

2004 | ANNUAL REPORT

STEADFAST COMMITMENT TO A HEALTHY FUTURE

CareFirst  
BlueCross BlueShield



The Mission of CareFirst BlueCross BlueShield

is to provide health benefit services of value to customers across the region
comprised of Maryland, Delaware, and the National Capital Area.

To fulfill this mission, CareFirst BlueCross BlueShield commits:

- To offer a broad array of quality, innovative insurance plans
and administrative services that are affordable and accessible to our customers.
- To fairly address the needs of customers in each of the jurisdictions in which we operate.
 - To conduct business responsibly as a non-profit health service plan,
to ensure the plan's long-term financial viability and growth.
- To support public and private efforts to meet needs of persons lacking health insurance.
- To collaborate with the community to advance health care effectiveness and quality.
 - To foster health systems integration and health care cost containment
to benefit people in areas we serve.
 - To promote respect, fairness and opportunity for our associates.



William L. Jew, CareFirst Inc. President
and Chief Executive Officer

One word describes CareFirst BlueCross BlueShield's (CareFirst's) performance in 2004 — "focused." By resolutely remaining focused on serving the needs of all of our customers, we faced the year's many challenges and emerged an even stronger company — customer-centered, financially secure, and more determined than ever to continue a tradition of community outreach that dates back more than 70 years.

We go forward with confidence that we can build on 2004's solid results — through serving our policy holders with products supported by the company's strongest financial performance ever. We are equally confident that, by embracing new technologies, CareFirst will further enhance efficiency, while improving the satisfaction of customers, be they members, accounts, health care providers or brokers. Even with that, we are not satisfied with our record of paying 99 percent of the 41.7 million claims submitted last year within 30 days. Our target for 2005 is to continue improving our service metrics for our customers.

By offering a comprehensive portfolio of products and services that provide an array of options for individuals, families and employers, CareFirst continues to be a leader in an increasingly competitive marketplace. Responding to the demands of our customers, we moderated pricing and introduced new products, including innovative, cost-effective consumer-directed health plans. To provide more coordinated services for our customers, CareFirst contracted with Davis Vision, a nationally recognized provider of vision services, and purchased The Dental Network, offering members an even broader choice of dental providers.

While providing an array of product options is important, ensuring the quality of those products was another area where CareFirst focused in 2004. CareFirst's BlueChoice HMO and BluePreferred PPO received the highest possible accreditation from the National Committee for Quality Assurance.

We also focused on technological improvements — better serving members, providers and brokers. Through the "My Account" link on our www.carefirst.com Web site, customers have 24-hour, 7-day-a-week access to view the status of their claims, change personal information or select a provider. They can even send emails directly to our customer service department. Through "CareFirst Direct," physicians and other health care professionals can check the status of claims they submitted on behalf of our members, view eligibility status of their patients, and check their patients' benefits. The new "Broker Express" offers brokers a Web-based tool to develop, price and track proposals to their accounts.

As we celebrated our 70th year of serving the health care coverage needs of our members in Delaware, Maryland, Washington, D.C. and Northern Virginia, we also focused on strengthening and enhancing our outreach to all of the communities we serve. Embracing our mission as a not-for-profit health care plan, we focused on strategies for delivering the best value to customers while increasing affordability of coverage, and on partnerships promoting quality and safety, preventing disease and injury, and restraining spiraling health care costs. Finally, much of our charitable giving was directed to innovative health and wellness initiatives, including nearly \$500,000 to a dozen groups to address the crisis of obesity facing our communities.

Looking forward, we remain firmly committed — and focused — on fulfilling our mission to provide quality, affordable and accessible health care coverage to the more than 3.3 million members who depend on us to be there when needed while expanding the health care resources in the communities in which we operate.

Sincerely,

A handwritten signature in black ink, appearing to read "William L. Jew". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

William L. Jew
President and Chief Executive Officer



Michael R. Merson, Chairman,
CareFirst, Inc. Board of Directors

Since being named chair of the CareFirst, Inc. Board of Directors in mid-2004, I am pleased to report that CareFirst BlueCross BlueShield has continued to take meaningful steps to make health insurance coverage more affordable, to close gaps in health care access and quality, and to address the community's health care needs. While CareFirst experienced dramatic changes in 2004, especially in the realm of governance, operationally the company recorded one of the finest years in its history. Enrollment grew to a record 3.3 million members and financial results were strong. New dental, vision and consumer-directed health care products were introduced for our beneficiaries and physicians and hospitals relationships were improved by efficiently and effectively processing more claims than ever before.

The 14 new members who were added to CareFirst's governing Boards in 2004 represent a diverse range of business and community interests and offer new ideas and fresh perspective. These new Board members, working with the incumbent directors, quickly focused on setting a path for positioning the company over the long term, while carefully balancing CareFirst's community responsibilities as a not-for-profit health plan. While enhancing our mission, CareFirst's primary responsibility is to provide access to quality — and affordable — health care coverage to our members and potential customers throughout our market service area. We exist so that our policyholders can be assured that their health care coverage will be there for them when they need it most.

We also understand that CareFirst must reach out to the communities in which it operates. Guided by a newly established Mission Oversight Committee, the foundation was laid for a plan under which CareFirst would take bold, new steps in advancing an aggressive new community outreach initiative that we have called "CareFirst Commitment," under which CareFirst will invest more than \$90 million over the next year to help ease the burden of rising costs of health care and to further expand the company's support of community-based access to health care.

A major component of CareFirst Commitment is the Board's decision to reduce the 2005 earnings target by \$60 million in order to moderate premiums for many of our customers. This commitment was further enhanced by the decision to absorb a new tax on HMO premiums, saving our HMO customers in Maryland nearly \$20 million in 2005. The company will also work to expand access to safe, quality health care. Under a unique partnership with the national Bridges to Excellence initiative, CareFirst has committed \$3.6 million over three years to recognize and reward physicians who adopt guidelines that promote quality of care and patient safety. Other initiatives are planned to better meet the needs of the increasingly diverse communities CareFirst serves.

In sum, you can be assured that all of CareFirst — its directors, executives and nearly 6,000 associates — will continue to work in creative and significant ways to earn your continued trust and confidence in 2005, just as it has for the prior 70 years.

Sincerely,

A handwritten signature in black ink that reads "Michael R. Merson". The signature is written in a cursive, flowing style.

Michael R. Merson
Chairman, CareFirst, Inc. Board of Directors

A close-up photograph of a person's hand held palm-down just above a surface of clear blue water. The hand is positioned centrally, with fingers slightly spread. Two small droplets of water are visible on the tips of the index and middle fingers. The water surface is disturbed by the hand, creating concentric ripples that spread outwards. A clear reflection of the hand and the water droplets is visible on the water's surface below. The background is a soft-focus blue, suggesting an outdoor setting like a pool or a large body of water. The overall color palette is dominated by various shades of blue, from light sky blue to deep cerulean.

THE COMMITMENT BEGINS WITH EACH OF US

For 70 years, CareFirst BlueCross BlueShield has served our members with one unwavering principle: our mission is your health.

CareFirst, Inc. faced a year of dramatic change in 2004, and we're proud that our strong performance and innovative programs demonstrated steadfast commitment to our more than 3.3 million members.

Through our affiliate Blues Plans — Group Hospitalization and Medical Services, CareFirst of Maryland and Blue Cross Blue Shield of Delaware — we remain focused on providing effective, high-quality and reliable health insurance.

During a year of accomplishment:

- Fourteen new directors joined CareFirst and affiliate boards. Together, the CareFirst, Inc. Board created the Mission Oversight Committee to foster our not-for-profit mission.
- CareFirst achieved our strongest ever financial performance, through reduced expenses, increased sales and improved care costs.
- CareFirst worked to keep health insurance affordable and available by developing health plans to control costs and meet members' diverse needs.
- We harnessed the promise of the Internet by introducing quick, convenient ways for members and providers to communicate with us.
- CareFirst and its affiliate companies voluntarily adopted certain principles of the federal Sarbanes-Oxley law to proactively ensure high governance standards.

Also in 2004, the Mission Oversight Committee developed CareFirst Commitment, a \$92-million plan advancing our not-for-profit mission. During 2005, we will:

- Help moderate premiums by forgoing \$60 million in projected earnings.
- Invest \$3.5 million to improve health care quality and safety.
- Respond to the special health needs of underserved ethnic and community groups.
- Commit \$2.6 million — 2% of our net operating income — to charitable giving.

CareFirst strives in many ways to serve our members. For example, CareEssentials is our comprehensive disease and care management program that starts with prevention, and if members face serious illness, provides one-on-one guidance.

For the seventh consecutive year, a CareFirst affiliate has won a Brand Excellence Award from the national Blue Cross and Blue Shield Association — recognizing service and business performance.

This report describes how CareFirst is working to ensure that health care is delivered compassionately and efficiently, continuing a tradition that has earned us the trust of generations.





SERVING EVERY MEMBER



At CareFirst, we believe every member is important and should lead a healthy, vigorous life.



Brenda O'Donald, (left), Blue Cross Blue Shield of Delaware member, and Barbara Little, Blue Cross Blue Shield of Delaware Case Manager

When Brenda O'Donald needed a heart transplant, Barbara Little, a nurse case manager for Blue Cross Blue Shield of Delaware, telephoned to help. The young production coordinator burst into tears. "She was really devastated," Little recalls. Along with the medical uncertainties, there were daunting paperwork burdens.

Little shouldered the necessary bureaucratic chores, encouraging Brenda to focus on health decisions. Hospitalized and awaiting a donor heart, Brenda was determined to try a cardiac exercise program, and Little helped clear the way. Then, a stunning development: Brenda's heart function improved. Transplantation, with its many unknowns, was called off. Back home, Brenda calls Little "a godsend."

Introduced in 2004, our CareEssentials program is a unified approach to health care, beginning with preventive care. We mail reminders to our members to get immunizations and screenings that avert illnesses and detect conditions early. When medical care is needed, we help members find appropriate physicians and other health professionals. In 2004, we added 77,000 new members to our CareEssentials program.

The disease management component of CareEssentials offers 24-hour access to health experts and regular monitoring of treatment plans for chronic illnesses like diabetes. And when members face serious illness, our trained case manager nurses help them and their families plan their medical care. The result? Better outcomes and peace of mind.

CareFirst continues to develop new, affordable and flexible programs. We're offering lower cost plans, with members controlling health spending accounts to help defray out-of-pocket costs, such as doctors' office visits. New individual plans have lower premiums, offset by deductibles or co-pays.

Choice is important, so HMO Open Access members can make their own specialist appointments without referrals. And our Options program offers valuable discounts for alternative therapies, such as acupuncture, chiropractic and yoga.

At CareFirst, our members come first.

KEEPING YOU INFORMED AND WELL:

- **The My Account section of our Web site, www.carefirst.com, provides prompt, private information about your coverage, out-of-pocket payments and claims status and history.**
- **My Care First, also on our Web site, is a state-of-the-art wellness resource where members can track personal health goals, find 15,000 pages of health information and take interactive quizzes and polls.**
- **Blue Cross Blue Shield of Delaware members can find the same health and wellness information at bcbsde.com.**

The background of the entire page is a close-up photograph of blue water with concentric ripples. The ripples are centered on the left side and spread out towards the right. The color is a vibrant, slightly darker blue. The text is centered horizontally and vertically over the image.

ENSURING AFFORDABILITY AND ACCESS

CareFirst works diligently to keep health insurance affordable and available.



Mike Gollobin, President,
Control Concepts Inc.,
Chantilly, VA, and employees.

After Control Concepts, Inc. went independent, President Mike Gollobin promised his 10 employees their health benefits would be as good or better than the parent company had provided. Gollobin knew health care was valued by the Virginia company's talented information technology workers — and that costs would be critical to his young firm's success.

CareFirst is working to keep quality health care affordable, by developing innovative insurance plans and lowering earnings targets to stabilize premiums. When Control Concepts compared health care packages, CareFirst was the clear choice. Gollobin kept his promise. "CareFirst allowed us to do that," he says. "And that is saying a lot."

As part of our CareFirst Commitment program, we will forgo \$60 million in projected earnings in 2005 to help stabilize premiums. Prices will go down for some groups, and others will see lower increases than expected. In 2004, savings realized by CareFirst's administrative efficiency and care management allowed us to reduce rates for some small businesses by as much as 20 percent.

Our sales representatives and brokers offer an ever-expanding menu of plan options to hold down costs. Blue Cross Blue Shield of Delaware launched BlueAdvantage®, a new line of consumer-directed health products. In development is our new CareFirst BlueFund family of consumer-directed health plans that will provide premium relief combined with health savings accounts. These tax-free savings accounts can help members meet copayments and deductibles, which, in turn, help control premiums.

Today, CareFirst provides more plan flexibility than ever: HMO members can select their own specialists; new plans reduce premiums through higher doctor copays and deductibles; new vision and dental options offer members even broader choice.

As an expert in health care, CareFirst has worked for 70 years to provide access to high quality care at the lowest possible cost.

CAREFIRST'S RECORD OF SERVICE AND QUALITY:

- Our HMO and PPO plans received the highest three-year accreditation from the National Committee for Quality Assurance (NCQA), the industry standard for measuring service excellence and customer satisfaction.
- For the seventh consecutive year, our Federal Employee Plan division received the Blue Cross and Blue Shield Association's "High Performance/Low Cost" award for claims processing efficiency.
- Blue Cross and Blue Shield of Delaware was named one of the top five plans for quality care in the South Atlantic region as part of NCQA's 2004 State of Health Care Quality Report.

The background of the page is a solid blue color with a pattern of concentric, overlapping ripples, similar to water droplets on a surface. The ripples are more pronounced in the lower half of the page, creating a sense of depth and movement. The text is centered horizontally and vertically in the middle of the page.

PROMOTING QUALITY AND SAFETY

CareFirst is partnering with the many physicians and other providers in our health networks to enhance the quality and safety of medical care.



Dr. Maislyn Christie
pediatric physician,
Cheverly, MD

Pediatrician Maislyn Christie writes 25 to 50 prescriptions daily at her Cheverly, MD, practice. It used to be laborious: writing each child's name, the drug, the dose, signing the form — often several times for each patient. But thanks to a CareFirst pilot program, Dr. Christie and other physicians have a powerful new tool: electronic prescription-writing.

CareFirst is providing free hand-held computers and software to a pilot group of primary care physicians. The system eliminates handwriting errors, checks drug interactions, then speeds orders to pharmacies — ready for customer pickup. “The handheld has really made a big difference,” says Dr. Christie. Another way CareFirst is making health care safer and more efficient.

Over the next three years, for example, we're investing \$3.6 million in Bridges to Excellence, a national program to increase physician efficiency and effectiveness.

Participating physicians receive bonuses for using advanced systems, like electronic medical records, to track patients' health and make sure they get necessary services. Someone with diabetes receives regular reminders to see her physician. In turn, her doctor makes sure she's taking medicines to head off strokes or heart attacks.

Also, CareFirst is investing more than \$5 million over the next three years to fund hospital patient safety centers to reduce medical errors, to promote the advancement of health information technology and to improve intensive care unit services.

Why? Lapses in safety and efficiency put lives at risk and raise costs. Experts estimate that only 55 percent of insured patients get all the care that medical professionals agree is needed.

As a leader in effective health care delivery, we're using our resources to improve medical care for everyone. Because at CareFirst, our mission is your health.

OUR COMMITMENT TO PROVIDERS:

- **CareFirst Direct is our expanded on-line system to help physicians and other providers check members' eligibility and the status of claims.**
- **iExchange helps our participating hospitals by generating on-line authorizations more efficiently.**
- **Our Quality Improvement program supports educational programs for providers about chronic disease, preventive care and office operations.**

A blue-tinted photograph of water droplets creating ripples on a surface. The image is filled with concentric circles and splashes of water, all rendered in various shades of blue. The text "BUILDING OUR COMMUNITIES" is centered in the middle of the image.

BUILDING OUR COMMUNITIES

CareFirst believes that health care is best advanced when all members of our communities are served.



Katherine Jones (left) of Baltimore, MD, and Susan Zator MPH, RN, Peoples Community Health Center at Open Gates

For Katherine Jones — overweight, with arthritic knees — walking was agony. Even with leg braces, she couldn't go more than a block from her Baltimore home. Today, she's walking 3 miles. How? She's lost 41 pounds, much of that after joining a weight loss program at People's Community Health Center at Open Gates.

Funded by CareFirst, "Get Hip, Get Healthy" features group and individual meetings with Susan Zator MPH, RN. Katherine has learned much about nutrition and exercise. She's developed a taste for skim milk, works out with weights. And those braces? "They are in a corner."

Because our mission is your health, CareFirst is committed to meeting the needs of our increasingly diverse communities.

We're focusing on improving delivery of care to groups that face important medical issues but don't always receive the appropriate care to identify and treat illnesses. CareFirst is working to reduce health disparities in these illnesses of critical importance to racial and ethnic groups:

- Cardiovascular disease in African Americans
- Diabetes in Latinos
- Cervical cancer in Asian women

CareFirst will set up programs to improve education and communication about health conditions, to ensure that patients get appropriate care and stay current with prescribed treatments.

Further, because language barriers are sometimes an issue for members, CareFirst will boost efforts to translate health information that can be used by people for whom English is not their primary language.

We're reserving part of our corporate giving to not-for-profit organizations that work to eliminate health care disparities.

CareFirst is committed to healthy communities in which all groups have access to quality, effective care.

CAREFIRST SERVES KEY POPULATIONS:

- We're continuing our support of more than \$20 million a year for Maryland's senior prescription program
- We're the only insurance carrier that offers an open enrollment plan — a product offered to anyone regardless of health — in Washington, D.C.
- We've filed for approval to offer prescription drug benefits under the new Medicare Part D law in Maryland, Delaware and Washington, D.C.

CareFirst is committed to supporting community-based organizations that promote healthy communities.



In 2004, our charitable donations totaled \$2.3 million. And we'll increase these investments in coming years.

The results can be seen in many areas:

Thanks to a \$100,000 CareFirst grant to the Whitman-Walker clinic in Washington, D.C., two vans brought HIV/AIDS testing services to neighborhood residents.

Every time a Baltimore Orioles' pitcher struck out a batter, CareFirst's "K's for Kids" program donated \$25 to the American Cancer Society's "Healthy Kids" program, a total of \$25,000. And we donated \$15,000 to the YMCA and Boys and Girls Clubs in areas served by Orioles' minor league teams.

Delaware residents, along with those in Maryland, Washington and Northern Virginia, benefited from \$489,000 in 12 grants to "Shape Up ... Live Well" programs addressing the serious issue of obesity.

A not-for-profit company, CareFirst's contribution to our communities is providing vital, affordable health insurance to our 3.3 million members. And we're just as serious about our mission in supporting key charities.

Here are more examples:

- Contributed \$1,000 for each Baltimore Ravens home game touchdown, a total of \$33,000 to Health Care for the Homeless in Maryland.
- Supported the "Living Well With Cancer" information campaign in partnership with Washington Hospital Center and NBC4-TV.
- Sponsored 17 March of Dimes walks that raised more than \$1 million to alleviate problems associated with premature births.
- Warned about signs of a stroke in TV announcements featuring CareFirst President and CEO Bill Jews, in cooperation with the American Heart Association.
- With our 6,000 associates in 2004, pledged \$922,000 to United Way programs in five states and the District of Columbia.
- Granted \$50,000 to the Greater Washington End of Life Partnership for hospice care and advocacy.
- Supported the health and fitness component of the Latino youth development program, Identity, Inc., donating \$25,000.
- Supported through our Blue Cross Blue Shield of Delaware affiliate, a statewide conference on health disparities, an initiative launched by Delaware's Lt. Governor John C. Carney, Jr. and the Metropolitan Wilmington Urban League.

2004 HIGHLIGHTS

Financial Summary:

CareFirst turned in its strongest financial performance to date in 2004, with revenues of \$4.98 billion*, up from \$4.64 billion the year before. Our membership has reached a record 3.3 million, an indication of our continuing strength.

Net income was \$140.5 million in 2004, compared to \$171.3 million the year before, reflecting the pressures facing the health insurance industry. CareFirst's net worth grew to \$1.2 billion in 2004, reflecting financial stability that ensures that CareFirst will be there for our customers when they need us most.

* Beginning in 2004, CareFirst revenue does not include claims from self-insuring groups, in keeping with current accounting procedures. These funds, totaling \$2.9 billion during 2004, previously were included in total revenue. *Results from prior years were also restated.*

CareFirst 2004 Highlights:

Continued investments in technology led to the launch of the Unified Service System designed to enhance customer service efficiency and satisfaction. The results were strong:

- We handled over 41.7 million claims and processed over 99 percent within 30 days.
- Our customer service department handled almost 10 million calls during 2004.

A new subsidiary company was created for CareFirst to manage the FEP operations center in Washington, D.C. The FEP Operations Center:

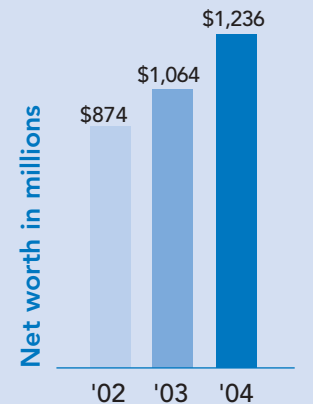
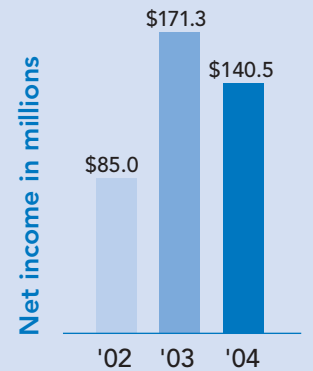
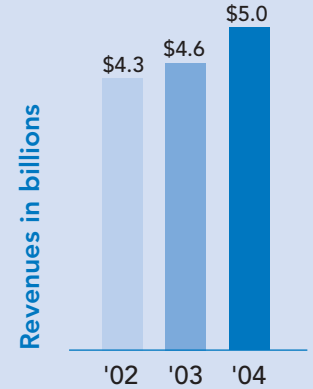
- Processes 150 million claims per year.
- Handles centralized enrollment processing for 4.5 million federal employees.

CareFirst and its affiliate companies voluntarily adopted certain principles of the federal Sarbanes-Oxley law to proactively ensure high governance standards.

CareFirst acquired The Dental Network, providing Maryland members with more dental coverage options.

CareFirst contracted with Davis Vision, a nationally recognized provider of vision services, to offer members a regional vision provider network and enhanced products.

National Claims Administrative Services, a CareFirst subsidiary, provided health care claims processing, data management and other administrative services to more than 200 self-insured, large group accounts and some 200,000 members nationally.



LEADERSHIP

Board of Directors CareFirst, Inc. as of 1/1/05

Michael R. Merson
*(Chairman of CareFirst, Inc.)
Former President
MedStar Health*

Edward J. Baran
*(Vice Chairman of CareFirst, Inc.)
Former Chairman and
Chief Executive Officer
BCS Financial Corporation*

Max S. Bell, Jr.
*Retired Partner
Richards, Layton and Finger*

Gregory V. Billups
*President and CEO
Systems Maintenance and
Technology, Inc.*

Trena Taylor Brown
*Former Vice President
AT&T Government Solutions*

William F. Bruther, M.D., P.C.
*(Ex officio)
Anne Arundel County
Ophthalmologist*

William J. Byron, S.J.
*Research Professor
Selling School of Business
Loyola College Maryland*

John M. Colmers
*Program Officer
Milbank Memorial Fund;
Former Executive Director
Maryland Health Care Commission*

Michel L. Daley
*Co-Owner,
Zanzibar on the Waterfront
Chief Operating Officer
Allian International*

Bernard J. Daney, C.P.A.
Business Consultant

Sister Carol Keehan, R.N., M.S.
*Chair of the Board of Directors
Sacred Heart Health System*

Michael J. Kelly, Ph.D., LL.B.
*Consultant
Center for Applied Research;
Former Dean
University of Maryland
School of Law*

Elizabeth St. J. Loker
*Director and co-founder
Acumen Global, Inc.;
Former Vice President
The Washington Post*

C. James Lowthers
*President, Local 400
United Food and Commercial
Workers Union*

Floretta D. McKenzie, Ed.D.
*Chairwoman and Chief
Executive Officer
The McKenzie Group, Inc.*

Kevin G. Quinn
*President
Wye River Capital, Incorporated*

Robert F. Rider
*Chairman and Chief
Executive Officer
O.A. Newton & Son Company*

Wayne L. Rogers
*(Ex officio)
Founder and Chairman
Synergics' Companies*

Giuseppe Savona
*Past Vice President and
Chief Financial Officer
UnitedHealth Group
Government Programs*

Loretta L. Schmitzer, Esq.
*Vice President
Government Affairs
The Boeing Company*

Clemon H. Wesley, M.S., LL.B.
*President and CEO
TEXCOM, Inc.*

Kathleen M. White, PhD, RN
*Associate Professor/
Director Faculty Practice
The Johns Hopkins
School of Nursing*

George B. Wilkes, III
*Past Chairman of the Board
Healthcare Council of the
National Capital Area*

The following CareFirst, Inc. Directors completed service during 2004

William R. Brody, M.D., Ph.D.
*President
The John Hopkins University*

Beverly B. Byron
*Former Member
U.S. House of Representatives*

Geneva Cannon
*Former Supervisor of Instruction
Worcester County Public Schools*

James M. Dale
*President
James Dale, Inc.*

Anne Osborn Emery, Ph.D.
Osborn/Emery Associates, Inc.

Ernest R. Grecco
*President
Metropolitan Baltimore Council
AFL-CIO Unions*

J. Richard Lilly, M.D.
*Founding Partner
The Doctors Community Hospital
Past President
MedChi (Maryland Medical Society)*

Patricia E. Lund, Ed.D., R.N.
*President
Lund Associates*

Board of Directors CareFirst of Maryland, Inc. as of 1/1/05

John M. Colmers
*(Chairman of CareFirst
of Maryland, Inc.)
Milbank Memorial Fund
Former Executive Director
Maryland Health Care Commission*

Andrea M. Amprey
*Executive Vice President
and co-owner
The KimKeli Group, Inc.*

Michael J. Kelly, Ph.D., LL.B.
*Consultant
Center for Applied Research;
Former Dean
University of Maryland
School of Law*

Elizabeth St. J. Loker
*Director and co-founder
Acumen Global, Inc.;
Former Vice President
The Washington Post*

Loretta L. Schmitzer
*Vice President,
Government Affairs
The Boeing Company*

Clemon H. Wesley
*President and CEO
Texcomm, Inc.*

The following CareFirst of Maryland, Inc. Directors completed service during 2004

Geneva Cannon
*Former Supervisor of Instruction
Worcester County Public Schools*

James M. Dale
*President
James Dale, Inc.*

Ernest R. Grecco
*President
Metropolitan Baltimore Council
AFL-CIO Unions*

J. Richard Lilly, M.D.
*Founding Partner
The Doctors Community Hospital
Past President
MedChi (Maryland Medical Society)*

Patricia E. Lund, Ed.D., R.N.
*President
Lund Associates*

Board of Directors BCBSD, Inc. as of 1/1/05

Max S. Bell, Jr.
*(Chairman of BCBSD, Inc.)
Retired Partner
Richards, Layton and Finger*

Thomas E. Archie
*Retired Business Manager
Laborers International Union
of North America, Local 199*

Ben Corballis, M.D.
*Retired Chairman
Doctors for Emergency Services, Inc.;
Chairman Emeritus
Department of Emergency
Medicine, Christiana Care Hospital*

Bernard J. Daney, C.P.A.
Business Consultant

Garrett B. Lyons, D.D.S.
*Practicing General Dentistry
Dental Director
A.I. du Pont Hospital for Children*

Robert F. Rider
*Chairman and Chief Executive
Officer
O. A. Newton & Son Company*

Frances M. West, Esq.
*Past President
Better Business Bureau
of Delaware, Inc.*

Board of Trustees Group Hospitalization and Medical Services, Inc. as of 1/1/05

Edward J. Baran
*(Chairman of GHMSI)
Former Chairman and
Chief Executive Officer
BCS Financial Corporation*

Larry D. Bailey*
*President
LDB Consulting*

William J. Byron, S.J.
*Research Professor
Selling School of Business
Loyola College Maryland*

Michel L. Daley
*Co-Owner
Zanzibar on the Waterfront;
Chief Operating Officer
Allian International*

Sister Carol Keehan, R.N., M.S.
*Chair of the Board of Directors
Sacred Heart Health System*

Elizabeth Lisboa-Farrow*
*President and Chief Executive Officer
LISBOA, Inc.*

Natalie O. Ludaway, Esq.*
*Managing Member
Leftwich & Ludaway, LLC*

Floretta D. McKenzie, Ed.D.
*Chairwoman and
Chief Executive Officer
The McKenzie Group, Inc.*

George B. Wilkes, III
*Chairman of the Board
Healthcare Council of the
National Capital Area*

James Wallace*
*Retired Partner of Arthur Anderson
Currently President of the
Wallace Group*

Robert M. Willis, Esq.
*Attorney
Former Commissioner
Washington, D.C.
Department of Insurance and
Securities Regulation*

** Joined the GHMSI Board of
Trustees in January 2005*

OFFICERS AND SENIOR MANAGERS

Officers of CareFirst, Inc.

William L. Jews
President and
Chief Executive Officer

G. Mark Chaney
Executive Vice President and
Chief Financial Officer

Gregory A. Devou
Executive Vice President,
Chief Marketing Officer and
President, NCAS Administrators

Leon Kaplan
Executive Vice President
Operations

John A. Picciotto, Esq.
Executive Vice President,
General Counsel and Corporate Secretary

Sharon J. Vecchioni
Executive Vice President
and Chief of Staff

David D. Wolf
Executive Vice President,
Medical Systems and Corporate Development

Senior Managers of CareFirst Affiliated Companies

Christine L. Alrich
Vice President, Corporate Marketing
Blue Cross Blue Shield of Delaware

Eric R. Baugh, M.D.
Senior Vice President and
Chief Medical Officer

Sam Bennet
Vice President,
IT Operations

Livio R. Broccolino, Esq.
Vice President and
Deputy General Counsel

Janice E. Carman
Vice President,
FEP Systems Support

Booker T. Carter, Jr.
Vice President,
Claims and D.C. Operations

Timothy J. Constantine
President
Blue Cross Blue Shield of Delaware

Rita A. Costello
Senior Vice President,
Strategic Marketing

Ted R. DellaVecchia
Senior Vice President and
Chief Information Officer

Pamela S. Deuterma
Vice President,
Federal Programs

Frances P. Doherty
Vice President,
Government Affairs

M. Bruce Edwards
Senior Vice President,
Networks Management

Jay Emerson
Vice President,
IT Strategic Architecture

George H. English, Jr.
Vice President, Operations
Blue Cross Blue Shield of Delaware

Michael J. Felber
Senior Vice President,
Sales

Andrew J. Fitzsimmons
Vice President,
Financial Planning and Data Management

Ann T. Gallant
Vice President,
Corporate Communications

Mary Anne Heckwolf
Vice President,
Dental

Susan E. B. Homar
Vice President,
NCIA Insurance Agency

Robert J. Huber
Vice President,
Underwriting

Jeffrey S. Joy
Vice President,
Operations Support Services

Jeanne A. Kennedy
Vice President
and Corporate Treasurer

William E. Kirk, III
Vice President, General Counsel
and Corporate Secretary
Blue Cross Blue Shield of Delaware

Mary Jane Konstantin
Vice President,
Business Systems Integration

Patricia A. Malone, R.N.
Vice President,
Care Management

Maynard McAlpin
Vice President,
Strategic Planning

Michael A. McShane
Vice President,
Human Resources

Bryan Munchel
Vice President,
IT Applications

Jack Nelson
Vice President,
Service

Edward W. O'Neil
Senior Vice President
and Chief Actuary

Kevin C. O'Neill
Vice President,
Project Management Office

Joseph G. Rampone
Senior Vice President,
Operations

Gwendolyn D. Skillern
Senior Vice President
and General Auditor

William V. Stack
Vice President
and Corporate Controller

Michael Thompson
Vice President,
NCAS Administrators

T. Michelle Twohig
Vice President,
Operations
CASCI



FINANCIALS

CAREFIRST, INC. AND AFFILIATES
CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2004 AND 2003 WITH REPORT OF INDEPENDENT AUDITORS

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REPORT OF INDEPENDENT AUDITORS
BOARD OF DIRECTORS OF CAREFIRST, INC.
BOARD OF DIRECTORS OF CAREFIRST OF MARYLAND, INC.
BOARD OF TRUSTEES OF GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
BOARD OF DIRECTORS OF BCBSD, INC.

We have audited the accompanying consolidated balance sheets of CareFirst, Inc. and affiliates (collectively referred to as the Company) as of December 31, 2004 and 2003, and the related consolidated statements of operations, changes in reserves and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards 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 consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also 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.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Company at December 31, 2004 and 2003, and the consolidated results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

As discussed in Note 2 to the consolidated financial statements, in 2004 the Company changed its presentation of the revenue received and claims incurred under its administrative service arrangements.

February 7, 2005

Ernst + Young LLP

CAREFIRST, INC. AND AFFILIATES
CONSOLIDATED BALANCE SHEETS
(IN THOUSANDS)

	December 31	
	2004	2003
Assets		
Current assets:		
Cash and cash equivalents	\$ 293,662	\$ 180,371
Short-term investments	52,798	33,990
Advances to providers	180,044	161,897
Accounts receivable, less allowance for doubtful accounts of \$10,562 and \$15,468 as of December 31, 2004 and 2003, respectively	406,156	424,067
Interest income receivable	12,137	13,898
Current assets of discontinued operations	1,054	5,670
Other current assets	584,828	497,115
Deferred tax assets, net	25,123	24,374
Total current assets	1,555,802	1,341,382
Long-term investments	1,332,578	1,373,049
Property and equipment, net	144,118	146,697
Goodwill	29,956	25,405
Long-term assets of discontinued operations	19,621	19,966
Other assets	116,478	42,046
Total assets	\$ 3,198,553	\$ 2,948,545
Liabilities and reserves		
Current liabilities:		
Short-term borrowings	\$ 130,172	\$ 124,702
Medical claims payable	495,566	549,488
Accounts payable and accrued expenses	309,901	271,403
Unearned revenues	694,475	591,123
Group experience funds and advances	180,744	184,920
Current liabilities of discontinued operations	19,776	12,107
Total current liabilities	1,830,634	1,733,743
Obligations under capital lease	-	1,358
Deferred tax liabilities, net	34,340	11,170
Long-term employee benefit obligations	78,485	131,079
Long-term liabilities of discontinued operations	10,178	-
Other liabilities	8,675	7,585
Total liabilities	1,962,312	1,884,935
Reserves:		
Retained earnings	1,178,222	1,037,739
Accumulated other comprehensive income	58,019	25,871
Total reserves	1,236,241	1,063,610
Total liabilities and reserves	\$ 3,198,553	\$ 2,948,545

See accompanying notes.

CAREFIRST, INC. AND AFFILIATES
CONSOLIDATED STATEMENTS OF OPERATIONS
(IN THOUSANDS)

	Year ended December 31	
	2004	2003
Premiums earned	\$ 4,719,612	\$4,368,128
Amounts attributable to self-funded arrangements	3,166,750	3,005,796
Less amounts attributable to claims under self-funded arrangements	(2,932,973)	(2,758,717)
Other	29,756	27,792
Net revenue	<u>4,983,145</u>	<u>4,642,999</u>
Operating expenses:		
Cost of care	4,006,864	3,683,767
General and administrative	839,793	785,284
Total operating expenses	<u>4,846,657</u>	<u>4,469,051</u>
Income from operations	136,488	173,948
Investment income, net	94,107	75,960
Other than temporary impairment of investments	-	(3,871)
Other income, net	5,548	2,687
Income from continuing operations before provision for income taxes	<u>236,143</u>	<u>248,724</u>
Provision for income taxes	50,267	52,995
Income from continuing operations	<u>185,876</u>	<u>195,729</u>
Discontinued operations:		
Loss from discontinued operations, net of applicable income tax benefit of \$9,315 and \$3,570 for the years ended December 31, 2004 and 2003, respectively	(45,393)	(24,450)
Net income	<u>\$ 140,483</u>	<u>\$ 171,279</u>

See accompanying notes.

CAREFIRST, INC. AND AFFILIATES
CONSOLIDATED STATEMENTS OF CHANGES IN RESERVES
YEARS ENDED DECEMBER 31, 2004 AND 2003
(IN THOUSANDS)

	Accumulated Other Comprehensive Income (Loss)			
	Retained Earnings	Unrealized Gains (Losses) on Securities, Net	Minimum Pension Liability	Total Reserves
Balance, as of December 31, 2002	\$ 866,460	\$ 40,801	\$(32,917)	\$ 874,344
Net income	171,279	-	-	171,279
Other comprehensive income (loss), net of tax:				
Change in net unrealized gains and losses on investments, net of reclassification adjustments	-	22,194	-	22,194
Minimum pension liability adjustment	-	-	(4,207)	(4,207)
Total comprehensive income				189,266
Balance, as of December 31, 2003	1,037,739	62,995	(37,124)	1,063,610
Net income	140,483	-	-	140,483
Other comprehensive income (loss), net of tax:				
Change in net unrealized gains and losses on investments, net of reclassification adjustments	-	(3,002)	-	(3,002)
Minimum pension liability adjustment	-	-	35,150	35,150
Total comprehensive income				172,631
Balance, as of December 31, 2004	\$1,178,222	\$ 59,993	\$ (1,974)	\$1,236,241

See accompanying notes.

CAREFIRST, INC. AND AFFILIATES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(IN THOUSANDS)

	Year ended December 31	
	2004	2003
Operating activities		
Net income	\$ 140,483	\$ 171,279
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	50,085	51,043
Realized gains on investments, net	(33,558)	(14,949)
Building impairment loss	1,300	-
Other than temporary impairment of investments	-	3,871
Provision for deferred income taxes	13,382	6,923
Goodwill impairment	-	2,251
Changes in operating assets and liabilities:		
Increase in advances to providers	(18,147)	(12,297)
Decrease (increase) in accounts receivable, net	18,067	(33,646)
Decrease (increase) in interest income receivable	1,761	(3,622)
Decrease in other current assets	8,701	17,007
Increase in other assets	(74,428)	(7,201)
(Decrease) increase in medical claims payable	(54,054)	2,554
Increase (decrease) in accounts payable and accrued expenses	38,321	(138)
Increase in unearned revenues	6,906	43,258
Decrease in group experience funds and advances	(4,336)	(458)
(Decrease) increase in other liabilities	(51,664)	13,417
Changes in net assets and liabilities of discontinued operations	21,508	(11,779)
Net cash provided by operating activities	64,327	227,513
Investing activities		
Purchases of investments	(1,284,847)	(979,597)
Proceeds from sales of investments	1,381,506	674,721
Acquisition of subsidiary, less cash acquired	(4,404)	-
Purchases of property and equipment	(47,403)	(28,618)
Net cash provided by (used in) investing activities	44,852	(333,494)
Financing activities		
Increase in short-term borrowings	\$ 5,470	\$ 16,046
Payments on obligation under capital lease	(1,358)	(629)
Repayment on long-term debt	-	(81)
Net cash provided by financing activities	4,112	15,336
Net increase (decrease) in cash and cash equivalents	113,291	(90,645)
Cash and cash equivalents at beginning of year	180,371	271,016
Cash and cash equivalents at end of year	\$ 293,662	\$ 180,371
Supplemental disclosures		
Cash paid for income taxes	\$ 35,715	\$ 40,817
Cash paid for interest	\$ 73	\$ 320

See accompanying notes.

CAREFIRST, INC. AND AFFILIATES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2004
(IN THOUSANDS)

1. ORGANIZATION

CareFirst, Inc. (CFI) and affiliates (collectively referred to as the Company) provide a comprehensive array of health insurance and managed care products and services primarily through indemnity health insurance, health benefits administration and health maintenance organizations (HMOs). These products and services are provided to individuals, businesses and governmental agencies primarily in the states of Maryland and Delaware and in the Washington, D.C., metropolitan area.

CFI was incorporated on January 16, 1998 to become the not-for-profit parent of CareFirst of Maryland, Inc. (CFMI) and Group Hospitalization and Medical Services, Inc. (GHMSI). These affiliates do business as CareFirst BlueCross BlueShield. CFI has also entered into a business affiliation with BCBSD, Inc. (BCBSD), whereby CFI maintains the sole membership interest in BCBSD. On November 20, 2001, WellPoint Health Networks, Inc. (WellPoint) and CFI signed a definitive agreement to merge. Under the agreement, as amended in January 2003, WellPoint agreed to acquire CFI for \$1.37 billion following CFI's conversion to for-profit status and pending approval from various regulatory agencies. The purchase price would be provided to benefit residents in CFI's three principal operating areas: Maryland, Delaware and the District of Columbia.

On March 5, 2003, the application for conversion to for-profit status and to merge with WellPoint was denied by the Maryland Insurance Administration (MIA). In May 2003, the Maryland General Assembly passed legislation affecting CFI and its affiliates and subsidiaries. The new legislation, among other things, mandated replacement of all 12 Maryland domiciled board members on the CFI board of directors, which represent a majority of the 21-member board, and created certain oversight committees to monitor CFI. As of January 1, 2004, CFI had elected five replacement directors to the CFI board of directors. In June 2004, the CFI board selected the remaining mandated replacement members. The other nine CFI directors will remain on the CFI board until the expiration of their respective terms and until their respective successors are appointed, unless any such director earlier resigns, dies or is removed. The new legislation also prohibited CFI or any of its affiliates from implementing a conversion to for-profit status for a period of five years. The legislation led the Blue Cross Blue Shield Association (BCBSA) to terminate the service mark licenses of CFI and its affiliates in May 2003. In June 2003, the licenses were reinstated retroactively pursuant to a consent decree settling the litigation over the license terminations.

In response to the 2003 Maryland legislation and the reactions to this legislation by the District of Columbia Department of Insurance, Securities and Banking (DISB) and the Delaware Department of Insurance, the CFI board of directors approved changes in its affiliation arrangements with each of GHMSI and BCBSD and their respective affiliates, in each case subject to appropriate regulatory or other approvals. The CFI board of directors has approved, among other things, granting greater authority to the GHMSI representative directors on the CFI board regarding the nomination and removal of individuals to and from the GHMSI board of trustees, but has not approved any changes related to CFI's membership interest in GHMSI. The CFI board of directors also approved, among other things, the relinquishment of its sole membership interest in BCBSD and the creation of a new administrative services agreement between CFI and BCBSD, subject to approval of the appropriate regulatory authorities. Management believes that the proposed changes to the BCBSD affiliation, if approved by the regulatory authorities in their current form, would result in deconsolidation of BCBSD from CFI's consolidated financial statements on a prospective basis. On June 30, 2004, the Delaware Department of Insurance issued a ruling ordering termination of the affiliation agreement between CFI and BCBSD, but also providing that CFI could continue its affiliation with BCBSD on a contractual basis only if CFI transferred its corporate membership, BCBSA license and service mark back to the control of the BCBSD Board. CFI appealed that order to the New Castle County, Delaware, Superior Court, partly on the basis that the affiliation agreement could not be changed without the Maryland Insurance Commissioner's consent. On October 4, 2004, the court ruled in favor of the Delaware Department of Insurance on all issues. That ruling was appealed to the Delaware Supreme Court which affirmed the ruling. The Maryland Insurance Commissioner has rejected the proposed amendments to the BCBSD structural relationship and stated that CFI can appeal his decision, submit a new plan of affiliation, continue to operate under the existing agreement, or apply for permission to end the affiliation. CFI subsequently filed a motion requesting that the Federal District Court in Baltimore, Maryland assume jurisdiction over this matter. All parties have agreed to a 60-day stay period, beginning January 6, 2005, pending further discussions among the parties. There is no certainty at this time regarding the conclusion of these various matters. As of December 31, 2004, CFI maintains its full membership interest in BCBSD and control over the operations of BCBSD. As a result, the future impact, if any, of the above actions by the regulatory departments in Maryland, Delaware and the District of Columbia on the accompanying consolidated financial statements cannot be determined.

1. ORGANIZATION (CONTINUED)

On November 1, 2004, the Company completed its acquisition of The Dental Network, Inc. and The Dental Network Administrative Services, LLC (collectively, TDN) which market and administer managed dental benefits. The purchase price and related acquisition costs of approximately \$5,000 exceeded the estimated fair value of net assets acquired by \$4,551. Under the purchase method of accounting, the Company assigned this amount to goodwill. In addition, the terms of the transaction include a provision for additional contingent payments of up to \$1,500 based on TDN achieving certain performance targets during 2005 and 2006. The final amount of goodwill may increase as a result of these contingent payments. The operating results for TDN are included in the accompanying consolidated statements of operations for the period following the completion of the acquisition.

Effective January 1, 2005, a new subsidiary of GHMSI was created to operate the Federal Employee Program (FEP) operations center, which had previously been operated by GHMSI under a contract with the Blue Cross and Blue Shield Association (BCBSA). The newly created subsidiary, Service Benefit Plan Administrative Services Corporation (SBPASC), is 90% owned by GHMSI and 10% owned by BCBSA. See also Note 2.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of CFI and its wholly-owned subsidiaries; CFMI, GHMSI, CareFirst BlueChoice, Inc. (CFBC), and BCBSD. All intercompany transactions have been eliminated in consolidation.

Change in Presentation

During the year ended December 31, 2004, the Company changed the presentation of the revenue received and claims incurred under its administrative service arrangements. The Company has administrative service arrangements with certain customers under which the Company earns fees for processing medical claims and is reimbursed for the cost of such claims. Through December 31, 2003, the Company recorded all reimbursements and fees received under these administrative service arrangements as revenues and all claims paid for members under administrative service arrangements as cost of care. Beginning in 2004, the Company reclassified claims paid under its administrative service arrangements as a contra-revenue item in arriving at net revenue. Although the Company continues to believe that its administrative service arrangements meet certain of the "gross" revenue indicators, as stated in Emerging Issues Task Force No. 99-19, *Reporting Gross Revenue as a Principal vs. Net as an Agent (EITF 99-19)*, the Company also believes that such agreements meet certain net

revenue indicators, including the fact that the amount the Company can earn is generally fixed. The Company concluded in 2004 that "net" revenue presentation for administrative service arrangements provides a clearer representation of the risks and rewards related to such arrangements and provides greater comparability of the Company's financial statements to its industry peers. The 2003 statement of operations has been reclassified in order to conform to the 2004 presentation. This change had no impact on consolidated income from operations or net income for 2004 or 2003.

Consistent with this change in presentation, the Company also adopted a net presentation related to medical claims payable and the offsetting accounts receivable related to its administrative service arrangements. Accordingly, the Company has reduced amounts previously reported in the December 31, 2003 consolidated balance sheet for medical claims payable and accounts receivable, each by \$381,537. This change had no impact on consolidated reserves.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States (GAAP) requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Reclassifications

Certain amounts from the prior year financial statements have been reclassified in order to conform with the current year presentation. During the year ended December 31, 2004, the Company changed the classification of its broker fees and premium taxes from contra-revenue to general and administrative expenses. Broker fees and premium taxes incurred in 2003 of \$155,329 were reclassified in the accompanying 2003 consolidated statement of operations to conform with this presentation.

Fair Value of Financial Instruments

The carrying amounts of financial instruments, including cash and cash equivalents, advances to providers, accounts receivable, interest income receivable, other current assets, investments, short-term borrowings, medical claims payable, accounts payable and accrued expenses, unearned revenues, and group experience funds and advances, approximate fair value.

Cash and Cash Equivalents and Short-Term Borrowings

Cash and cash equivalents include amounts invested in accounts that are readily convertible to cash. Investments with contractual maturities of ninety days or less from the date of original purchase

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

are classified as cash and cash equivalents. In accordance with the Company's cash management policy of maximizing the amount of funds invested in income-earning assets, the Company routinely anticipates the timing and amount of future cash flows. This policy frequently results in the existence of negative book cash balances, which are reflected as short-term borrowings in the accompanying consolidated financial statements.

Accounts Receivable

Accounts receivable primarily represent uncollected amounts earned from insured and self-funded groups. Provision is made for accounts considered uncollectible and/or potential adjustments that arise as a result of review by management or a third party.

Advances to Providers

The Company has advances on deposit with certain hospitals in the state of Maryland. These advances permit the Company to earn differentials of 2.25% and 2.00% of allowed inpatient and outpatient charges, respectively, by these hospitals.

Investments

Investment Securities

Investments consist primarily of U.S. Treasury and agency securities, foreign government bonds, corporate bonds, equity securities and mortgage-backed securities.

The Company has determined that its debt and equity securities are available-for-sale. Debt and equity securities are carried at estimated fair value based on quoted market prices for the same or similar instruments. The Company's policy is to classify all investments with contractual maturities within one year as current. Investment income is recognized when earned and reported net of investment expenses. Unrealized holding gains and losses are excluded from earnings and are reported as a separate component of other comprehensive income until realized, unless the losses are deemed to be other than temporary. Realized gains or losses, including any provision for other than temporary declines in value, are included in the consolidated statements of operations.

The Company periodically evaluates whether any declines in the fair value of investments are other than temporary. This evaluation consists of a review of several factors, including but not limited to: length of time and extent that a security has been in an unrealized loss position; the existence of an event that would impair the issuer's future earnings potential; the near term prospects for recovery of the market value of a security; and the intent and ability of the Company to hold the security until the market value recovers. Declines in value below cost for debt securities where it is considered probable that all contractual terms of the security will

be satisfied, the decline is due primarily to changes in interest rates (and not because of increased credit risk), and where the Company intends and has the ability to hold the investment for a period of time sufficient to allow a market recovery, are not assumed to be other than temporary. Unrealized losses related to equity securities greater than one year are not significant. The unrealized losses related to equity securities less than one year, except as discussed below, have not been deemed to be other than temporary impairments. Declines in fair value below cost that are deemed to be other than temporary are recorded as realized losses and are included in "other than temporary impairment of investments" in the accompanying consolidated statements of operations. Based on its evaluation, the Company has recorded an other than temporary impairment of investments of \$3,871 for the year ended December 31, 2003. There were no other than temporary impairments of investments for the year ended December 31, 2004.

Investment Real Estate Held for Sale

During 2004, in connection with discontinuance of physician group operations discussed in Note 3, certain owned buildings of the Company were reclassified as investment real estate held for sale in accordance with Statement of Financial Accounting Standards No. 60, *Accounting and Reporting by Insurance Enterprises* (SFAS No. 60). Investment real estate held for sale is carried within long-term assets of discontinued operations at the lower of carrying value or fair value less estimated selling costs. Fair value is generally estimated using comparable sales information. At the time of sale, the difference between the sales price and carrying value is recorded as a realized capital gain or loss. Upon revaluing the real estate held for sale under SFAS No. 60, an impairment loss of \$1,300 (pre-tax) was recognized during the year ended December 31, 2004. This loss is included as a component of discontinued operations in the accompanying 2004 statement of operations.

Property and Equipment

Property and equipment are recorded at cost and are depreciated using the straight-line method over useful lives ranging from three to five years for purchased computer equipment and software, three to five years for capitalized software, four to twelve years for furniture and equipment, and fifteen to forty years for buildings and building improvements. Leasehold improvements are amortized over the terms of the respective leases or over the estimated useful life of the improvements, if shorter than the lease term.

Certain costs related to the development or purchase of internal-use software are capitalized and amortized over the estimated useful life of the software. Computer software costs that are incurred in the preliminary project stage are expensed as incurred. Direct consulting costs, payroll and payroll-related costs for employees incurred during the development stage that are directly

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

associated with each project are capitalized and amortized over the estimated useful life of the software once placed into operation.

Goodwill

Goodwill represents the excess of the cost of businesses acquired over the fair value of the net identifiable assets at the date of acquisition.

The Company follows Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets* (SFAS No. 142) and does not amortize goodwill. The Company has determined that it has five reporting units: third party administrative (TPA), HMO, indemnity risk, indemnity non-risk, and the Federal Employee Program (FEP). In accordance with SFAS No. 142, the Company completed its annual goodwill impairment evaluations at October 1, 2003 and 2004. Due to lower than projected growth rates, combined with the loss of certain contract lives, operating profits and cash flows for the TPA reporting unit were lower than expected during 2003. Based on that trend, the earnings forecast for the next five years was revised. As a result, a goodwill impairment loss of \$2,251 was recognized in the TPA reporting unit and has been included within general and administrative expenses in the accompanying consolidated statement of operations for the year ended December 31, 2003. The fair value of the reporting unit was estimated using the expected value of future cash flows.

The changes in the carrying amount of goodwill are as follows for the years ended December 31:

	HMO Reporting Unit	TPA Reporting Unit	Total
Balance as of January 1, 2003	\$ 25,405	\$ 2,251	\$ 27,656
Impairment loss	–	(2,251)	(2,251)
Balance as of December 31, 2003	25,405	–	25,405
Acquisition of TDN (see Note 1)	4,551	–	4,551
Balance as of December 31, 2004	\$29,956	\$ –	\$29,956

Other Assets

Other assets primarily include prepaid pension costs, an investment in a real estate joint venture, which is accounted for under the equity method, and cash surrender value of life insurance policies.

Medical Claims Payable

The liability for medical claims payable is computed in accordance with generally accepted actuarial practices and is based upon authorized health care services and past claims payment experience, together with current factors which, in management's judgment, require recognition in the calculation to determine its best estimate or amounts to be paid. These estimates are reviewed periodically and any adjustments are reflected in current operations. Due to uncertainties inherent in the claims estimation process, it is reasonably possible that the claims paid could differ materially from accrued amounts.

Revenue Recognition

Premiums earned are recognized when earned on a monthly basis for the period the health care coverage is in effect. Unearned revenues represent prepayments of premiums for future health care coverage and FEP unearned premiums.

The Company provides coverage for certain groups whose contracts provide for payments based on group experience factors (experience rated contracts). Under these contracts, revenue is generally recorded on the basis of incurred claims, plus retention. In certain cases, maximum rates are established by contract, and losses can result if claims and retention exceed these maximum rates. Any such losses are recorded in the year incurred and may, in many cases, be recouped against subsequent years' gains.

The Company participates with other Blue Cross and Blue Shield plans in administering the health care benefits of various accounts of the other plans. Administrative fees are generally recognized as earned for the period the participating agreement is in effect and are recorded as a reduction of general and administrative expenses.

Certain claim payments, premium rates, administrative expense reimbursements and provider discounts are subject to review and potential retroactive adjustment by third parties. Reserves to reduce revenue are established for potential obligations arising from such reviews. While claims for such adjustments have been asserted against the Company, management believes that the resolution of these claims will not be materially different from amounts recorded in the accompanying consolidated financial statements.

Cost of Care

Cost of care is recognized in the period in which members receive medical services. In addition to actual benefits paid, cost of care includes the impact of accruals for estimates of reported and unreported claims, which are unpaid as of the balance sheet date.

The Company negotiates contractual agreements with physicians and medical management groups to provide defined health care services to its members. All other physician and institutional services are provided by medical providers to whom the Company pays fees based upon fee schedules.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Income Taxes

The Company's provision for income taxes reflects the estimated current and future tax consequences of all events that have been recognized in the consolidated financial statements as measured by the provisions of currently enacted tax laws and rates applicable to future periods.

Comprehensive Income

Comprehensive income encompasses all changes in reserves and includes net income, net unrealized gains or losses on available-for-sale securities, and minimum pension liability adjustments. Comprehensive income is net of reclassification adjustments to adjust for items currently included in net income, such as realized gains or losses on investment securities.

Federal Employee Program

The Company participates in the Blue Cross and Blue Shield FEP, which is one of the plans offered through the Federal Employee Health Benefits Program (FEHBP), administered by the Office of Personnel Management (OPM). Claims incurred on behalf of FEP are reimbursed by OPM and reported as revenues during the period in which the claims are incurred. The related administrative fees are recognized as revenues as they are earned during the contract period. BCBSA contracts directly with OPM to administer FEP and subcontracts with CFMI, GHMSI and BCBSD. BCBSA also provides information to the Company for inclusion in the accompanying consolidated financial statements. The BCBSA contract and the Company's subcontract are experience rated and could result in losses to the Company under certain circumstances. OPM conducts periodic audits to verify compliance with FEHBP requirements.

OPM holds certain reserves on behalf of the Company to provide funding, if necessary, for excess claims costs, subject to certain limitations. The Company records its allocable share of amounts held by OPM as an asset, with an equivalent amount recorded as unearned revenues. These amounts are \$561,387 and \$465,017 as of December 31, 2004 and 2003, respectively, and are included in other current assets and unearned revenues, respectively, in the accompanying consolidated balance sheets. Amounts incurred in excess of these reserves would not be reimbursed to the Company. The BCBSA contract renews automatically each year unless written notice of termination is given by either party.

FEP represented approximately 65% and 64% of accounts receivable as of December 31, 2004 and 2003, respectively. FEP represented approximately 36% and 35% of net revenues for the years ended December 31, 2004 and 2003, respectively.

Reimbursement of FEP Operations Center Expenses

GHMSI performs certain administrative functions as the national operations center for FEP under a cost reimbursement contract with BCBSA. The reimbursement of allocable costs under this contract is recorded as a reduction to general and administrative expenses. FEP reimbursed the Company for costs incurred in connection with this agreement totaling \$55,803 and \$55,896 for the years ended December 31, 2004 and 2003, respectively.

During 2004, the Company was notified by BCBSA that this cost-reimbursement contract, which expired December 31, 2004, would not be renewed under its then-present structure. Effective January 1, 2005, a new subsidiary of GHMSI was created to operate the FEP operations center under a 10-year contract with BCBSA. The newly created subsidiary, Service Benefit Plan Administrative Services Company, is owned 90% by GHMSI and 10% by BCBSA. The arrangement contains automatic termination provisions upon the occurrence of certain triggering events. The creation of the new subsidiary will not have a significant impact on the accompanying consolidated financial statements.

Reimbursement of Medicare Claims Cost and Expenses

CFMI acted as a fiscal intermediary under contract with BCBSA for Part A of the Medicare program in 2004 and 2003. Under this contract, CFMI processed claims of approximately \$4.4 billion and \$3.9 billion for the years ended December 31, 2004 and 2003, respectively. Payment and reimbursement of Medicare claims are not included in the accompanying consolidated financial statements.

Administrative expense reimbursements received from the Medicare program were approximately \$10,220 and \$10,617 for the years ended December 31, 2004 and 2003, respectively. Operating expenses in the accompanying consolidated statements of operations are recorded net of these reimbursements. During 2004, CFMI entered into a Corporate Integrity Agreement with the Centers for Medicare and Medicaid Services related to certain compliance issues which occurred in its Medicare fiscal intermediary operations (see Note 13).

Recent Accounting Pronouncements

In January 2003, the FASB issued Interpretation No. 46, *Consolidation of Variable Interest Entities* (VIE), which was subsequently reissued in December 2003 as Interpretation No. 46 – Revised (FIN 46). FIN 46 requires the consolidation of entities in which an enterprise absorbs a majority of the entity's expected losses, receives a majority of the entity's expected residual returns, or both, as a result of ownership, contractual or other financial interests in the entity. Currently, entities are generally consolidated by an enterprise when it has a controlling financial interest through ownership of a majority voting interest in the entities. FIN 46 also

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

requires additional disclosure of an entity's relationship with a VIE. The Company chose to early adopt FIN 46 during 2004. As a result, Potomac Physicians, P.A. (PPPA), a related professional association, was consolidated in the accompanying consolidated financial statements.

The 2003 financial statements have been restated to consolidate PPPA in order to conform with the 2004 presentation. As PPPA's losses have been funded by the Company through an ongoing support arrangement, there was no impact on net income or retained earnings of the Company in the accompanying consolidated financial statements as a result of the consolidation. Also, the impact of consolidating PPPA on the Company's total assets was not material. During 2004, the Company also terminated its affiliation with PPPA, as discussed in Note 3.

3. DISCONTINUED OPERATIONS

Potomac Physicians, P.A.

As noted in Note 2, PPPA has been consolidated in the accompanying financial statements as a result of the Company's adoption of FIN 46. The PPPA operations are no longer considered part of the Company's core business, and as a result, effective August 13, 2004, the Company terminated its affiliation with PPPA. The termination met the requirements for discontinued operations treatment under SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, as PPPA meets the definition of a component of an entity.

In connection with the discontinuance of PPPA, the Company recorded expenses of \$7,530, which included estimated severance costs, lease terminations, a write-down of real estate held for sale and certain other direct and incremental costs.

The results of operations of PPPA, including the costs of discontinuance, included in discontinued operations are as follows:

	December 31	
	2004	2003
Revenues	\$ 8,801	\$15,195
Operating expenses:		
Cost of care	12,218	19,733
General and administrative	12,199	4,414
Total operating expenses	24,417	24,147
Loss from discontinued operations before benefit for income taxes	(15,616)	(8,952)
Benefit for income taxes	(1,534)	-
Loss from discontinued operations	\$(14,082)	\$(8,952)

The major classes of assets and liabilities of discontinued operations related to PPPA as of December 31, 2004 and 2003, respectively, which are reflected in the accompanying consolidated balance sheets are as follows:

	2004	2003
Cash and cash equivalents	\$ -	\$ 646
Accounts receivable, net	-	1,104
Other current assets	-	387
Property and equipment	-	862
Investment real estate held for sale	5,363	7,467
Other assets	1,264	-
Total assets	6,627	10,466
Accounts payable and accrued expenses	(10,272)	(7,712)
Reserves for discontinued operations	(4,511)	-
Net (liabilities) assets	\$ (8,156)	\$ 2,754

A rollforward of reserves related to the discontinuance of PPPA for the year ended December 31, 2004 is as follows:

	Beginning reserve (August 13, 2004)	Payments	December 31, 2004
Lease obligations	\$4,852	\$(402)	\$ 4,450
Employee severance and termination	160	(99)	61
	\$5,012	\$(501)	\$ 4,511

Patuxent Medical Group

Effective November 1, 2004, the Company ceased operations of Patuxent Medical Group (PMG), a wholly owned subsidiary. Similar to PPPA, the PMG operations are no longer considered part of the Company's core business. This event met the requirements for discontinued operations treatment under SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, as PMG meets the definition of a component of an entity.

In connection with the discontinuance of PMG, the Company recorded expenses of \$20,400, which included estimated contract terminations, severance and certain other direct and incremental costs.

3. DISCONTINUED OPERATIONS (CONTINUED)

The results of operations of PMG, including the costs of discontinuance, included in discontinued operations are as follows:

	December 31	
	2004	2003
Revenues	\$ 8,043	\$ 10,161
Operating expenses:		
Cost of care	47,665	31,291
Loss from discontinued operations before investment (loss) income and benefit for income taxes	(39,622)	(21,130)
Investment (loss) income, net	(13)	17
Benefit for income taxes	(7,926)	(4,085)
Loss from discontinued operations	\$(31,709)	\$(17,028)

The major classes of assets and liabilities of discontinued operations related to PMG as of December 31, 2004 and 2003, respectively, which are reflected in the accompanying consolidated balance sheets are as follows:

	2004	2003
Cash and cash equivalents	\$ 975	\$ 880
Accounts receivable, net	62	844
Other current assets	17	1,809
Property and equipment	798	911
Investment real estate held for sale	9,848	10,253
Other assets	2,348	473
Total assets	14,048	15,170
Medical claims payable	(569)	(1,047)
Accounts payable and accrued expenses	(4,165)	(2,819)
Reserves for discontinued operations	(10,437)	-
Net (liabilities) assets	\$(1,123)	\$ 11,304

A rollforward of reserves related to the discontinuance of PMG for the year ended December 31, 2004 is as follows:

	Beginning reserve (November 1, 2004)	Payments	December 31, 2004
Physician severance and contract termination	\$16,213	\$(7,348)	\$ 8,865
Other employee severance and termination	3,096	(1,524)	1,572
	<u>\$19,309</u>	<u>\$(8,872)</u>	<u>\$10,437</u>

Public HMO Segments—FSHP

In July 2000, management and the Board of Directors of the Company adopted a formal plan for one of the Company's HMOs, Free State Health Plan, Inc. (FSHP), to fully exit its Medicare HMO segment effective December 31, 2000. In December 2000, management and the Board of Directors also adopted a formal plan for FSHP to fully exit its Medicaid HMO segment effective March 31, 2001. These segments included all of the operations surrounding FSHP's Medicare and Medicaid risk products. As of December 31, 2001, the Company had completed its exit from these businesses.

The Company accounted for the disposal of the segments under Accounting Principles Board Opinion No. 30, *Reporting the Results of Operations—Reporting the Effects of Disposal of a Segment of a Business, and Extraordinary, Unusual and Infrequently Occurring Events and Transactions* (APB 30). APB 30 requires that the results of continuing operations be reported separately from those of discontinued operations for all periods presented and that any gain or loss from disposal of a discontinued business segment be reported in conjunction with the related results of the discontinued operations.

The following is a summary of the current assets and liabilities of the FSHP discontinued segments as of December 31, 2004 and 2003, respectively, which are reflected in the accompanying consolidated balance sheets.

	2004	2003
Medical claims payable	\$ -	\$(529)
Current liabilities of discontinued operations	\$ -	\$(529)

For the years ended December 31, 2004 and 2003, net income from discontinued operations was \$398 and \$1,112, respectively.

3. DISCONTINUED OPERATIONS (CONTINUED)

International Operations—BCBSD

During 2000, BCBSD entered into transactions that effectively resulted in a discontinuance of its international operations through the sale of foreign subsidiaries. In November 2001, the Company finalized these sales transactions. BCBSD accounted for these transactions as discontinued operations under APB 30.

For the year ended December 31, 2003, income from discontinued operations was \$418, net of provision for income taxes of \$105, and was related to changes in estimated liabilities under reinsurance contracts.

4. REGULATORY MATTERS

The Company is subject to regulation and supervision by regulatory authorities of the various jurisdictions in which they are licensed to conduct business. These jurisdictions mandate the maintenance of minimum statutory reserves and unassigned funds and prohibit certain transactions between the Company and its affiliates without prior regulatory approval. In addition, the Company also must comply with various conditions, restricting certain operations and financial transactions that were contained in regulatory orders approving the affiliation of CFMI and GHMSI and the affiliation of the Company and BCBSD.

Financial statements filed by CFI and its affiliates with their respective state insurance regulators are prepared in accordance with statutory accounting practices, which differ from GAAP. The most significant differences result from the exclusion of certain assets from statutory reserves, recording subordinated notes payable as a component of reserves and unassigned funds for statutory accounting and as a liability for GAAP, differences in the carrying value of investments, valuation of investments in subsidiaries, treatment of subsidiary net income (losses) as an unrealized capital gain (loss), and the modification or exclusion of certain Statements of Financial Accounting Standards.

At December 31, 2004, the Company's regulated subsidiaries' statutory reserves and unassigned funds exceed the minimum statutory requirements as determined by each of the jurisdictions in which those subsidiaries conduct business.

5. INVESTMENTS

The Company's investments consist of the following:

	Amortized Cost Basis	Gross Unrealized Loss	Gross Unrealized Gains	Fair Value
December 31, 2004:				
Debt securities issued by the U.S. Treasury and other U.S. government agencies	\$ 262,333	\$ 1,834	\$ 4,673	\$ 265,172
Foreign government debt securities	782	–	99	881
Corporate debt securities	480,738	2,569	26,337	504,506
Equity securities	152,179	3,297	55,461	204,343
Mortgage-backed securities	408,817	2,168	3,825	410,474
Total investments	\$1,304,849	\$9,868	\$90,395	\$1,385,376
December 31, 2003:				
Debt securities issued by the U.S. Treasury and other U.S. government agencies	\$ 240,138	\$ 2,592	\$ 7,879	\$ 245,425
Foreign government debt securities	3,962	36	304	4,230
Corporate debt securities	567,937	2,510	35,958	601,385
Equity securities	152,287	5,970	43,284	189,601
Mortgage-backed securities	362,402	2,211	6,207	366,398
Total investments	\$1,326,726	\$13,319	\$93,632	\$1,407,039

The amounts shown above as amortized cost basis include the effects of other than temporary impairments of investments previously recognized through net income.

5. INVESTMENTS (CONTINUED)

The amortized cost and estimated fair value of debt securities at December 31, 2004, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities of mortgage-backed securities because borrowers have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost Basis	Fair Value
Within 1 year	\$ 52,510	\$ 52,798
After 1 year through 5 years	295,259	300,825
After 5 years through 10 years	197,670	204,603
After 10 years	198,414	212,333
Mortgage-backed securities	408,817	410,474
Total	<u>\$1,152,670</u>	<u>\$1,181,033</u>

Available-for-sale securities were sold as follows for the years ended December 31:

	2004	2003
Proceeds from sales	\$1,381,506	\$ 674,721
Gross realized gains	46,686	28,488
Gross realized losses	13,128	13,539

For purposes of computing realized gains and losses, the specific identification method of determining cost was used.

6. PROPERTY AND EQUIPMENT

Property and equipment are comprised of the following as of December 31:

	2004	2003
Land	\$ 315	\$ 315
Buildings and building improvements	9,863	18,587
Leasehold improvements	27,112	22,202
Purchased computer equipment and software	77,650	74,281
Capitalized software	187,884	167,491
Furniture and equipment	69,071	67,888
	371,895	350,764
Less accumulated depreciation and amortization	227,777	204,067
Property and equipment, net	\$ 144,118	\$ 146,697

Depreciation and amortization expense on property and equipment was \$50,085 and \$51,043 for the years ended December 31, 2004 and 2003, respectively, and is included as a component of cost of care and general and administrative expenses, as applicable, in the accompanying consolidated statements of operations.

7. MEDICAL CLAIMS PAYABLE

Activity in the liability accounts for medical claims is summarized as follows:

	2004	2003
Balance as of January 1	\$ 549,488	\$ 538,962
Acquisition of TDN (see Note 1)	132	-
Incurred related to:		
Current year	4,073,669	3,762,695
Prior years	(66,805)	(78,928)
Total incurred	4,006,864	3,683,767
Paid related to:		
Current year	3,591,487	3,230,748
Prior years	469,431	442,493
Total paid	4,060,918	3,673,241
Balance at December 31	\$ 495,566	\$ 549,488

For the years ended December 31, 2004 and 2003, approximately \$(20,465) and \$(22,865) of the incurred amount related to prior years was a result of changes in estimates for FEP contracts. These changes were offset by similar changes in revenue and thus, no significant change in income from operations arose as a result of these changes.

Changes in the estimates associated with medical claims payable are recorded prospectively as changes in claims payment patterns, membership and utilization trends are identified and quantified.

The Company accrues estimated claims processing expenses relating to the liability for unpaid claims. These accruals totaled \$19,277 and \$21,878 as of December 31, 2004 and 2003, respectively, and are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets.

8. LEASE COMMITMENTS

Operating Lease Obligations

The Company leases certain administrative offices and medical facilities and equipment under operating leases. Some of these lease agreements contain escalation clauses for increases in real estate taxes and operating costs over base year amounts. These leases expire on various dates with renewal options available on many of the leases.

8. LEASE COMMITMENTS (CONTINUED)

Future noncancelable minimum payments for leases are as follows:

2005	\$ 42,204
2006	41,800
2007	39,129
2008	30,338
2009	20,562
Thereafter	51,761
	<u>\$ 225,794</u>

Rent expense for the years ended December 31, 2004 and 2003 for all operating leases was \$42,968 and \$38,033, respectively, and has been included within general and administrative expenses in the accompanying consolidated statements of operations.

9. PENSION BENEFITS

Prior to December 31, 2002, CFMI and GHMSI maintained qualified noncontributory defined benefit retirement plans covering substantially all full-time employees. Effective December 31, 2002, these plans merged to become the CareFirst, Inc. Retirement Plan. Although the Company merged the CFMI and GHMSI plans, it has committed to maintain separate record keeping of plan assets and benefit obligations so that it will comply with certain regulatory restrictions that apply to CFMI and GHMSI. Consistent with the standards for multiple-employer plan accounting, CFMI and GHMSI have accounted for their net pension

obligation as if the plans had remained separate. BCBSD also has a qualified noncontributory defined benefit retirement plan covering substantially all full-time employees.

The annual contributions are not less than the minimum funding standards set forth in the Employee Retirement Income Security Act of 1974, as amended. The plans provide for eligible employees to receive benefits based principally on years of service with the Company and a percentage of certain compensation prior to normal retirement.

For financial reporting purposes under SFAS No. 87, *Employers' Accounting for Pensions* (SFAS 87), a pension plan is considered underfunded when the fair value of plan assets is less than the accumulated benefit obligation. When that is the case, an additional pension liability must be recognized for the difference between the accrued pension cost and the minimum liability which represents the amount of the unfunded accumulated benefit obligation. In recognizing such a liability, an intangible asset may also be recorded up to the amount of the prior service cost not yet recognized. When the liability is greater than the intangible asset limit, a charge is recorded to accumulated other comprehensive income for the excess amount, net of any tax effects. As of December 31, 2003, the Company has recorded charges to other comprehensive income as the result of certain minimum pension liabilities for its qualified plans. During 2004, these charges have been reversed since additional minimum pension liabilities were not required for the qualified plans as of December 31, 2004.

The following tables set forth the Company's plans' obligations, funded status, amounts recognized in the accompanying consolidated financial statements and certain other related information as of December 31:

	CFMI	2004 GHMSI	BCBSD
Accumulated benefit obligation	\$184,164	\$240,187	\$ 70,218
Change in projected benefit obligation:			
Benefit obligation at beginning of year	\$185,966	\$236,063	\$ 71,754
Service cost	10,341	6,601	2,401
Interest cost	11,636	14,245	4,555
Actuarial loss	18,704	5,841	4,317
Plan curtailment	(2,480)	–	–
Benefits paid	(14,634)	(8,398)	(2,333)
Benefit obligation at end of year	\$209,533	\$254,352	\$ 80,694
Change in plan assets of the qualified pension plans:			
Fair value of plan assets at beginning of year	\$110,289	\$240,794	\$ 39,513
Actual return on plan assets	16,039	18,834	6,484
Employer contributions	77,730	900	30,132
Benefits paid	(14,634)	(8,398)	(2,333)
Fair value of plan assets at end of year	\$189,424	\$252,130	\$ 73,796

9. PENSION BENEFITS (CONTINUED)

	CFMI	2004 GHMSI	BCBSD
Funded status	\$ (20,109)	\$ (2,222)	\$ (6,898)
Unrecognized actuarial loss	74,824	38,435	22,509
Unrecognized prior service asset	(9,020)	(13,419)	(156)
Net amount recognized—prepaid pension asset	\$ 45,695	\$ 22,794	\$ 15,455
Amounts recognized in the consolidated balance sheet consist of:			
Prepaid pension asset	\$ 45,695	\$ 22,794	\$ 15,455
Additional information			
Decrease in minimum liability included in other comprehensive income (pre-tax)	\$ (31,284)		\$ (13,938)
Components of net periodic benefit cost (credit) for the year ended December 31, 2004, are as follows:			
Service cost	\$ 10,341	\$ 6,601	\$ 2,401
Interest cost	11,636	14,245	4,555
Expected return on plan assets	(11,612)	(20,267)	(3,971)
Amortization of prior service asset	(1,688)	(1,905)	(59)
Plan curtailment	(1,107)	—	—
Net recognized actuarial loss	3,995	—	1,971
Net periodic benefit cost (credit)	\$ 11,565	\$ (1,326)	\$ 4,897
Weighted-average assumptions to determine benefit obligations:			
Discount rate – benefit obligation	5.75%	5.75%	5.75%
Discount rate – net benefit cost	6.25%	6.25%	6.25%
Rate of compensation increase	4.50%	4.50%	4.50%
Expected return on plan assets	8.50%	8.50%	8.50%

	CFMI	2003 GHMSI	BCBSD
Accumulated benefit obligation	\$162,043	\$ 225,974	\$ 63,232
Change in projected benefit obligation:			
Benefit obligation at beginning of year	\$171,659	\$ 211,186	\$ 57,747
Service cost	9,211	5,797	2,088
Interest cost	10,909	14,273	4,284
Actuarial loss	2,842	12,619	10,354
Plan amendments	168	317	(832)
Benefits paid	(8,823)	(8,129)	(1,887)
Benefit obligation at end of year	\$185,966	\$ 236,063	\$ 71,754
Change in plan assets of the qualified pension plans:			
Fair value of plan assets at beginning of year	\$ 91,330	\$ 202,910	\$ 34,461
Actual return on plan assets	19,612	44,313	5,182
Employer contributions	8,170	1,700	1,757
Benefits paid	(8,823)	(8,129)	(1,887)
Fair value of plan assets at end of year	\$110,289	\$ 240,794	\$ 39,513

9. PENSION BENEFITS (CONTINUED)

	CFMI	2003 GHMSI	BCBSD
Funded status	\$ (75,677)	\$ 4,731	\$(32,241)
Unrecognized actuarial loss	67,022	31,161	22,676
Unrecognized prior service asset	(11,815)	(15,324)	(215)
Net amount recognized—(accrued pension cost) or prepaid pension asset	\$ (20,470)	\$ 20,568	\$ (9,780)
Amounts recognized in the consolidated balance sheet consist of:			
Accrued pension (cost) or prepaid pension asset	\$ (20,470)	\$ 20,568	\$ (9,780)
Additional liability—other comprehensive loss	(31,284)		(13,938)
Required minimum liability	\$ (51,754)		\$(23,718)
Additional information			
Increase in minimum liability included in other comprehensive income (pre-tax)	\$ 2,287	\$ —	\$ 4,534
Components of net periodic benefit cost (credit) for the year ended December 31, 2003, are as follows:			
Service cost	\$ 9,211	\$ 5,797	\$ 2,088
Interest cost	10,909	14,273	4,284
Expected return on plan assets	(9,853)	(20,188)	(2,990)
Amortization of transition asset	—	—	(24)
Amortization of prior service asset	(2,069)	(2,211)	(59)
Net recognized actuarial loss	2,395	—	1,536
Net periodic benefit cost (credit)	\$ 10,593	\$ (2,329)	\$ 4,835
Weighted-average assumptions to determine benefit obligations:			
Discount rate – benefit obligation	6.25%	6.25%	6.25%
Discount rate – net benefit cost	6.75%	6.75%	6.75%
Rate of compensation increase	4.50%	4.50%	4.50%
Expected return on plan assets	8.50%	8.50%	8.50%

During the year ended December 31 2004, the Company recorded a \$1,107 curtailment gain as a result of the discontinuance of PPPA and PMG, as discussed in Note 3. The curtailment gain is included within the 2004 loss from discontinued operations in the accompanying consolidated statement of operations.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the investment categories, weighted based on the median of the target allocation for each class. Equity securities are expected to return 8% to 12% over the long-term, while cash and fixed income securities are expected to return between 4% and 6%. Based on historical experience, the CareFirst, Inc. Retirement Committee expects that the Plan's asset

managers will provide a modest (0.5% – 1.0% per annum) premium to their respective market benchmark indices.

The Company's investment policy, as established by the CareFirst, Inc. Retirement Committee, is to provide for growth of capital with a moderate level of volatility by investing assets per the target allocations stated below. The assets are reallocated as needed to meet the above target allocations. The investment policy is reviewed on a quarterly basis, under the advisement of a certified investment advisor, to determine if the policy should be changed.

The pension plan weighted-average asset allocations by asset category are as follows as of December 31:

9. PENSION BENEFITS (CONTINUED)

	Target Allocation	CFMI	2004 GHMSI	BCBSD
Domestic equity securities	46%-58%	53%	51%	53%
International equity securities	10%-16%	13	16	13
Debt securities	32%-38%	29	30	29
Cash	Residual	5	3	5
Total		100%	100%	100%

	Target Allocation	CFMI	2003 GHMSI	BCBSD
Domestic equity securities	46%-58%	53%	53%	54%
International equity securities	10%-16%	14	14	12
Debt securities	32%-38%	33	32	31
Cash	Residual	–	1	3
Total		100%	100%	100%

The Company expects to make contributions during 2005 of \$8,531 to the CFMI plan, \$1,983 to the GHMSI plan and \$3,949 to the BCBSD plan.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending December 31:

	CFMI	GHMSI	BCBSD
2005	\$ 12,619	\$ 15,776	\$ 6,034
2006	15,513	15,781	6,225
2007	14,664	17,066	6,444
2008	16,611	18,987	7,076
2009	22,152	20,594	7,524
2010 through 2014	146,223	118,487	41,126
Total	\$227,782	\$206,691	\$74,429

The Company has nonqualified supplemental retirement benefit plans covering certain officers, which provide for eligible employees to receive additional benefits based principally on compensation and years of service. These plans provide for incremental benefit payments from the Company's funds so that total benefit payments equal amounts that would have been payable from the Company's principal retirement plan if it were not for limitations imposed by income tax regulations. As of December 31, 2004 and 2003, CFMI has accrued \$17,801 and \$14,541, respectively, GHMSI has accrued \$2,302 and \$2,069, respectively, and BCBSD has accrued \$2,796 and \$2,785, respectively, for these benefits. Supplemental retirement benefit plan expense for the years ended December 31,

2004 and 2003, for CFMI was \$3,261 and \$2,996, respectively, for GHMSI was \$264 and \$232, respectively, and for BCBSD was \$10 and \$(7), respectively.

As of December 31, 2004 and 2003, an additional minimum pension liability of \$3,903 and \$2,938, respectively, was recognized for CFMI's supplemental retirement plans. In accordance with SFAS 87, as of December 31, 2004 and 2003, respectively, an intangible asset of \$943 and \$1,072 was also recorded.

In addition, the Company sponsors 401(k) plans for the benefit of all eligible employees. The Company contributes to certain of these plans and recognized expenses for the years ended December 31, 2004 and 2003, of \$5,941 and \$6,212, respectively.

10. POSTRETIREMENT BENEFITS

The Company provides certain healthcare benefits for retired employees. Substantially all employees become eligible for these benefits if they reach early retirement age while working for the Company and meet certain eligibility requirements. The Company's postretirement benefit programs provide for specific benefits based primarily on the retiree's age and years of service with the Company.

In accordance with SFAS No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, the Company records the expected cost of these benefits as expense during the years that employees render service.

10. POSTRETIREMENT BENEFITS (CONTINUED)

The Company funds postretirement benefits as benefits are paid. The following tables show the funded status of the postretirement plans and the amounts recognized in the accompanying consolidated financial statements as of December 31:

	CFMI	2004 GHMSI	BCBSD
Change in benefit obligation:			
Benefit obligation at beginning of year	\$38,303	\$ 22,111	\$ 17,537
Service cost	1,644	861	592
Interest cost	2,336	1,390	1,066
Actuarial loss	1,664	1,815	1,554
Benefits paid	(1,214)	(591)	(1,341)
Benefit obligation at end of year	\$42,733	\$ 25,586	\$ 19,408
Funded status	\$(42,733)	\$ (25,586)	\$(19,408)
Unrecognized transition liability	-	4,712	3,502
Unrecognized actuarial loss	14,001	385	31
Unrecognized prior service (asset) cost	(494)	318	-
Net amount recognized accrued benefit cost	\$ (29,226)	\$ (20,171)	\$(15,875)
Components of net periodic benefit cost (credit) for the year ended December 31, 2004, are as follows:			
Service cost	\$ 1,644	\$ 861	\$ 592
Interest cost	2,336	1,390	1,066
Amortization of transition liability	-	588	348
Amortization of prior service (asset) cost	(207)	40	-
Recognized actuarial loss	892	-	-
Net periodic benefit cost	\$ 4,665	2,879	\$ 2,006

	CFMI	2003 GHMSI	BCBSD
Change in benefit obligation:			
Benefit obligation at beginning of year	33,079	\$ 16,534	\$20,910
Service cost	1,467	759	523
Interest cost	2,257	1,320	1,045
Actuarial loss (gain)	3,056	3,868	(3,490)
Benefits paid	(1,556)	(370)	(1,001)
Plan amendments	-	-	(450)
Benefit obligation at end of year	\$ 38,303	\$ 22,111	\$ 17,537
Funded status	\$ (38,303)	\$ (22,111)	\$(17,537)
Unrecognized transition liability	-	5,300	3,849
Unrecognized actuarial loss (gain)	13,229	(1,430)	(1,522)
Unrecognized prior service (asset) cost	(701)	358	-
Net amount recognized—accrued benefit cost	\$ (25,775)	\$ (17,883)	\$(15,210)

10. POSTRETIREMENT BENEFITS (CONTINUED)

	CFMI	2003 GHMSI	BCBSD
Components of net periodic benefit cost (credit) for the year ended December 31, 2003, are as follows:			
Service cost	\$ 1,467	\$ 759	\$ 523
Interest cost	2,257	1,320	1,045
Amortization of transition liability	–	590	348
Amortization of prior service (asset) cost	(207)	40	–
Recognized actuarial loss (gain)	828	–	(126)
Net periodic benefit cost	\$ 4,345	\$ 2,709	\$ 1,790

For measurement purposes, a 5.75% and 6.25% discount rate was assumed for the years ended December 31, 2004 and 2003, respectively. A 6.0% annual rate of increase in the per capita cost of covered health care benefits was also assumed for the years ended December 31, 2004 and 2003.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending December 31:

	CFMI	GHMSI	BCBSD
2005	\$ 2,138	\$ 938	\$ 1,086
2006	2,392	1,092	1,179
2007	2,617	1,263	1,241
2008	2,870	1,437	1,311
2009	3,115	1,637	1,429
2010 through 2014	19,709	11,342	8,365
Total	\$32,841	\$ 17,709	\$14,611

On December 8, 2003 the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Act) was enacted. The Act introduces a prescription drug benefit under Medicare (Medicare Part D) as well as a federal subsidy to sponsors of retiree health care benefit plans that provide a benefit that is at least actuarially equivalent to Medicare Part D. The Company anticipates that the benefits it pays in 2006 and beyond will be lower as a result of the new Medicare provisions. As permitted by FASB Staff Position (FSP) 106-1, *Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003*, the Company deferred the recognition of the impact of the new Medicare provisions at December 31, 2003. During 2004, FSP 106-2 was issued and included final guidance on accounting for the provisions

of this legislation, which will be required for the year ending December 31, 2005. The impact of adopting FSP 106-2 is not likely to be material to the consolidated financial statements.

11. INCOME TAXES

The Company files a consolidated federal income tax return. For federal taxes, the Company benefits from a special deduction available to certain Blue Cross plans under Internal Revenue Code Section 833(b) (the 833(b) deduction). Due to the 833(b) deduction, the Company has effectively incurred federal taxes at Alternative Minimum Tax (AMT) rates. The Company could lose the benefit of the 833(b) deduction in the future if CFMI, GHMSI and/or BCBSD ceases to be not-for-profit, if CFMI's, GHMSI's and/or BCBSD's reserves reach certain levels or if certain other events occur. The statutory AMT rate was 20% during 2004 and 2003. If the Company would lose the benefit of the 833(b) deduction in the future, the Company would be subject to Federal income taxes at the regular statutory rate of 35%. In such situation, the Company would have available certain regular net operating loss carryforwards and/or AMT credits.

CFMI is exempt from Maryland state income tax under Title 10, Subtitle 1, Section 10-104(2) of the Maryland Code and is governed by Title 14, Subtitle 1, Section 14-102 of the Maryland Insurance Code. GHMSI is exempt from all income taxes in the District of Columbia, Maryland and Virginia. BCBSD is exempt from Delaware State income taxes. Subsidiary operations are subject to the applicable state or District of Columbia income taxes.

Provision for income taxes includes deferred income taxes resulting primarily from temporary differences between the tax basis of assets and liabilities and their reported amounts in the consolidated financial statements. The principal sources of temporary differences include nondeductible accruals, accounts receivable, property and equipment and medical claims payable.

11. INCOME TAXES (CONTINUED)

As of December 31, 2004 and 2003, the Company had deferred tax assets of \$30,330 and \$48,453, respectively, and deferred tax liabilities of \$39,547 and \$35,249, respectively. Management has determined, based on the Company's long-term history of operating earnings and its expectations for the future, that operating income of the Company will more likely than not be sufficient to fully realize any net recorded deferred tax assets.

The provision (benefit) for income taxes for the years ended December 31, 2004 and 2003 attributable to income from continuing operations consists of the following components:

	2004	2003
Current:		
Federal	\$ 29,880	\$ 43,934
State	7,005	2,138
	36,885	46,072
Deferred:		
Federal	13,025	3,041
State	357	3,882
	13,382	6,923
Provision for income taxes	\$ 50,267	\$ 52,995

12. OTHER COMPREHENSIVE INCOME

The components of other comprehensive income, including the reconciliation of net unrealized holding gains and losses to net unrealized holding gains and losses, net of reclassification adjustments and taxes, are as follows for the years ended December 31:

	2004		
	Before-Tax Amount	Tax Expense	Net-of-Tax Amount
Net unrealized gains and losses arising during the period	\$ 31,489	\$ (6,791)	\$ 24,698
Less: reclassification adjustments for net gains and losses realized or recognized in net income	33,558	(5,858)	27,700
Net unrealized gains and losses	(2,069)	(933)	(3,002)
Minimum pension liability adjustment	43,936	(8,786)	35,150
Total other comprehensive income (loss)	\$ 41,867	\$ (9,719)	\$ 32,148

	2003		
	Before-Tax Amount	Tax Expense	Net-of-Tax Amount
Net unrealized gains and losses arising during the period	\$ 43,198	\$ (9,206)	\$ 33,992
Less: reclassification adjustments for net gains and losses realized or recognized in net income	14,949	(3,151)	11,798
Net unrealized gains and losses	28,249	(6,055)	22,194
Minimum pension liability adjustment	(5,264)	1,057	(4,207)
Total other comprehensive income (loss)	\$ 22,985	\$ (4,998)	\$ 17,987

13. COMMITMENTS AND CONTINGENCIES

The health care and health insurance industries are subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid

fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care insurers and providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

13. COMMITMENTS AND CONTINGENCIES (CONTINUED)

Management believes that the Company is in compliance with fraud and abuse as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. During 2004, CFMI settled an investigation by CMS related to CFMI's Medicare Part A fiscal intermediary operations. The investigation involved certain adjudication activities which the Company performed with respect to the reimbursement of a specific provider. In connection with this settlement, CFMI has entered into a Corporate Integrity Agreement with CMS, which agreement imposes certain compliance and monitoring requirements on CFMI. CFMI is monitoring its compliance with the Corporate Integrity Agreement, which has a term of three years. The Company believes the outcome of this matter will not have a significant impact on the accompanying consolidated financial statements.

During 2003, a federal grand jury subpoena was served on CFI, its subsidiaries and affiliates, requesting information and documentation pertaining to the attempted conversion and sale of those companies to WellPoint (see Note 1). The subpoena covers the time period from January 1, 1998 to August 1, 2003. The companies have produced the documents specified in the subpoena and provided them to the U.S. Attorneys Office in Baltimore.

Beginning in 1999, a series of class action lawsuits were filed against virtually all major entities in the health benefits business, including BCBSA and the BCBSA licensees. The suits allege that over a course of years the defendants have conspired to use criteria and standards for adjudication of provider claims that result in underpayment of provider claims. They allege that the defendants have been involved in a conspiracy to make false representations to providers and to conceal material information from providers about the manner in which claims are adjudicated. The plaintiffs assert that the alleged misconduct violates the Racketeer Influenced and Corrupt Organizations Act (RICO). Plaintiffs seek treble damages and injunctive relief under RICO. The Company is engaged in discovery in this matter. The Company intends to vigorously defend these proceedings; however, their ultimate outcomes cannot presently be determined. Various other lawsuits, including class action lawsuits and other claims, occur in the normal course of business and are pending against the Company. The Company records accruals for such matters when a loss is deemed to be probable and estimable. Management, after consultation with legal counsel, is of the opinion that the lawsuits and other claims, when resolved, will not have a material adverse effect on the accompanying consolidated financial statements; however, there can be no assurance in this regard.

CFI and its affiliates have employment contracts and other benefit arrangements with certain executives which contain provisions that could trigger the acceleration of certain benefits and/or payment of additional compensation upon a change in control of CFI. These

potential incremental payments have not been accrued at December 31, 2004, as management believes all of the required triggering events have not occurred.

The Company also has a Supplemental Value Added Bonus Plan, established in 2004, whereby certain officers and other employees are entitled to payments for certain services which have been performed through 2004. This plan is being reviewed by regulators and is subject to the possibility that the payments could be disapproved; however, as of December 31, 2004, management believes the payments under the plan are probable. Therefore, the cost of the plan of \$8,547 has been accrued in the accompanying December 31, 2004 consolidated financial statements. In the event that regulators do not disapprove of the payments under the plan, participants will be required to waive their rights under a prior retention bonus plan, established in 2002, before they receive any payments under the 2004 plan.

In the jurisdictions in which the Company is licensed to conduct business, associations have been created for the purpose, among others, of protecting insured parties under health insurance policies. The Company is contingently liable for assessments in any calendar year, in order to provide any required funds to carry out the power and duties of the association.

The Company operates under licensing agreements with BCBSA whereby the Company uses the service marks of BCBSA in the course of its business. The Company files periodic reports with BCBSA.

The Company's professional liability coverage is on a claims-made basis. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, will be uninsured. The claims-made policy has been renewed through April 30, 2005. In connection with ceasing operations of PMG and PPPA (the medical groups) as discussed in note 3, the Company purchased an extended reporting period (ERP) endorsement to ensure that claims made against physicians that were employed by the Company are insured. This ERP for the medical malpractice program covers the period November 2, 2004 through November 1, 2009. Reserves have been established to cover exposure related to this program not covered by the ERP.

The Company has a commitment for a credit facility with a commercial bank under which certain of its affiliates may borrow up to a maximum amount of \$60,000. There have been no draws made on this line of credit during 2004 or 2003.

In January 2005, the Maryland General Assembly passed new legislation which imposes a premium tax on managed care organizations (MCO) at 2 percent of earned premiums. Effective January 1, 2005, this premium tax will replace the existing state income tax requirements of MCOs prior to the legislation. This legislation will affect CFBC. Management estimates that CFBC's premium taxes due in 2005 under the new legislation will exceed the reduction in the Maryland state income taxes.



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