabling only modest levels of sustainable operating margins. Two direct implications are that (i) a pattern of consistent gains year-after-year for any extended period is rarely achieved without loss years interspersed throughout, even for a well run insurer, and (ii) full recovery from a period of substantial and prolonged losses is very difficult without radical actions. These point to the importance of financial "staying power" – sufficient surplus or other sources of equity capital to recover from cyclical downturns and unexpected adversities.

Competing in the Market as a Not-For-Profit Company. Highmark is a not-for-profit health insurer offering health care products in its licensed service areas, directly under the Highmark Blue Cross Blue Shield and Highmark Blue Shield brands as well as through Keystone Health Plan West, Inc. and HealthGuard of Lancaster, Inc., its HMO subsidiaries. It also offers a range of insurance and related services through other subsidiaries and affiliates, which complement its core health insurance products.

The corporate mission of Highmark, as stated earlier, is to "provide access to affordable, quality health care enabling individuals to live longer, healthier lives." To fulfill this mission, Highmark must compete successfully in the market against all competitors who elect to enter, whenever they choose to do so. It must not only sell its health care coverage products to willing customers, but it must do so on a basis which can be sustained indefinitely.

A significant requirement of meeting this mission and competing effectively is to maintain sufficient equity capital resources. Highmark, as an enterprise, faces the same insuring and business needs for equity capital as its major competitors – for-profit or not-for-profit. Since it is not owned by shareholders, it has no access to equity capital other than its surplus. This necessitates both the maintenance of a strong surplus level, and the cautious management of that surplus. Failure to do so would jeopardize the entire foundation of Highmark – including its future viability, and therefore its ability to reliably and sustainably provide access to affordable and quality health care.

During the normal course of business, Highmark contributes substantial amounts to charitable activities, including particularly those that address medically and economically disadvantaged individuals. Our understanding is that the company attempts to do so in a way that it can reasonably anticipate future funding levels, ensure the provision of such funding, and sustain its level of charitable activity and support over time. Undertaking these charitable activities should not be considered contrary to the prudent financial management of the surplus of the enterprise. The successful financial operation of Highmark, including management of its surplus, is essential if the company is to be counted on to continue to undertake its historical level of support for charitable activities.

Access to Capital. Historically, most health insurers were mutual or not-for-profit companies. The surplus held by such companies comes largely from accumulated operating gains and investment income. Today, most of the major national health insurers and managed care companies, as well as many regional ones, are publicly traded stock companies. This affords them long-term access to equity capital markets for risk-taking, operational development, or growth needs – in addition to their accumulated operating gains and investment income (i.e., in addition to their surplus).

The magnitude of the funds involved in the equity capital markets for publicly traded health insurers and managed care companies is very large, relative to the surplus of such companies accumulated from operations. The excess of their market value over tangible net worth (a rough proxy for surplus) represents additional equity capital value to which the company can gain access for various purposes, if necessary. Clearly, this is a major financial advantage which these for-profit companies hold in access to equity capital.

Catastrophic Risks. Virtually all types of insuring entities in today's world face the risk of certain catastrophic events occurring. Such events, by definition, have a low probability of occurring and very severe adverse financial consequences. For health insurers such as Highmark, potential catastrophic events range from the impact associated with terrorism, to epidemics or pandemics, to natural or other disasters, to extraordinarily high damage awards from major class action or other litigation.

Because of the low probability of particular catastrophic events occurring, and their changing prospects and nature over time, it is not unexpected that a company would not have actually experienced an occurrence of the sort of catastrophic event for which it is presently at risk. Failure of the insurer to provide protection against such risks, however, means that the company is exposed to ruin or incapacity from such an event. More importantly, it means that the company does not maintain the resources to protect its subscribers and members, its providers, and its vendors against catastrophic loss – should such an event occur. Prudence regarding fundamental soundness and assuring ongoing viability dictates a meaningful level of surplus protection against such events.

B. Surplus and Risk-Taking Capital Needs

The surplus for a Plan like Highmark is the equity capital (excess of assets over liabilities) available to ensure the future viability of the company. Ensuring future viability recognizes (i) the possibility of adverse financial results and of unexpected events occurring, (ii) the periodic need to provide for extraordinary health care development costs or investments in support of the company's operations, and (iii) the capacity necessary to enable reasonable growth.

The overall surplus needs of a not-for-profit Blue Cross Blue Shield Plan include all of these considerations – risk capital, funding of health care development costs, and growth capital. All of Highmark's risk-taking capital needs created by the varying risk characteristics of its business and all other immediate needs for equity capital must be met by the company's surplus.

To ensure the future viability of a health insurer requires recognition of all of the kinds of adverse financial results and unexpected events or circumstances that might occur. Some of these adverse results and unexpected occurrences are directly related to the types of insurance risk assumed by the company through the normal course of conducting its business. Other types of risk pertain more generally to various aspects of the operation of the company – including fluctuations in expense levels, fluctuations in interest rates and asset values, and various business risks. Finally, risk is associated with a variety of catastrophic events that might occur, and that a company like Highmark must be prepared to withstand.

Broadly speaking, these risks represent the adverse cyclical results and the contingencies or unexpected occurrences faced by a health insurer in the day-to-day conduct of its business. The term risk capital can be used to refer to the level of surplus needed by the company to prudently manage and absorb these risks.

Maintaining an adequate level of risk capital is necessary for a health insurer in order to ensure that provision is made for all of these risks assumed by the company. Without adequate risk-taking capital of its own, a health insurer is faced with a small number of potential alternatives. They may include:

- permanent equity capital infusion from an external source (not generally available to a not-for-profit insurer, other than possibly as part of a merger or acquisition).

- temporary equity capital infusion from an external source, such as a surplus note (which may or may not be available or affordable, and which usually has significant strings attached, typically involving loss of some or all of the control of the Board of Directors).

- transfer of risk to another entity with adequate risk capital (which may or may not exist or be feasible), and the loss of control that might accompany such a shift.

- compensation for inadequate surplus by immediately charging extraordinarily high premium rates for the company's products (difficult, if not impossible, in a competitive and closely regulated market), to eliminate as much as possible the risk of future losses.

- compensation for inadequate surplus by immediately taking inordinately deep cost cutting actions, to mitigate as much as possible the risk of future losses.

Some of these potential alternatives may not be feasible, and none of them is likely to come without serious ramifications. Specifically, extraordinarily high premium rates or inordinately deep cost cutting actions cannot be made in a vacuum; they may have severely adverse effects such as significant enrollment losses due to uncompetitive pricing or poor customer service.

C. Use of Capital for Development and Growth

An additional need for surplus is the funding of health care development costs or operational capacity (infrastructure) investments. These might be improvements or innovations such as new product development; periodic revamping of delivery system networks, reimbursement structures, or management of utilization; or development or acquisition of new communications, information, or processing systems. Such investments must be made periodically, and the corresponding costs incurred, if the company is to be successful in the health insurance business. Often such capital expenditures do not produce hard assets that can be admitted on the company's statutory balance sheet. This means that such expenditures generally must be absorbed immediately out of surplus.

Growth and expansion is a major goal for most successful business entities operating in a competitive market. This requires the presence of market opportunity, plus the resources necessary to pursue growth from such opportunities. Growth can be achieved directly through day-to-day competition in existing markets, through entry into relatively new markets, or through long-term affiliation in existing or new market areas. Examples at this particular time include new consumer oriented product demands and opportunities, and expansion of insured products to the senior market under Medicare reform.

Developing and absorbing growth requires growth capital to fund developmental costs, to cover the initial losses resulting from the need to be price-competitive at the outset in order to become established, to absorb any losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in surplus). Obviously, a prerequisite for financially sound growth for a not-for-profit health insurer is strong surplus.

III. MINIMUM SURPLUS REQUIREMENTS

A. Background

In the wake of various insolvencies (and near insolvencies) around the country in the not-too-distant past, attention has been directed at minimum standards for the surplus of managed care organizations generally, and of Blue Cross and Blue Shield Plans specifically. Historically, individual states had done little to effectively monitor the financial condition of such organizations and to detect organizations that were becoming troubled financially, prior to the immediate threat of insolvency. Notwithstanding any differences of opinion among parties with regard to appropriate thresholds for minimum surplus levels, the common theme of this growing industry and regulatory attention has been ensuring adequate minimum levels of surplus to protect against organizational insolvency, thereby protecting the insured members from loss.

For a number of years, the Blue Cross and Blue Shield Association (BCBSA) has required that all BCBS Plans calculate Plan-specific measures related to solvency, and that a Plan's surplus not fall below certain thresholds relative to such measures. This process has been part of the BCBSA membership requirements; and compliance has been necessary in order to maintain good standing and retain use of the trademark.

Over time, the Association's minimum requirements became formalized in the form of Capital Benchmark formulas and calculated values. With the development and adoption of Risk Based Capital (RBC) formulas and standards for managed care organizations by the National Association of Insurance Commissioners (NAIC), BCBSA likewise adopted RBC as the foundation for its own membership requirements (effective late 1999).

The RBC mechanism is now widely recognized as a standardized approach to developing minimum solvency indicators. Calculated RBC values are required for inclusion in the NAIC annual financial statements filed by health insurers; and most States (including Pennsylvania) have adopted the NAIC's RBC-based compliance standards to help assure that health plans meet minimum requirements for solvency. The RBC methodology provides for the calculation, by

detailed formula, of a benchmark or reference value, multiples of which are used to establish standards for external monitoring and intervention.

The use of RBC as a methodology, and the values calculated from it, obviously have significant limitations. The RBC formula is a structured and mechanical approach to trying to capture and quantify the risk characteristics for a wide range of different types of companies operating in a variety of environments, with changing circumstances over time. As a structured and mechanical formula that attempts to address complex matters, it necessarily contains elements that are judgmental. Nonetheless, it serves a highly useful purpose in identifying companies whose surplus levels may be precarious, and therefore warrant careful scrutiny. Such scrutiny cannot be applied in a meaningful way, however, without a detailed examination of company conditions and circumstances by knowledgeable professionals experienced in the field. Because of these factors, the principal and most important role of calculated RBC values is to serve as a screening or flagging mechanism, to indicate potentially serious situations that may warrant undertaking more thorough and comprehensive evaluations.

The RBC formula was designed and developed for identifying companies that may be facing the prospect of impending insolvency. At such a point, all efforts (internal and external) should be directed at stabilization and financial rehabilitation, in order to prevent going out of business. The RBC formula does not address needs associated with ongoing business viability and success. In developing an optimal range for a company's surplus, as opposed to a minimum threshold for solvency monitoring, surplus needs for matters not contemplated in the RBC formula must be considered and addressed.

B. Minimum Capital Thresholds

The use of Risk Based Capital (RBC) measurements is intended to provide a systematic approach to developing benchmarks for individual companies for use in monitoring minimum levels of statutory surplus needed for protection from insolvency. As indicated above, the RBC formula adopted by the NAIC for managed care organizations (including Blue Cross and Blue Shield Plans) provides an objectively calculated reference value that can be used for this purpose. Although far from perfect, it does recognize a company's size, structure, and volume of retained risk. It also incorporates elements that address underwriting or insurance risk, asset risk associated with affiliates and otherwise, and various forms of business risk.

The key reference value developed by the RBC formula is termed the "Authorized Control Level" (we refer to this as RBC-ACL). Multiples of the RBC-ACL (e.g., 800% of RBC-ACL) can then be used to establish thresholds, with higher multiples producing an increased likelihood of security against insolvency.

This use of consistently calculated reference values, along with various multiples for different purposes or degrees of concern and security, provides a useful tool for State regulators and industry organizations (such as BCBSA). Key RBC threshold levels applicable to Highmark are described below[2]. Also indicated are the actions associated with these key RBC-based levels, along with equivalent measurements of them in terms of percentages of annual premium.

Consistent with an overall enterprise perspective, we have analyzed the operating characteristics of Highmark and its subsidiaries as an overall, combined entity. This is not unlike viewing the respective segments of insurance business within Highmark and its subsidiaries as if they were lines of business within a single insuring entity.

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[2] All surplus and related financial items addressed in this report are on a statutory basis, unless indicated to the contrary. Further, consideration of historical operating results and surplus requirements is on a "combined" basis across the enterprise, reflecting Highmark's proportionate share of any jointly owned entities or related parties.

BCBSA Minimum RBC-Based Thresholds. BCBSA maintains certain minimum financial requirements that Blue Cross and Blue Shield Plans must meet, as part of the membership standards for use of the trademark. Two key thresholds involving surplus are based on the RBC formula, and are expressed generally as follows:

BCBSA Threshold	Percent of RBC-ACL
Early Warning Monitoring Level	375%
Loss of Trademark Level	200%

Commonwealth of Pennsylvania RBC Requirements. The Commonwealth of Pennsylvania has adopted statutory minimum requirements for the surplus levels of commercial health insurance companies, nonprofit hospital service corporations, and HMOs domiciled in the State (Section 501-B(40 P.S. §221.1-B)). These minimum requirements are expressed in terms of a company's RBC-ACL level, and are generally consistent with the corresponding standards recommended by the NAIC and adopted by most states around the country. Upon triggering the 200% of RBC-ACL threshold, a domestic insurer must formally notify the Pennsylvania Insurance Commissioner of the corrective actions it plans to take. Direct regulatory interventions are triggered if surplus drops to even lower percentage levels.

As indicated above, 200% of RBC-ACL is the threshold for mandatory corrective action plan notification by domestic insurers to the Pennsylvania Insurance Commissioner. The 200% of RBC-ACL level is also the threshold at which a Blue Cross and Blue Shield Plan loses the use of the trademark. Stated in terms that may be more intuitive to grasp, 200% of RBC-ACL equates to just over 8% of annual claims and administrative expenses for the Highmark enterprise, or about 4 weeks' worth.

The loss of trademark due to inadequate financial strength would likely be a catastrophic event: if the trademark were lost the remaining organization, and more importantly its Pennsylvania subscribers, would lose the breadth and strength of the Blues' system. Product recognition, favorable reimbursement rates out-of-area, and a level of service that is often sought out by employer groups would be forfeited. Certain other financial opportunities would also be lost as a result, such as the ability to offer benefits to certain large national accounts and the Federal Employees Health Benefits Program and the access fees for offering Highmark's network to other Blue Plans. Furthermore, removal of the trademark due to financial weakness would open the door to the entry of a non-Pennsylvania replacement Blue Plan. Such an organization could potentially be a for-profit company with a very different mission than Highmark.

C. Minimum Thresholds vs. Optimal Range

The BCBSA risk capital thresholds indicated above are directed at minimum levels – specifically, early warning monitoring, and withdrawal of the trademark. Where states have adopted the RBC-based standard, the application is likewise directed at minimum solvency levels. The focus of oversight and regulatory bodies on adequate minimum surplus levels is understandable and appropriate. These bodies bear responsibility for monitoring the continuing solvency of the health plans under their jurisdiction, and for taking actions before impending insolvency and closure. They had been widely criticized in the past for not maintaining adequate minimum surplus standards or sufficient monitoring of financial strength, and for not taking timely and forceful action with regard to health plans with poor performance.

The proper focus of a financially healthy non-profit Blue Cross Blue Shield Plan, however, is on achieving and maintaining an optimal ongoing surplus level. Such a level is intended to (i) ensure the continuing viability of the company, (ii) inspire warranted confidence by groups, subscribers and providers, (iii) enable the development of competitive yet adequate premium rates for customers, (rather than needing to be excessively high, because of inadequate surplus to back them), and (iv) provide funding for long-term development costs and investments. Such a focus by company management is prudent and appropriate.

An optimal ongoing operating range for a company's surplus level clearly will be higher than the minimum level used by regulators and oversight bodies as a benchmark for warning signals against insolvency and necessary intervention. Prudent company management will focus not only on an appropriate range for its ongoing and long-term needs, but also on the avoidance of approaching levels that may trigger special external scrutiny or intervention, or that may create subscriber, provider, or public concern. Such a range, therefore, must be (i) high enough to avoid having the company's surplus falling to a level where external scrutiny is initiated, and (ii) wide enough to absorb the rises and declines in relative surplus levels that occur during the normal course of business over an extended period of time.

A maximum level for surplus, by contrast, represents the point at which additional accumulation of funds does not contribute meaningfully to furthering the goal of ensuring the future viability of the company or protecting its members. By definition, exceeding such a level does not add to the well being of the company.

IV. BUSINESS CYCLES

A. Underwriting Cycles in the Health Insurance Industry

Nature of the Business. A basic characteristic of health insurance is that the ultimate cost to the insurer of the services which will be used by the purchaser under the coverage being sold is not known at the time of sale. The insurer does not know the volume and scope of the benefits that will be used; and the actual cost of the benefits also varies depending on the provider that renders the service. As a result, the actual costs cannot be fully determined until some time after the coverage period has expired, when all claims have been submitted and processed. In providing coverage, a health insurer bears the financial risk in the event that actual costs exceed the expected cost reflected in the premiums being charged.

Operating or underwriting gains and losses are a result of the differences between premium revenue and expenses. Premium rates are established by the insurer based on assumptions as to future claim cost levels (cost of care), administrative and other expenses, and investment income, with allowances for profit and/or contributions to surplus. The most important of these components is the claim cost level, which often constitutes 80%-90% of the total premium. Although estimation and uncertainty are present for all of the premium components, uncertainty as to future claim cost levels creates the most substantial risk for the insurer.

Under normal circumstances, estimates of future claim cost levels are projected from historical claims experience, with consideration as to changes in benefits, likely rates of change for factors such as price and utilization trends, changes in health care practices and technology, impact of care management initiatives, or changes in the characteristics of the covered population. Despite continuous efforts by most health insurers to contain or stabilize these rates of change, their impact cannot be predicted with certainty.

The period of time required for medical claims to be reported, processed and adjudicated is approximately two months for typical health insurance coverages. Because of the resulting delays in measuring historical claims experience and because premium rates must be determined many months in advance of their applicable rating periods, claims must often be projected for a

period of 21 to 24 months, and even then using imperfect historical claims data. Health care costs in recent years have frequently increased at annual rates of 10% to 15%, or even higher. Therefore, the uncertainty in projected aggregate claim cost levels for even a large block of mature business can be substantial over a multi-year period of time.

When variances do occur, their timely recognition is crucial. By the time financial reports have been compiled to show underwriting results for the previous year, premium income for the current year has been largely determined through twelve-month rate guarantees that are already in place. Corrective actions taken in response to these financial reports are unlikely to yield results until the subsequent year, because of the lead time needed to implement rate changes and the development time required for cost control initiatives. As a consequence of this inherent nature of health insurance operations, multi-year periods of unexpected or unplanned gains or losses commonly arise. This tends to produce cyclical operating results for health insurance business.

Historical Underwriting Cycles. Underwriting or operating results of health insurers have been characterized historically by marked underwriting cycles, resulting in part from such delays in response time. Periods of industry-wide underwriting or operating gains have been followed by periods of losses, and then again by periods of gains.

While specific patterns have varied by company and by market segment or region, marketwide results have historically exhibited a consistent six-year underwriting cycle – three years of gains followed by three years of losses – throughout the twenty-five year period from the mid-1960s to the end of the 1980s. This is shown in Chart 1, which summarizes aggregate annual underwriting or operating gain/(loss) for all Blue Cross and Blue Shield Plans. Note that these results do not reflect investment income, nor do they reflect Federal income taxes. Comparable data available for commercial insurance companies through 1993 exhibits a similar pattern.

Underwriting cycles in the industry have been driven to a significant extent by changes in claim trends, which historically have also followed a cyclical pattern. Chart 1 also shows the pattern of health care cost trends, as represented by the Health Cost Index™ maintained by Milliman. This measure of health care cost trends reflects nationwide changes in non-Medicare health costs,

exclusive of factors affecting specific carriers such as adverse selection, shifts among product types, deductible leveraging, and changes in comparative discounts; as a result, it tends to understate the trend levels that would have been experienced by a particular carrier in one market or another. Nevertheless, it is apparent that underwriting results and health care trends have been inversely correlated.

This correlation has occurred because carrier rating practices tend to reflect past claims experience projected at recent trend levels. When claim trends increase unexpectedly, underwriting losses materialize because carrier premium rate levels have not anticipated the higher trends. Once recognized, the higher trends are considered in the calculation of future premiums, which leads to higher premium rate increases by carriers, often generating underwriting gains once trends begin to decline.

The delay involved in carriers' abilities to recognize trend and other rating parameter changes and build them into future premium rates contributes to cyclical underwriting results. Another factor, highly related, is that when recent underwriting results have been favorable the marketplace often begins to reflect optimism, which translates into relatively more aggressive pricing by competitors; similarly, after a period of losses carriers generally become more pessimistic, which translates into more conservative pricing. Further, carrier development costs and/or losses associated with the introduction of new products has compounded these results.

While underwriting cycles have long been recognized by health insurers, predicting their course has never been a simple matter -- particularly because the precise timing and magnitude of such cycles tend to vary by carrier, region, and market segment. Further, competitive pressures limit any individual carrier's ability to increase rates significantly faster than competitors.

As shown in Chart 1, the cyclical pattern of the Blue Cross and Blue Shield underwriting results for the system as a whole has changed somewhat in recent years. Beginning in 1989 these results exhibit an extended period of six years of moderate underwriting gains overall, followed by an extended period of moderate losses in the subsequent years, then with gains in the most recent four years. The experience of many HMOs was similar during this period. The extended duration of these phases represents a departure from previous cycles.

There are a number of possible explanations for this recent change in the pattern of underwriting results. Foremost is a moderation in health cost trends during the 1990's, resulting at least in part from low inflation coupled with aggressive carrier contracting with providers and significant expansion of managed care activities. In addition, many health plans had negotiated global fee schedules, and even provider risk-taking arrangements that provided some protection to the insurer against losses by transferring risk to providers. Many of these moderating factors have since diminished or disappeared, creating considerably more uncertainty and volatility for health insurers.

Considerations for the Future. A number of specific features of the health insurance business environment have changed over the course of the past 20-25 years, but the fundamental nature of the uncertainties that exist and the characteristics of the products that give rise to cyclical results still remain.

As noted in the previous section, and shown in Chart 1, the cyclical pattern of Blue Cross and Blue Shield underwriting results for the system as a whole has changed somewhat in recent years. Within the past 3-4 years, a number of specific changes have occurred that warrant consideration and ongoing attention with regard to the Highmark enterprise's need for surplus. Principal among them are:

- Reduction in managed care constraints, affecting utilization levels and trends, without incorporation of other forms of compensating controls by providers.

- Intensity of provider price and contracting pressures, due at least in part to government program cost-shifting and provider consolidations.

- Resulting high and volatile medical cost per member trends.

- Underlying market instability, produced by recent but continuing high medical cost trends.

- Legislative and regulatory mandates and compliance requirements, necessitating ongoing operational investments.

- Escalating technology support and information demands.

- Growing market pressure for new group and individual products, with stronger financial incentives for members.

- Ongoing reform of Medicare, with the opportunities and uncertainties created for health plans.

- Growing catastrophic risks, from litigation and terrorism.

The first four of these environmental factors are all contributors to, or consequences of, high and volatile medical cost trends. Historically, uncertainty as to trends, and periodic intervals of high trend levels, has contributed directly to downward business cycles. In addition, trends create "surplus strain" – not unlike enrollment growth – where the absolute dollar level of required surplus grows significantly simply because the dollar volume of business has grown.

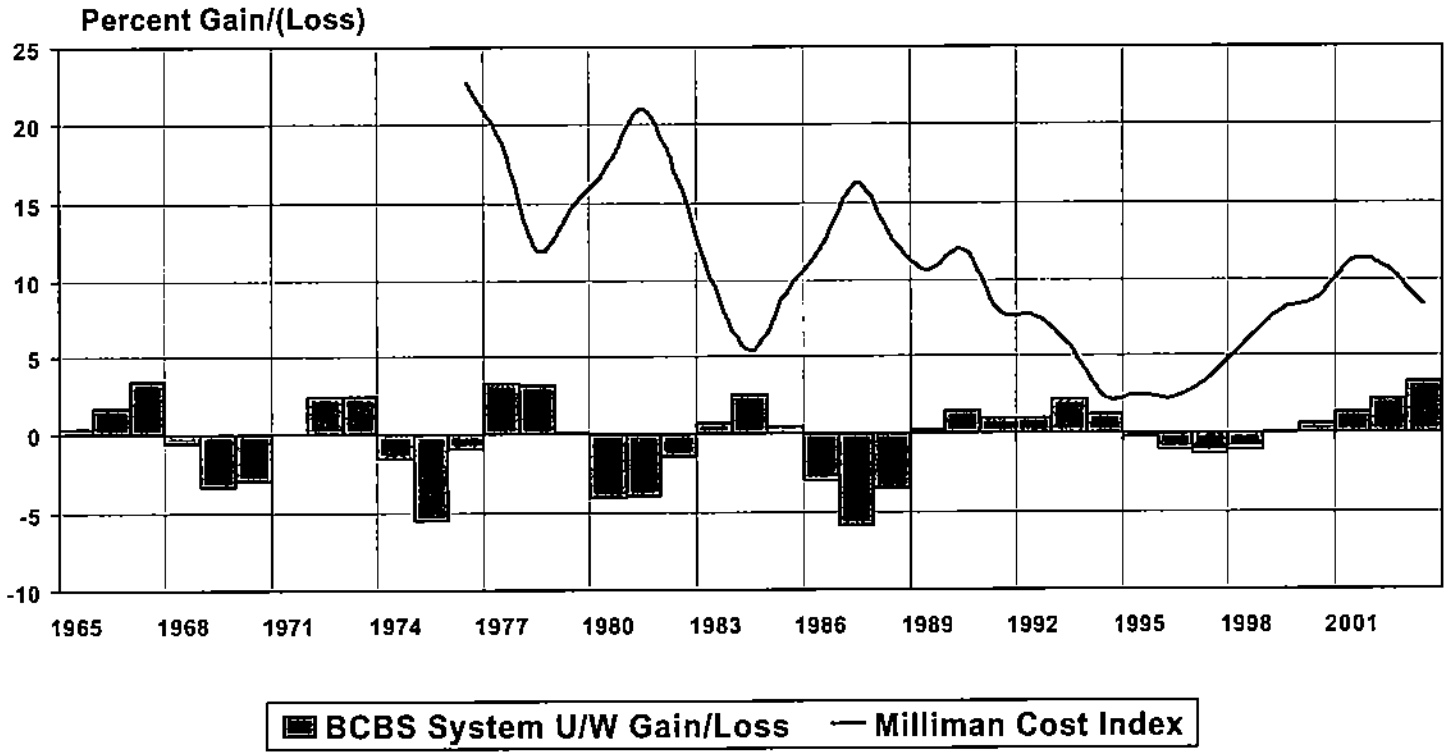
The remaining five environmental factors contribute to either significant investment needs or the risk of catastrophic loss. The pressure on capital investments for infrastructure and new products is likely to be ongoing; responses to market opportunities and pressures is essential; and the prospects for catastrophic events are heightened, in our judgment.

It is impossible to predict the form of future business cycles and whether the traditional six-year underwriting cycle will reappear at the industry-wide level, in either its previous form or some modified version. Nevertheless, the forces and factors at work serve to create cyclical financial results for a health insurer. As a result, multi-year cycles in financial results at the company level are virtually inevitable. Health insurers can take steps to minimize the impact of the

adverse part of the cycles facing them, but cyclical results are heavily driven by the basic nature of health insurance and its guarantees, and by external competitive forces. Note that trend escalation and volatility, which has historically led to adverse cycles, continues. Such volatility in trends is a reminder of the considerable uncertainties in the health insurance business, and historically has been a direct contributor to cyclical underwriting results.

Chart 1

Underwriting Cycles and Trends



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B. Adverse Operating Gain/(Loss) Cycles Experienced by Highmark

Highmark is subject to the same types of cyclical forces that drive the results for the industry overall. It is subject to uncertainty in trends, as well as to periodic cycles in the trend levels themselves. With its geographic market, and resulting concentration of business, Highmark is sensitive to this sort of risk. Once losses have begun and have been measured, Highmark then faces the same inherent delays in effecting corrections, due to the basic nature, advance notice of rates, and rate guarantees associated with health insurance. Chart 2 displays the operating gain/(loss) cycles experienced by Highmark since 1980. As can be readily seen, there were three distinct adverse cycles during this period.

The Highmark operating gain/(loss) cycles displayed in Chart 2 are shown as percentages of premium (as in Chart 1). They are shown, however, on two different bases – as percentages of total premium (insured plus self-funded) and as percentages of insured premium only. This distinction is important because the magnitudes, when expressed as percentages, differ significantly (expressed relative to total vs. insured-only premium); and the statutory reporting of premium changed for Highmark from total to insured only premium beginning in 2000.

A careful comparison of the historical operating gains and losses for Highmark (Chart 2) and for the industry as a whole (Chart 1) indicates that the timing of the favorable and adverse cycles was highly consistent for most of this historical period. In addition, the magnitudes of the cycles were generally consistent.

Chart 3 summarizes the cumulative operating losses for the three adverse business cycles experienced by Highmark since 1980, expressed as a percent of annual insured premium. Operating gain/(loss) reflects the excess of premium over claims and expenses, prior to such items as investment income and Federal income taxes; it provides a direct measure of business performance, in terms of the adequacy of premium rates (relative to claims and administrative expenses). Operating losses are shown in Chart 3 for Highmark Inc. as a separate operating company and for the combined enterprise (i.e., Highmark Inc. plus its subsidiaries and affiliates). Expressed as percentages of premium, the patterns of the operating company and the combined enterprise losses were similar in magnitude.

Each adverse or down cycle shown in Chart 3 was a distinct multi-year period of operating losses – 1980-82, 1986-88, and 1995-99. Separating these adverse operating loss cycles have been multi-year periods of gains, or upward business cycles. The three adverse cycles for the combined Highmark enterprise each produced cumulative operating losses that ranged from approximately 13% to over 18% of a year's insured premium, averaging about 15%.

It should be noted that investment income was significant in magnitude during each of these three historical operating loss cycles. This provided a meaningful offset (an average of over 3% of premium for each year of the cycle) to the impact of these adverse cycles on Highmark's surplus. Recently, however, investment income levels have been substantially lower.

Chart 2
Highmark Operating Gain/(Loss) Cycles

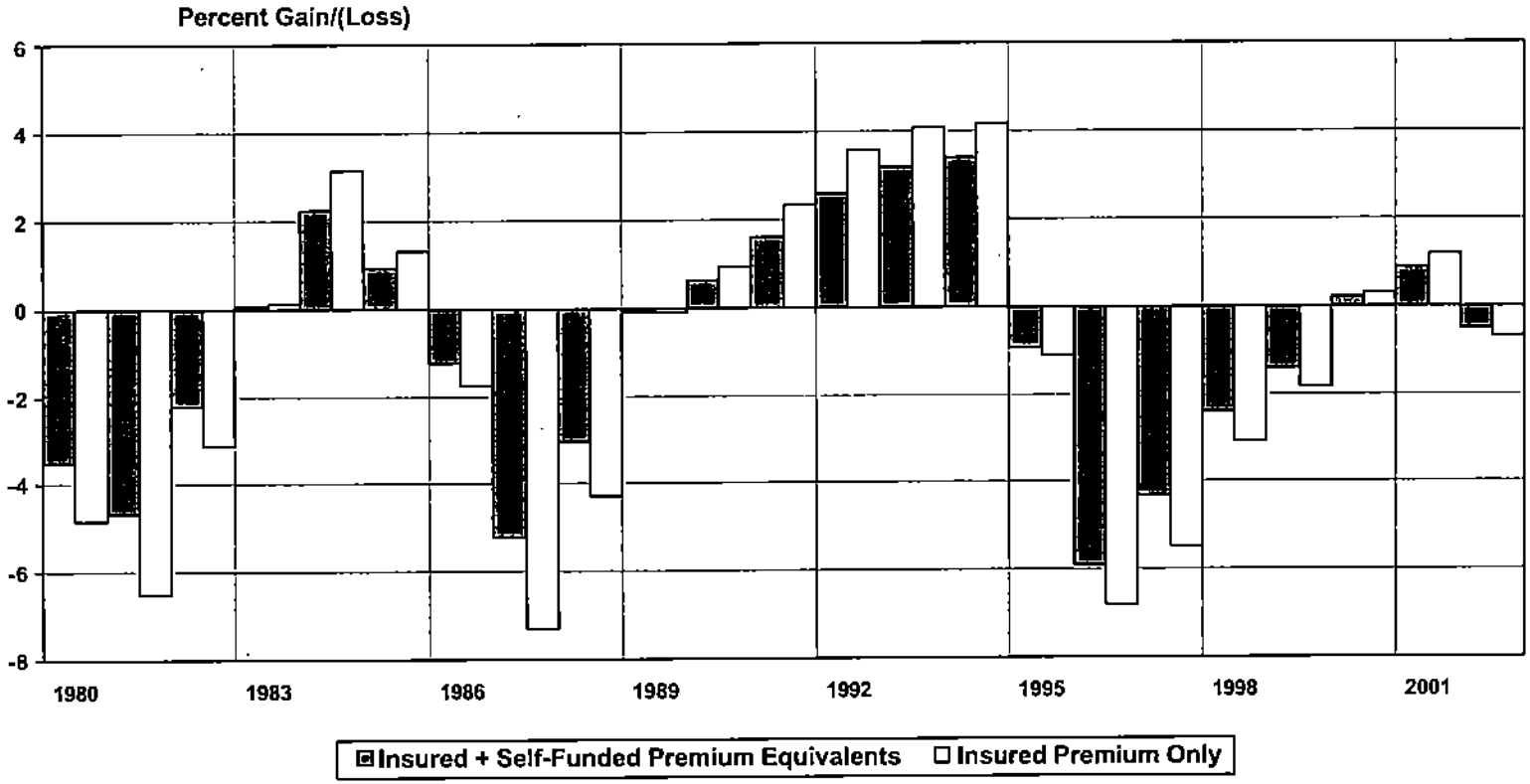

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Chart 3

Highmark Operating Loss Cycles[1]

Entity	Cumulative Operating Loss for Entire Cycle[2]			
	1980-82	1986-88	1995-99	Average
Highmark Inc.	(14.0)%	(12.6)%	(18.3)%	(14.9)%
Combined Highmark Enterprise	(14.5)	(13.3)	(18.4)	(15.4)
Combined Highmark Enterprise, excluding Keystone East & Central	(14.5)	(13.1)	(20.1)	(15.9)

Notes:

(1) Gain/(loss) expressed as a percent of insured annual premium. Excludes estimated self-funded premium equivalents for all years.

(2) Operating gain/(loss) is the excess of premium over claims and expenses, prior to investment income or taxes. Cumulative percentages are the sum of annual loss percentages, over the loss cycle indicated.

C. Adverse Cycles for a Comparison Set of Blue Plans

In order to take a closer look at adverse cycles experienced by individual companies within the health insurance industry, we compiled operating results as a percent of premium for the top (i.e., largest) nearly half of all reporting Blue Plans in the country, starting with 1980. The results are shown in Chart 4. Also shown on this chart are the results for Highmark and the overall results for the industry as a whole. Although Highmark has experienced its own unique circumstances, the similarities among Plans are apparent.

Among these 18 Blue Plans, there were a total of 52 adverse cycles during the period 1980 – 2003. Most of the Blue Plans in the set had three adverse cycles during this period, the same as experienced by Highmark. The following table summarizes the total loss percentages corresponding to the 90th, 85th, 80th and 75th percentiles of all 52 adverse cycles experienced by this set of Blue Plans.

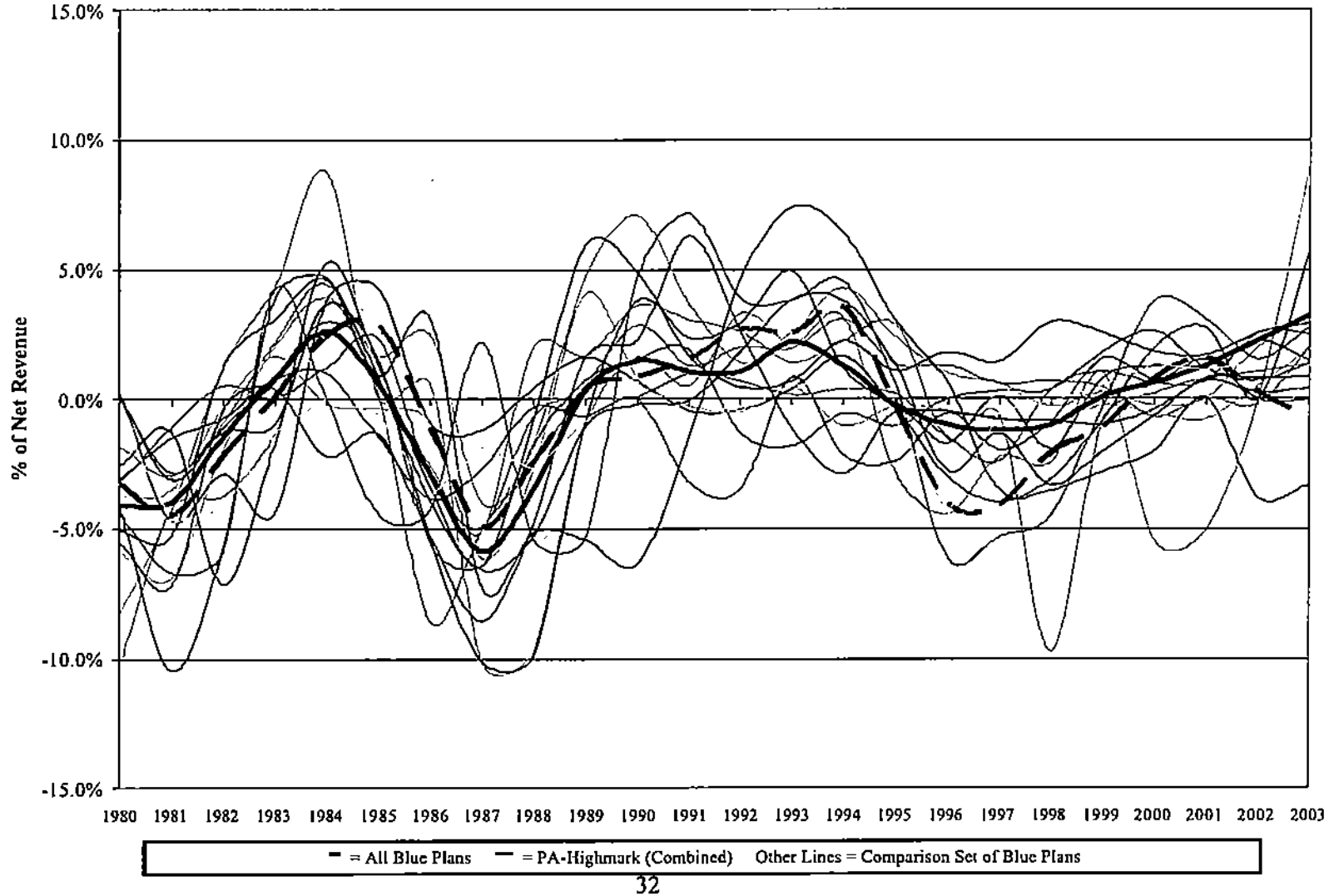
Adverse Cycle Results for Selected Set of Blue Plans

Percentile of Adverse Cycles*	Cumulative Underwriting Gain/(Loss) Percentage
90th	(22)%
85th	(20)
80th	(18)
75th	(17)

* Percentile of all adverse cycles for the period 1980-2003, among the set of 18 Blue Plans observed.

Chart 4

Underwriting Gain/(Loss) for Selected Blue Plans



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V. RISKS AND CONTINGENCIES

By observing multi-year operating results for health insuring entities – Highmark, other Blue Plans, or the industry as a whole – one can measure the combined actual impact of the risks and contingencies, including expenditures for developmental activities, faced by such entities on their operating gains or losses. In the previous section of this report, we presented such results for historical periods beginning with 1980. This provides an empirical, experience base for evaluating loss periods that carriers have had to withstand.

In this section of the report we take an alternative approach to quantifying the risks and contingencies which Highmark faces. This approach involves developing a range of possible values and associated probabilities for each of several major categories of risk and funding contingencies in Highmark's operations, for which surplus requirements need to be recognized.

A. Major Risks and Contingencies

We have identified several major categories of risks and contingencies for which surplus is required. They can be summarized as follows:

Major Risk and Contingency Category	
(1)	Rating adequacy and fluctuation
(2)	Unpaid claim liabilities and other estimates
(3)	Interest rates and portfolio asset values
(4)	Overhead expense recovery risk
(5)	Other business risks, including self-funded business
(6)	Catastrophic events, including litigation
(7)	Provision for development and growth

These categories generally follow the types of risk categories recognized in the RBC formula for managed care companies, but they further reflect components associated with ongoing viability (beyond solvency alone).

Rating Adequacy and Fluctuation. Highmark's development of premium rate increases is intended to make provision for expected trends in claims cost and utilization as well as changes in required retention components. Highmark must determine the annual trends in claims cost to use in developing its premium rates which involves a high degree of uncertainty for its overall major segments of business and, even higher, for its individual group customers or other rating pools. Similarly, variations between actual and budgeted expenses occur during the normal course of business. In addition, Highmark may be faced with an unbudgeted and yet necessary expense as a result of some unexpected event. Unfavorable variances for any of these factors require drawing on surplus.

In general, a substantial lag exists for all health insurers between a change in trends and its recognition. An inherent delay is present in the evaluation of claims incurred during an experience period due to lags in reporting claims, as discussed previously. Even after claims have been sufficiently developed, the initial manifestations of a trend change are generally so slight as to be obscured by other phenomena, such as seasonal fluctuations. Finally, when the effects become clearly perceptible, the actuary and Plan management are faced with the question as to whether they represent a change in the underlying trend or a temporary random fluctuation. Because evidence of trend change is generally not obvious before a substantial period of time has elapsed, a trend change can deplete surplus for several years.

In order to provide as much of a factual, experience-based foundation as possible, the usual practice in setting trends for premium rates is to rely heavily on the trends observed over at least the most recent twelve-month period. Use of a twelve-month or longer period results in more gradual changes in rates than would be required if short-term fluctuations were given full credibility. The result is an understatement of premium income if trends worsen and an overstatement if trends improve.

In addition, since premium rates for a large portion of Highmark's business are guaranteed for a twelve-month period, following a significant period of advance notice, immediate implementation of trend changes cannot be made. Thus, provision must be made in surplus for withstanding delays in implementing trend or other rating parameter changes.

Unpaid Claim Liabilities and Other Estimates. Since a health insurer's surplus is defined as the excess of assets over liabilities, any misstatement or risk of fluctuation in either of them has a corresponding impact on reported surplus. The potential for misstatement applies, in particular, to those actuarial or other items contained in the company's statutory insurance blank which require estimation.

The single most significant of Highmark's actuarial items, in terms of the degree of estimation required, is its unpaid claim liabilities. To the extent that actual claim runoff differs from the liability estimate for unpaid claims, surplus will be correspondingly overstated or understated. Partially offsetting the risk of understatement in this liability is generally an estimation margin. Such margins mitigate, but do not eliminate, the risk of understatement. Surplus is the insurer's means of providing protection against this eventuality.

Other actuarial items contained in Highmark's balance sheet also require estimates, and therefore entail uncertainty. These include provider settlement liabilities, certain policy reserves, unpaid claims adjustment expense liability, and other items.

Interest Rates and Portfolio Asset Values. Most of the non-affiliated admitted assets carried by Highmark on its statutory balance sheets are effectively reported at market value (as required). Although the risk of misstatement in such values may not be significant, due to accounting and auditing controls in place, the risk of fluctuation in such values over time is significant.

The asset portfolio of Highmark Inc. contains a diverse mixture of interest bearing instruments and equities, in addition to its equity interest in subsidiaries and affiliates. Overall, about two-

thirds of the investment portfolio (excluding Highmark's equity interest in subsidiaries and affiliates) was invested in interest bearing instruments at the end of 2003, and the remainder was in equities.

Since long-term assets-to-liability matching is not a significant investment management issue for a company with mostly short-term obligations like Highmark, the primary matter of concern regarding surplus is fluctuation in market values of the asset portfolio, with the corresponding impact on surplus. Beyond the possibility of default or impairment, the primary risk of an adverse fluctuation in interest-bearing securities is an unexpected rise in interest rates generally in the market. For equities, risk is present with regard to market conditions generally, and the performance of individual securities and instruments specifically.

Overhead Expense Recovery Risks. A contingency for which surplus provision needs to be made is an unanticipated fluctuation in the level of administrative expense recoveries. These recoveries are made, under normal circumstances, through the administrative expense component of premium rates for insured business, fees paid by self-funded groups, and fees or revenue otherwise generated from other business activities. An adverse fluctuation may occur, for example, because a large group terminates unexpectedly, with a resulting decrease in retention revenue or self-funded fees. A corresponding decrease in expenses would not occur immediately, and expense ratios would therefore increase.

Other Business Risks, Including Self-Funded Business. As with any business enterprise, Highmark faces a host of business risks during the normal course of business. Most of these can be absorbed within the scale of Highmark's overall operations.

A particular category of risk, which is perhaps unique to a health insurer such as Highmark, is risk associated with self-funded group business. Unlike some self-funded business administered by a third party administrator for an employer using employer funds, Highmark's self-funded business entails a variety of risks for the insurer. These include default in reimbursement by an employer group, refusal to reimburse certain claims, defense of disputed claims, audit or

litigation related to payment policies and practices, contractual disputes regarding discounts, etc. Such risks are not insignificant.

Highmark has a substantial volume of self-funded business, primarily involving larger employer groups. For 2003, the volume of self-funded business was approximately one-half of the volume of insured business written by the Highmark enterprise.

Catastrophic Events, Including Litigation. As discussed earlier in this report, Highmark faces the risk of catastrophic events occurring. Such events include extraordinary medical costs due to terrorism, epidemics or pandemics, and natural or public health disasters. They also include other events with a potentially extraordinary adverse financial impact – such as major fire or other business interruption disaster, or excessive damage awards from major class action or other litigation.

A prudent insurer must provide protection against such risks, so that the company is not exposed to ruin or incapacity from such an event. This is necessary to remain a viable company. It is also necessary to protect the ability of Highmark's members, providers, and vendors to safely rely on the company for the financial security that they believe they have contracted for or purchased. Prudence dictates that surplus for Highmark be sufficient to withstand the risk created by such threats, to the maximum extent possible.

Provision for Development and Growth. To maintain competitiveness and ongoing viability, as discussed previously, Highmark must periodically make substantial investments in developmental activities and the acquisition of operational capabilities. These include such far ranging items as new product development, rebuilding of delivery networks, enhancement of care management capabilities, acquisition of new communications or information technology capacities, and adaptation of existing and integration of new administrative processes. Often these capital expenditures do not produce admitted assets, which means that they generally must be absorbed directly and immediately out of surplus.

Likewise, developing and absorbing growth requires equity capital to fund developmental costs, to cover the initial losses resulting from the need to be price-competitive at the outset in order to become established, to absorb any initial losses resulting from setbacks or inexperience in the new market, and to withstand the short-term surplus strain (i.e., growth in enrollment or volume of business in force, without corresponding immediate growth in surplus). Obviously, a prerequisite for financially sound growth is strong surplus.

B. Monte Carlo Simulation of Losses

Associated with each of the risk and contingency categories identified above is a range of possible impacts on Highmark's operating results. Under this alternative approach to quantifying the potential multi-year loss against which the company's surplus needs to provide protection, we have developed what we believe is a reasonable range of possible values for each risk and contingency category. Possible outcomes for each risk and contingency category are divided into a discrete number of representative outcome values, to each of which we have assigned a probability or likelihood.

These values and probabilities are based on analysis of historical data, our observation of similar results in connection with our work at various Blue Cross and Blue Shield Plans, interpretation of that data in light of the current and anticipated future operating environment of the Plan, and professional judgment. For those categories of risk involving fluctuations (e.g., rating parameters, unpaid claims liabilities, and interest rates and portfolio asset values), the range includes representative outcomes in which operating results would produce gains, as well as those in which overall cumulative losses would occur. Assignment of probabilities to be associated with each of these outcomes is based on the same considerations used in developing the ranges of values and representative outcomes.

Many of the risks and contingencies faced by Highmark are interrelated. We recognized this in our treatment of the probabilities by considering certain risks or contingencies to be independent, while considering others to be dependent. The primary independent risk category was fluctuation in rating parameter adequacy. Risks from unpaid claims liability fluctuation, overhead expense recovery, and other business matters (including self-funded business) plus provision for health care development were each considered to be fully or partially dependent on the rating fluctuation contingency.

The values and probability distributions for each risk and contingency category were combined using a computerized Monte Carlo simulation technique to produce a composite probability distribution. This composite distribution shows the resulting probability that cumulative

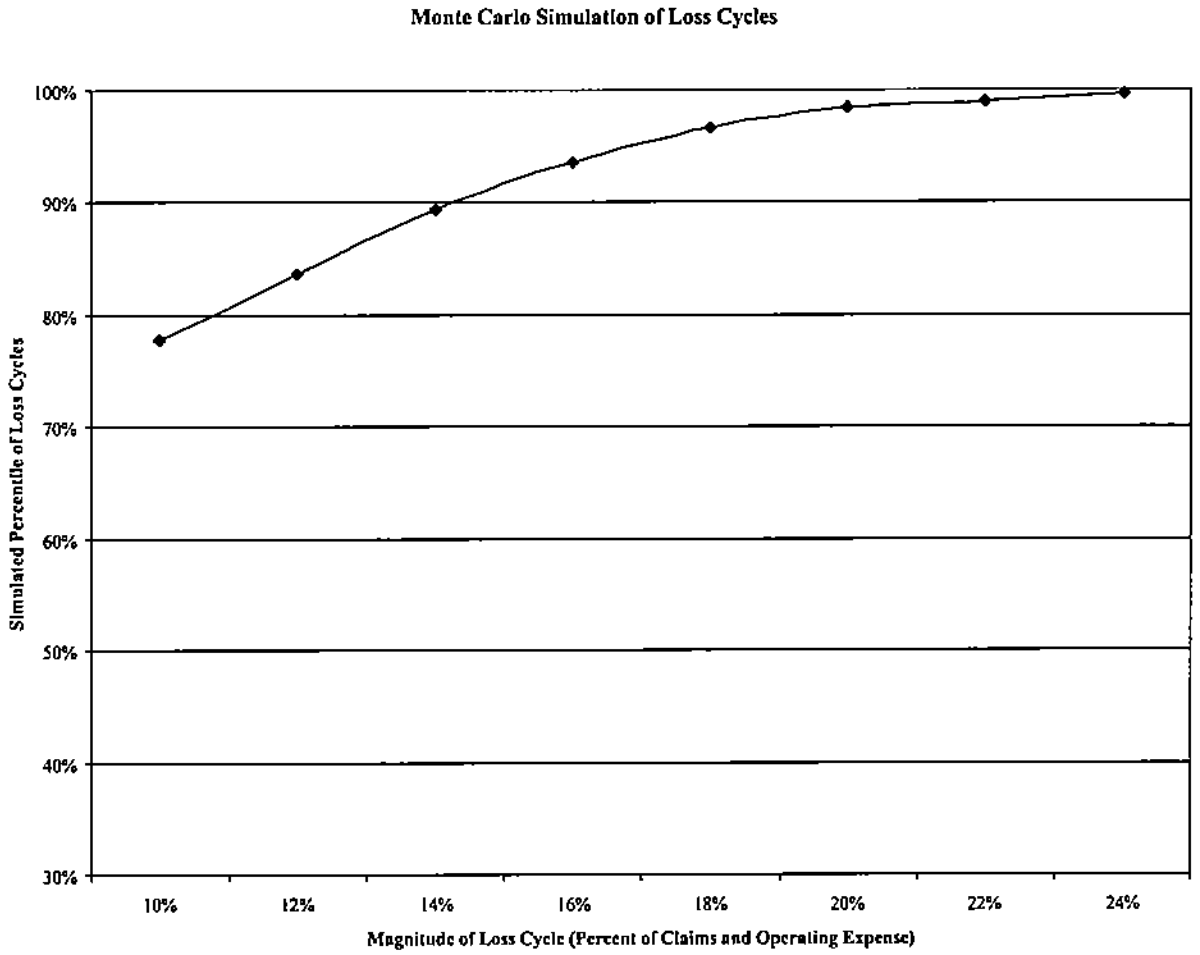
operating losses in total will not exceed given percentages of annual claims and expenses. From this distribution, a range of loss cycle amounts can be determined reflecting the combined risks which have been evaluated and a high probability or likelihood (e.g., greater than 90%) that such a loss level will not be exceeded, even under unforeseen adverse circumstances.

The results of our Monte Carlo simulation of these risks and contingencies are summarized in Chart 5. It shows in graph form the magnitude of cumulative operating loss cycles, expressed as percentages of claims and expenses, at various simulated percentiles of loss cycles. It also displays the cumulative loss cycle amounts for high confidence levels:

Simulated Percentile of Operating Loss Cycles	**Cumulative Loss for Adverse Cycle**
98th	19%
95th	17
90th	14

Based on this analysis and approach, we conclude that an optimal range for Highmark's surplus should be sufficient to withstand cumulative operating losses over a multi-year period of the magnitude of 14-19% of annual claims and expenses for the enterprise. We observe that these simulated results are highly consistent with the actual loss cycles experienced by Highmark over the past 25 years.

Chart 5



Simulated Percentile of Operating Loss Cycles	Cumulative Loss for Adverse Cycle
98th	19%
95th	17%
90th	14%

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VI. DEVELOPMENT OF TARGET RANGE FOR SURPLUS

A. Goals for Optimal Surplus Target Range

The establishment of an optimal target range for its surplus is one of the more important financial policy issues Highmark must address. It has fiduciary, business management, and strategic implications.

The goals for Highmark in determining a target surplus range should begin, we believe, with the BCBSA thresholds. Specifically, we recommend that they be established to achieve the following goals:

- ***Early Warning Monitoring Threshold Avoidance*** – Provide a high likelihood that the overall surplus level for Highmark, as an entire enterprise, will remain above the BCBSA Early Warning Monitoring threshold level, even after a particularly adverse period of multi-year operating or underwriting losses, thereby enabling ongoing viability;

- ***Loss of Trademark Avoidance*** – Assure with virtual certainty that surplus will remain above the BCBSA Loss of Trademark threshold level for the enterprise, even if a severely adverse period of multi-year underwriting losses were experienced, or if back-to-back loss cycles were to occur without adequate recovery between them, thereby avoiding failure; and

- ***Adequate Provision for Development and Growth*** – Provide equity capital to enable periodic investments in technology, product development, building or acquisition of complementary business capacity, and growth in business in force without jeopardizing the company's risk capital position.

This statement of goals for the Highmark enterprise is based, as indicated previously, on the perspective of the Highmark enterprise, including its subsidiaries and affiliates. The statutory surplus reported by Highmark Inc., as parent, is the surplus for the entire enterprise. Our understanding is that such surplus is effectively available for the mutual protection of all entities within the Highmark enterprise.

Historically, the operating loss cycles for Highmark Inc. (the parent company only) and for the Highmark enterprise on a combined basis have been of similar timing and magnitudes (see Chart 3 earlier in this report). Further, the preponderance of insurance products offered by the Highmark subsidiaries are related in some fashion to health insurance. These factors, taken together, indicate to us that quantifying Highmark's surplus needs on an enterprise-wide basis is appropriate. If circumstances should change materially in the future or new non-health products become a dramatically larger part of Highmark's business operations, this approach may need to be reconsidered.

The remainder of this section of our report is devoted to a quantitatively-based pro forma projection approach to evaluating and developing a target range for Highmark's surplus.

B. Provision for Operating Loss Cycles

The goals for an optimal operating range for Highmark's surplus, as stated above, entail surplus remaining above certain minimum thresholds regardless of the operating results that Highmark experiences, including the possibility of a particularly adverse multi-year period of operating losses. In approaching this analysis, we have established three different approaches to quantifying an appropriate magnitude for the loss cycles to be considered for purposes of making provision in surplus. In establishing the potential magnitude of such a loss cycle, we are not predicting it to occur, nor are we suggesting in any way that Highmark should accept the inevitability of such an adverse cycle occurring during the near term. Instead, we are attempting to establish a magnitude of adversity against which the company should protect itself, its members, and its providers and vendors.

The first of these approaches is to recognize the multi-year loss cycles that have been experienced by the Highmark enterprise, and to make provision for a loss period of comparable magnitude to occur again at some point in the future. The second approach is to recognize the multi-year adverse cycles that occurred during the past two decades within the industry, for generally similar Blue Plans, and to make provision for cycles of the corresponding magnitude to face Highmark sometime in the future. The third approach is to quantify the distributions of amounts of potential loss due to major risk and contingency categories, and to combine such amounts based on provision for their respective likelihoods.

In the preceding sections of this report, we developed the magnitude of cumulative multi-year losses for which surplus provision should be made under each of the three approaches identified above. The results can be summarized as follows:

Source/Basis	Cycle Operating Loss*
Highmark Experience	15-18%
Comparison Set of Blue Plans	17-22
Simulation of Risks and Contingencies	14-19
* Cumulative operating losses, as a percent of annual insured premium (claims and expenses, for the simulation).	

One of the three surplus goals identified earlier in this section of our report is to provide a high likelihood that the overall surplus level for Highmark will remain above the BCBSA Early Warning Monitoring threshold, even after a particularly adverse period of multi-year operating losses. In order to meet this goal of avoiding the Early Warning Monitoring threshold, the surplus target must be high enough so that (i) a particularly adverse loss cycle can be absorbed, without (ii) the surplus level dropping below the Early Warning Monitoring threshold (375% of RBC-ACL).

To represent a particularly adverse loss cycle – based on consideration of the actual loss cycles experienced by Highmark in the past, the history of loss cycles for other BCBS Plans, and the simulation of risks and contingencies for Highmark – we have assumed a multi-year operating loss period creating a cumulative loss falling in the range of 14-17% of annual insured claims and administrative expenses. Provision to withstand a loss cycle falling in this range would have covered two of the three adverse cycles experienced by the Highmark enterprise over the past 25 years, 75% of the loss cycles experienced by the Comparison Set of BCBS Plans, and 95% of the simulation loss periods. Using these criteria to establish a target surplus level means that a 14-17% cumulative loss over a 3 – 4 year period must be able to be absorbed by Highmark without surplus dropping below 375% of RBC-ACL.

Similar conditions apply to meeting the goal of avoiding the Loss of Trademark threshold. The surplus target must be high enough so that (i) a severely adverse loss cycle can be absorbed, without (ii) the surplus level dropping below the Loss of Trademark threshold (200% of RBC-ACL).

To represent a severely adverse loss cycle – based on the same three alternative considerations as described above – we have assumed multi-year cumulative operating losses falling in the range of 17-20% of annual insured claims and administrative expenses. Provision to withstand a loss cycle falling in this range would have covered substantially all of the historical loss periods experienced by Highmark and other larger Blue Plans, as well as almost all of the risk and contingency simulation scenarios. This is consistent with the Loss of Trademark goal of assuring with virtual certainty that failure does not occur as a result of breaching this threshold.

Together, these adverse cycle loss results form the foundation for our pro forma projection model development of Highmark target surplus levels. To develop such targets, provision for a multi-year loss cycle of the magnitudes indicated in the chart above is combined with minimum floor levels for Highmark's surplus, based on BCBSA thresholds, and with interest and other pro forma financial items needed to evaluate changes in surplus.

C. Pro Forma Modeling of Loss Cycle Impact

To establish the Highmark surplus operating range that would meet the goals established, we projected on a pro forma basis the level of Highmark surplus balances emerging year-by-year under the adverse loss cycle ranges identified above[3]. In each loss cycle scenario, we selected an initial potential surplus target level, and then tested by projecting the impact of the specific operating loss scenario to determine whether the resulting surplus balances projected over time remained above the thresholds within the goal.

Viability Testing Against Early Warning Monitoring Threshold. The upper portion of Chart 6 shows the range of RBC ratios needed at the onset of the indicated operating loss cycles for the company RBC ratio to remain above the BCBSA Early Warning Monitoring threshold of 375% of RBC-ACL. Results are shown under both 11% and 14% assumptions as to annual growth in Highmark enterprise aggregate premium (premium rates and volume of inforce business combined).

These pro forma results indicate that a starting or target surplus level of 800-950% of RBC-ACL for the Highmark enterprise is needed in order for the company to remain viable while withstanding a particularly adverse operating loss cycle (i.e., 14-17% of annual insured claims and expenses). Under the pro forma projections, Highmark could withstand such a loss period and remain above the BCBSA Early Warning Monitoring threshold.

Failure Testing Against Loss of Trademark Threshold. The lower portion of Chart 6 contains the corresponding range of RBC ratios needed at the onset of the indicated operating loss cycles to remain above the BCBSA Loss of Trademark threshold of 200% of RBC-ACL. Alternate annual premium growth rates of 11% to 14% are reflected. These assumptions are intended to reflect modest-moderate sustainable growth rates in enrollment, plus mid-range premium rate increases (high single digit to moderate double digit medical cost trends).

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[3] Other key projection assumptions include 5% average annual investment yield, other income levels consistent with Highmark's long-term forecast expectations, 200% RBC-ACL equating to approximately 8.7% of claims and expenses for the enterprise, and the elimination of Highmark's deferred tax asset with an adverse cycle loss period.

These pro forma results indicate that a starting or target surplus level of 650-800% of RBC-ACL is needed by Highmark in order for the company to avoid the loss of trademark as a result of a severely adverse loss cycle (i.e., 17-20% of annual insured claims and expenses). Under the pro forma projections, Highmark could withstand such a loss period and remain above the BCBSA Loss of Trademark threshold.

Surplus Target Range for Highmark. Based on this analysis, we have concluded that a reasonable target for Highmark's surplus is 650-950% of RBC-ACL under normal operating circumstances. This range encompasses the values developed from the pro forma projections and shown in Chart 6.

Chart 6

RBC Ratio Needed to Remain Above Minimum Surplus Floor Levels

Simulated Results under Range of Operating Loss Cycles

Operating Loss Cycle	Early Warning Monitoring Floor (375% of RBC-ACL)	
	11% Premium Growth*	14% Premium Growth*
14%	800%	850%
17	850	950

Operating Loss Cycle	Loss of Trademark Floor (200% of RBC-ACL)	
	11% Premium Growth*	14% Premium Growth*
17%	650%	700%
20	700	800

* Aggregate growth in premium revenue, including changes in both premium rates and enrollment.

VII. SURPLUS TARGET RANGE AND MANAGEMENT PROCESS

A. Basic Goal for Surplus Management within Target Range

As we indicated earlier, the establishment of a target range for its surplus is one of the more important financial policy issues that a company like Highmark must address. The same applies to the development, implementation, and periodic updating of business plans to reach and maintain a surplus position within an optimal target surplus range.

Based on the analysis contained in the previous sections of this report, we conclude that an appropriate target for Highmark's surplus falls in the range of 650-950% of RBC-ACL. A reasonable goal for Highmark with regard to achieving this, we believe, is to establish rates overall with a premium margin (surplus contribution factor, along with other financial elements) sufficient to place the company well within the target surplus range. The necessary level of annual contribution to surplus in order to simply maintain it at an optimal target level could well average at least 2-3% of premium. This 650-950% of RBC-ACL range is wide enough to allow for a reasonable degree of fluctuation in operating results year-to-year, under normal operating circumstances, over a multi-year horizon.

By positioning the Plan's surplus well within the range, the company can then take measured steps in the management of day-by-day financial operations. As the actual level of surplus fluctuates within this range, Highmark should generally take steps to (i) gradually increase the RBC ratio level as surplus nears the lower end of the target range, and (ii) slow the rate of surplus growth as it nears the upper end. Sustaining favorable operating results for an extended period of time has been rare within the industry, as has been discussed. By focusing on actions to strengthen surplus as it nears the lower end of the target range, and before it drops below the target range, Highmark can compensate for the fact that the lower end of the target range does not provide the degree of security that a viable company might wish to have. Likewise, by taking actions to ease surplus growth as it nears the upper end of the target range, Highmark can reduce the likelihood of accumulating surplus amounts that do not further the well-being of the company, without jeopardizing its security.

B. Actions When Surplus is Above Target Range

As indicated above, the basic goal for surplus management by Highmark under normal circumstances should be to continually attempt to maintain its level well within the target range established. Periodically, the continued appropriateness of the target range itself should be reconsidered, but revised only as fundamental changes in the environment or Highmark's circumstances and experience clearly warrant.

Needs Outside the Norm. On a regular basis, near-term circumstances that may not be "normal" on an ongoing basis should be closely monitored. From time-to-time, such circumstances may warrant a surplus level above the target range. Such circumstances might involve major upcoming development activities with significant expected costs, growth opportunities involving heightened uncertainty and/or probable surplus strain (i.e., downward movement in RBC ratios, due to increased business in force), attractive acquisition candidates requiring equity capital and many other possibilities. These are the sorts of specific circumstances that may require additional surplus, but vary over time as the market and business environment change.

Stable Operating Results and Surplus. For a large insurance company upon whom many depend for their health insurance coverage and the personal security it provides, financial strength and stability are essential. Financial strength has been addressed at length in this report. It is needed, in particular, to provide protection against the risks and uncertainties associated with medical costs and all of the other business matters affecting the insurer. A critical challenge for Highmark's management team is to manage these risks and, in particular, the premium revenue generated to pay for claims and expenses and to maintain surplus.

Management of premium revenue has its own set of financial and market or customer challenges. Among these are to stabilize year-to-year changes in premium rates to the extent possible, at levels which are sustainable. This is important for Highmark's customers, who must pay them, and for Highmark's own financial planning and management. This is a key reason why gradual steps to build or ease its surplus are important, since such steps directly affect the company's

premium rates. Taking other than gradual steps affecting surplus also increases uncertainty for the company, as opposed to steps which ease surplus levels up or down slowly and permit course corrections as ongoing experience emerges.

Disposition of Unneeded Surplus. Having unneeded surplus, for a not-for-profit company such as Highmark, means that the company has assets that do not contribute to its business success or welfare, and that do not serve its business purposes. Obviously, any such assets would be invested by Highmark so as to generate a return, which would then be reflected as an investment credit in premium rates. Such a situation can also potentially be treated as having principal amounts (as opposed to ongoing interest or investment income amounts) that could be returned through a similar sort of credit in premium rates (in lieu of future investment earnings credits).

As we noted at the beginning of this report, any step to distribute the company's surplus has legal and philosophical ramifications (as well as financial ones), which we have not considered. Our understanding of Highmark's corporate perspective and position is that (i) statutory surplus represents the amount of those assets of the company not necessary to back its statutory liabilities, (ii) any disposition of a material amount of such assets would require management and Board of Directors authorization, (iii) such authorization could only be given if they were determined not to further the well being of the company, (iv) such a determination could only be prudently made upon deliberate consideration of the conditions and circumstances present at the time, and (v) if such a decision were made, the appropriate recipients would be the Plan's ongoing customer base, who largely contributed premiums and fees to the company that generated its surplus and who as a general class would otherwise benefit (directly or indirectly) from future investment earnings.

Mechanism for Returning Unneeded Surplus to Customers. If Highmark were to consider distributing to its customers certain amounts of surplus that it determined were not needed to further the interests or welfare of the company, then we believe that adherence to certain key principles is essential in order to protect the financial stability and ongoing viability of the company. They flow from the discussions above, and are as follow:

- ***Use of Upper End of Target Range as a Flag Only*** – As previously discussed, the target surplus range we have developed is only that: a target, applicable under normal operating circumstances. As such, it is not appropriate, in our judgment, to use the upper end of the target surplus range as an absolute maximum for surplus. At most, it might serve as a flag, which could trigger a careful assessment of specific conditions and circumstances present at that time, in order to determine whether unneeded surplus has been accumulated.

- ***Evaluation of Specific Conditions and Circumstances*** – Only with a careful analysis and evaluation of specific conditions and circumstances at such time as Highmark's surplus might exceed the upper end of the target range can a determination be made as to whether or not any surplus amount held is not needed. To do otherwise, in our judgment, would be financially irresponsible.

- ***Distribute any Unneeded Amounts Slowly*** – If a determination were made that certain Highmark assets were unnecessary, and distribution were authorized, then the amount to be distributed should be modest relative to premium rate levels (e.g., over several years, and not more than perhaps 1% at any time), so as not to destabilize customer rates or the market.

- ***Re-evaluate Continuing Distributions Annually*** – Further assuming that a distribution were to be made, and that it would span more than a 12-month cycle of new issues and renewals, then a re-determination of the continuing presence of unneeded surplus and the appropriateness of continued distribution should be made each year, after the statutory blank has been completed. This is essential, to enable course corrections as financial experience emerges.

By following these principles (along with supporting administrative and reporting provisions), and using the 950% of RBC-ACL upper end of the target range as a flag, Highmark should be able to manage its surplus in a financially sound fashion, consistent with its corporate mission and its needs as a viable business enterprise.

C. Conclusions

We believe that targeting Highmark's overall surplus level in the range of 650 – 950% of RBC-ACL is reasonable and appropriate under normal operating circumstances, to ensure financial viability for the company and to provide security in the health coverage provided to its over 4 million Pennsylvania members.