FUNK & BOLTON
A PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW
100 LIGHT STREET, SUITE 1000
BALTIMORE, MARYLAND 21202-1036
(410) 659-7700
FACSIMILE (410) 659-7773

DAVID M. FUNK
BRYAN D. BOLTON
BRYSON F. POPHAM
LINDSEY A. RADER
GARY C. HARRIGER
DEREK B. YARMIS
JEFFERSON L. BLOMQUIST
REN L. TUNDERMANN
CHARLES D. MACLEOD

†ADMITTED IN NE AND DC ONLY
††ADMITTED IN VA ONLY
†††ADMITTED IN TX ONLY

JEROME D. BRESLIN†
JAMES F. TAYLOR
PETER C. ISMAY††
CYNTHIA L. MCCANN
E. ELIZABETH STABER
CHERYL A. C. BROWN
TALI RAPHAELY

OF COUNSEL
MICHAEL R. MCCANN
J. FRANK NAYDEN
KAY DOUGHTY PHILLIPS†††
DEBORAH R. RIVKIN
JOHN R. STIERHOFF

August 19, 2002

The Honorable Lawrence H. Mirel
Commissioner of Insurance and Securities Regulation
Department of Insurance and Securities Regulation
Government of the District of Columbia
810 First Street, N.E., Suite 701
Washington, D.C. 20002

Via Hand Delivery

Re: Acquisition of Group Hospitalization and Medical Services, Inc. and CareFirst BlueChoice, Inc.

Dear Commissioner Mirel:

CareFirst, Inc., Group Hospitalization and Medical Services, Inc. and WellPoint Health Networks Inc. submit the enclosed Amended and Restated Application in accordance with the Case Management Order, as amended, issued by you on July 15, 2002. This Amended and Restated Application, which supplements and restates the Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with you on January 11, 2002, sets out the proposed conversion of Group Hospitalization and Medical Services, Inc. to a for-profit entity and the acquisition of Group Hospitalization and Medical Services, Inc. and CareFirst BlueChoice, Inc. by WellPoint Health Networks Inc. pursuant to an Agreement and Plan of Merger dated November 20, 2001. In the interest of efficiency, exhibits to the Form A filed with you on January 11, 2002 that have not been revised or superseded have not been duplicated for this filing but are incorporated by reference into this Amended and Restated Application.

The enclosed Amended and Restated Application, with exhibits, is eligible for public disclosure in its entirety. However, CareFirst, Inc., Group Hospitalization and Medical Services, Inc. and WellPoint Health Networks Inc. renew their request that Exhibit 3-A to the Form A filed January 11, 2002 (Biographical Affidavits for all Current Directors and Executive Officers of WellPoint) be held confidential by the Department and not disclosed to the public. Exhibit 3-A contains information of a personal nature with respect to Executive Officers and Directors of WellPoint Health Networks Inc., the disclosure of which would constitute an unwarranted invasion of personal privacy.

Very truly yours,

David M. Funk

Change No. 1
August 19, 2002

FORM A
AMENDED STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

Group Hospitalization and Medical Services, Inc.
and CareFirst BlueChoice, Inc.
(Domestic Insurers - To Be Acquired)

By

WellPoint Health Networks Inc.
(Acquiring Person)

Filed with the District of Columbia
Department of Insurance & Securities Regulation
and the Office of Corporation Counsel

Date: August 19, 2002

Notices and correspondence concerning this Form A Statement should be addressed to:

David M. Funk
Ren L. Tundermann
Funk & Bolton, P.A.
100 Light Street, Suite 1000
Baltimore, MD 21202
Telephone: (410) 659-7766
Facsimile: (410) 659-7773

This Amended Statement Regarding the Acquisition of Control of or Merger With a Domestic Insurer (the "Acquisition Statement") seeks the prior approval of the Commissioner of Insurance of the District of Columbia for (i) the conversion of Group Hospitalization and Medical Services, Inc., a non-stock corporation organized under federal law and doing business as Blue Cross/Blue Shield of the National Capital Area ("BCBS-NCA"), to for-profit status and (ii) the acquisition of indirect control of BCBS-NCA and its wholly-owned for-profit subsidiaries through the acquisition of control of CareFirst, Inc., a Maryland nonstock corporation, by WellPoint Health Networks Inc., a Delaware corporation ("WellPoint"). CareFirst, Inc. is also the sole member of CareFirst of Maryland, Inc., a Maryland non-stock corporation ("BCBS-MD"), and BCBSD, Inc., a Delaware non-stock corporation ("BCBSD"), each of which owns various for-profit insurance-related subsidiaries. BCBS-NCA, BCBS-MD and BCBSD are sometimes collectively referred to as "Primary CareFirst Insurers" and the Primary CareFirst Insurers along with their respective subsidiaries are sometimes referred to as the "Acquired Subsidiaries." The conversion and merger together are referred to as the "Proposed Transaction." WellPoint has operated in the District of Columbia, Virginia and Maryland since 1996 through its affiliate, UNICARE Life & Health Insurance Company, a Delaware corporation.

ITEM 1. INSURER AND METHOD OF ACQUISITION.

The name and address of the domestic insurers to which this Acquisition Statement relates is:

Group Hospitalization and Medical Services, Inc.
550 12th Street, S.W.
Washington, D.C. 20065

CareFirst BlueChoice, Inc.
550 12th Street, S.W.
Washington, D.C. 20065

Group Hospitalization and Medical Services, Inc. is licensed to do business in the District of Columbia as a Hospital and Medical Services Corporation pursuant to §§ 31-3501 *et seq*. of the D.C. Code Annotated.

The sole member of BCBS-NCA is CareFirst, Inc., a Maryland non-stock corporation. Pursuant to the Commissioner's Order dated December 23, 1997, CareFirst, Inc. is licensed in the District of Columbia as a Hospital and Medical Services Corporation. *See* Decision and Order A-HC-97-01.

CareFirst BlueChoice, Inc. ("BlueChoice") is a wholly owned subsidiary of BCBS-NCA and is licensed in the District of Columbia to operate as a Health Maintenance Organization pursuant to §§ 31-3401 *et seq*. of the D.C. Code Annotated.

Control of BCBS-NCA and BlueChoice will be indirectly acquired by WellPoint pursuant to an Agreement and Plan of Merger (the "Merger Agreement") which is attached to this Acquisition Statement as Exhibit 1-A1. The Merger Agreement provides for an immediately successive two-step process: a conversion of CareFirst, Inc. and the Primary CareFirst Insurers to for-profit status (the "Conversion"), followed by a merger of a wholly-owned subsidiary of WellPoint with and into CareFirst, Inc. (the "Merger"). After the Merger is consummated, WellPoint will own 100% of the issued and outstanding stock of CareFirst, Inc. which will, in turn, own 100% of the issued and outstanding stock of BCBS-NCA, BCBS-MD and BCBSD.

The Conversion

Because WellPoint is a for-profit company and CareFirst, Inc., BCBS-NCA, BCBS-MD and BCBSD are nonprofit companies, the latter four companies will convert to for-profit status immediately prior to the consummation of the Merger. The Boards of Directors of CareFirst, Inc., BCBS-NCA, BCBS-MD and BCBSD have concluded, following extensive due diligence, that the Proposed Transaction will enhance the ability of the companies to provide quality and affordable health care products and services to their existing members and to the communities they serve. In addition, the Boards of Directors have concluded, with the assistance of a number of advisors, that the fair value of the CareFirst, Inc. holding company system is $1.3 billion. This amount will be donated to various nonprofit foundations (the "Foundations"), as determined by the Insurance Commissioner and Corporation Counsel of the District of Columbia, the Insurance Commissioner of the State of Maryland and the State of Delaware. The resolutions of the Boards of Directors of CareFirst, Inc., BCBS-NCA, BCBS-MD and BCBSD approving the Conversion and subsequent Merger are attached to this Acquisition Statement as Exhibits 1-A2, 1-A3, 1-A4 and 1-A5.

CareFirst, Inc. has retained an independent expert, Accenture, to evaluate the community impact of the Proposed Transaction on all of the affected communities. Accenture has determined that it is reasonable to conclude that the availability, accessibility and affordability of health care in the District of Columbia, Maryland and Delaware has a strong potential to be positively impacted by the proposed transaction. Accenture's report is attached to this Acquisition Statement as Exhibit 1-A6.

The Conversion of BCBS-NCA will be effected through its re-chartering in the District of Columbia as a for-profit corporation, which will require the approval of the U.S. Congress. As part of the Conversion, each of BCBS-NCA, BCBS-MD and BCBSD will issue 100% of its outstanding shares of common stock to CareFirst, Inc., thus becoming wholly-owned subsidiaries of CareFirst, Inc. CareFirst, Inc. will issue 100% of its outstanding shares of common stock to certain tax-exempt Foundations in the District of Columbia, Maryland and Delaware, representing the percentage of the aggregate value of CareFirst, Inc. represented by each subsidiary insurer, as determined by the Insurance Commissioner and Corporation Counsel of the District of Columbia, the Insurance Commissioner of the State of Maryland and the State of Delaware. Thus,

immediately preceding the Merger, CareFirst, Inc. will own 100% of the common stock of the three Primary CareFirst Insurers and will itself be 100% owned by the various tax-exempt Foundations.

The Merger

Pursuant to the Merger Agreement, WellPoint has incorporated in Maryland a direct, wholly-owned subsidiary, Congress Acquisition Corp. ("CFAC"), which will merge with and into CareFirst, Inc. Each share of CareFirst, Inc. common stock held by the tax-exempt Foundations will be converted into a consideration amount comprised of cash and WellPoint Common Stock having an aggregate value of $1.3 billion, as more fully described in Item 4 of this Acquisition Statement. The resolutions of the Boards of Directors of WellPoint and CFAC approving the Merger are attached to this Acquisition Statement as Exhibits 1-A8 and 1-A9.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT.

(a) The name and address of the applicant is:

WellPoint Health Networks Inc.
1 WellPoint Way
Thousand Oaks, CA 91362

(b) WellPoint is currently one of the nation's largest publicly-traded managed health care companies. The common stock of WellPoint (symbol: WLP) ("WellPoint Common Stock") is traded on the New York Stock Exchange ("NYSE"). WellPoint, through its subsidiary, UNICARE Life & Health Insurance Company ("UNICARE"), a Delaware domiciled stock health insurance corporation, has limited health insurance operations in the District of Columbia, with direct written premium amounting to less than 1% of the Accident and Health market for the year 2001. Approximately 5000 District of Columbia residents have health insurance through UNICARE and approximately 200 District of Columbia residents have self-insured health benefit plans to which UNICARE provides administrative services only.

Through its affiliated companies, WellPoint serves the health care needs of approximately 13 million medical members and approximately 45 million specialty members nationwide. WellPoint offers a broad spectrum of network-based health care benefit plans, including health maintenance organizations, preferred provider organizations, point-of-service plans, and other hybrid plans and traditional indemnity plans to large and small employers, individual and senior markets. In addition, WellPoint offers services for self-funded employers under management service contracts, including claims processing, actuarial services, network access, medical cost management and other administrative services. WellPoint also provides a broad array of specialty and other products, including pharmacy benefit management, dental, utilization management, vision, life, preventive care, disability, behavioral health, long term care insurance, COBRA, Medicare supplement and flexible benefits account administration. For a more detailed

description of WellPoint's business, see WellPoint's Annual Reports on Form 10-K for the years ended December 31, 2001, 2000, 1999, 1998, 1997 and 1996 attached as Exhibits 2-B1A, 2-B1, 2-B2, 2-B3, 2-B4 and 2-B5, respectively, (the "Annual Reports on Form 10-K"); WellPoint's 2001, 2000, 1999, 1998, 1997 and 1996 Annual Reports to Stockholders, attached as Exhibits 2-B6A, 2-B6, 2-B7, 2-B8, 2-B9 and 2-B10, respectively, (the "Annual Reports to Stockholders"); and WellPoint's Quarterly Report on Form 10-Q for the quarterly period ending June 30, 2002, attached as Exhibit 2-B11A (the "Quarterly Report on Form 10-Q"). WellPoint's financial condition, including the amount and character of its total assets and total liabilities at December 31, 2001, 2000, 1999, 1998, 1997 and 1996 and at June 30, 2002, is set forth in its Annual Reports on Form 10-K, in its Annual Reports to Stockholders and in its Quarterly Report on Form 10-Q. As of June 30, 2002, WellPoint had assets of $10.2 billion and total stockholders' equity of $3.6 billion. For the six months ended June 30, 2002, WellPoint had gross revenues of $8.2 billion, operating income of $573.6 million, and net income after tax of $311.8 million. As of December 31, 2001, WellPoint had assets of $7.5 billion and total stockholders' equity of $2.1 billion. For the year ended December 31, 2001, WellPoint had gross revenues of $12.4 billion and net income after tax of $414.7 million.

WellPoint was organized in 1992 to own and operate substantially all of the prepaid health care business of Blue Cross of California ("BCC"). This business was transferred from BCC to WellPoint, BCC's then wholly-owned subsidiary, effective as of February 1, 1993. WellPoint then conducted an initial public offering of its shares of common stock. Since January 27, 1993, WellPoint Common Stock has been listed on the NYSE. On May 20, 1996, WellPoint and BCC underwent a recapitalization transaction which resulted in the combination of WellPoint and BCC into the entity now known as WellPoint. In connection with this recapitalization transaction, WellPoint formed two new charitable foundations that received cash and WellPoint Common Stock that resulted in an initial charitable endowment of approximately $3 billion, which has now grown to approximately $4 billion, largely as a result of the performance of the WellPoint Common Stock. That same year, WellPoint acquired the Life and Health Benefits Management Division of Massachusetts Mutual Life Insurance Company. In 1997, WellPoint acquired the Group Benefits Operation of John Hancock Mutual Life Insurance Company. In August 1997, WellPoint reincorporated in the State of Delaware. In 2000, WellPoint completed the acquisition of Rush Prudential Health Plans and a mail order pharmacy fulfillment facility which now operates under the name of Precision Rx. Effective March 15, 2001, WellPoint acquired and merged with Cerulean Companies, Inc., a Georgia corporation which resulted in WellPoint acquiring, among other subsidiaries of Cerulean, Blue Cross and Blue Shield of Georgia, Inc. Effective January 31, 2002, WellPoint acquired RightCHOICE Managed Care, Inc., a Delaware corporation doing business as Blue Cross and Blue Shield of Missouri.

A brief description of the primary health insurance affiliates of WellPoint follows:

UNICARE

UNICARE Life & Health Insurance Company is WellPoint's national non-"blue" brand dedicated to the delivery of quality health care plans and products since 1996. Serving approximately 2 million medical members, UNICARE employs over 3000 full-time associates. As noted above, UNICARE writes a small amount of business within the District of Columbia metropolitan region.

With a reputation for innovation, UNICARE is committed to establishing a relationship with its customers as a trusted partner. UNICARE's strategy is to offer a diversified mix of products that preserves member choice at competitive prices while focusing on the development of new hybrid plans which take advantage of the best characteristics of traditional managed care and innovative open access models.

BLUE CROSS OF CALIFORNIA

BCC has been serving the health care benefit needs of California since 1937. As the California operating subsidiary of WellPoint, BCC, together with its branded affiliates, provides services to approximately 6.3 million California members. BCC employs more than 6500 full-time associates.

Offering a full continuum of product coverage options, BCC provides customers with unparalleled choice and flexibility in meeting their health plan needs. These options are continually fine-tuned to enhance access to affordable, quality health care. With its strong track record for innovation, BCC focuses on products and services designed to improve the health status of all Californians. Unique product offerings available in the individual, small group, large group, senior and Medi-Cal markets include a full range of medical and specialty products.

BLUE CROSS AND BLUE SHIELD OF GEORGIA

Blue Cross and Blue Shield of Georgia is WellPoint's operating subsidiary in Georgia. Blue Cross and Blue Shield of Georgia employs more than 3000 associates and is Georgia's largest and oldest health insurer, providing health benefits to more than 2 million Georgians.

Founded in 1937, Blue Cross and Blue Shield of Georgia is headquartered in Atlanta, with major operation centers in Atlanta and Columbus. Blue Cross and Blue Shield of Georgia offers significant value to its members by providing a wide range of products, including traditional indemnity insurance, open-access plans and managed care products. Blue Cross and Blue Shield of Georgia also markets specialty products, including life insurance, dental, vision, mental health and pharmacy.

RIGHTCHOICE MANAGED CARE, INC.

On January 31, 2002, WellPoint completed its merger with RightCHOICE Managed Care, Inc. ("RightCHOICE"), pursuant to which RightCHOICE has become a wholly owned subsidiary of WellPoint. RightCHOICE, through its exclusive license to use the Blue Cross and Blue Shield name and service marks in Missouri (excluding the metropolitan Kansas City area), is the largest provider of managed care benefits in the state of Missouri based on number of members. Through its HealthLinks subsidiary, RightCHOICE also provides network rental, administrative services, workers' compensation and other non-underwritten health benefit programs in Missouri and other states. As of January 31, 2002 RightCHOICE served approximately 2.2 million medical members in Missouri, Arkansas, Illinois, Indiana, Iowa, Kentucky and West Virginia.

Except as stated in Item 5, WellPoint intends to continue to conduct its business, and to cause its subsidiaries to continue to conduct their businesses, substantially in the manner in which such businesses are now conducted. WellPoint intends to continue to expand its own and its subsidiaries' operations through internal growth and possible further acquisitions.

(c) Attached as Exhibit 2-C1 is the present organizational structure of WellPoint and its affiliates, each of which is a corporation or limited liability company (other than UNICARE Health Plans, which is a general partnership). The jurisdiction of incorporation or formation of each affiliate is indicated. Each affiliate identified in Exhibit 2-C1 is owned 100% by its immediate parent, or another direct or indirect wholly owned subsidiary of WellPoint, except that WellPoint owns (i) only 50% of the voting securities of The Industry MSO, Inc., a California corporation; (ii) only 50% of the voting securities of MCS Health Management Options, Inc., a Puerto Rico corporation; (iii) only 51% of the voting securities of Atlanta Healthcare Partners, Inc., a Georgia corporation; (iv) only 51% of the voting securities of CSRA Healthcare Partners, Inc., a Georgia corporation; (v) approximately 80% of the voting securities of UNICARE National Capital Preferred Provider Organization, Inc., a Maryland corporation; and (vi) only 50% of the voting securities of the EPOCH Group, L.C., a Missouri limited liability corporation.

Attached as Exhibit 2-C2 is the proposed organizational structure of WellPoint and its affiliates, assuming the closing of the Proposed Transaction. In addition to the WellPoint affiliates mentioned above, the following are anticipated to be affiliates in which WellPoint will have less than a 100% ownership interest but may control within the meaning of the insurance holding company act: (i) Potomac Physicians, P.A. which is wholly-owned by three physicians one of whom is employed by BCBS-MD; (ii) Three Owings Mills Corporate Center Limited Partnership of which BCBS-MD is one of three limited partners; and (iii) Four Owings Mills Corporate Center Limited Partnership of which BCBS-MD is one of three limited partners. All other entities set forth on Exhibit 2-C2 will be wholly owned by WellPoint or a WellPoint affiliate.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH

THE APPLICANT.

The current directors of WellPoint are:

Leonard D. Schaeffer, Chairman of the Board and Chief Executive Officer
W. Toliver Besson
Roger E. Birk
Sheila P. Burke
Julie A. Hill
Elizabeth A. Sanders
Warren Y. Jobe
Jane G. Pisano

The current executive officers of WellPoint are:

Leonard D. Schaeffer
Chairman of the Board and Chief Executive Officer

D. Mark Weinberg
Executive Vice President and Chief Development Officer

David S. Helwig
Executive Vice President, Blue Cross of California Division

Joan E. Herman
Executive Vice President, Senior, Specialty and State-Sponsored Programs Division

David C. Colby
Executive Vice President and Chief Financial Officer

Thomas C. Geiser
Executive Vice President, General Counsel and Secretary

Alice D. Rosenblatt
Executive Vice President, Integration Planning/Implementation and Chief Actuary

Rebecca A. Kapustay
Executive Vice President, BCBS of Georgia Division

John A. O'Rourke
Executive Vice President, Central Region

Ronald G. Ponder

Executive Vice President and Chief Information Officer

Kenneth C. Zurek
Senior Vice President, Controller and Taxation

Woodrow A. Myers, Jr., M.D.
Executive Vice President and Chief Medical Officer

Biographical affidavits for some of the current directors and executive officers of WellPoint are attached as Exhibit 3-A. Such affidavits set forth for each person, among other information, his or her business address, present principal business activity, occupation or employment, including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on, as well as material occupations, positions, offices or employments held during the period specified therein, but in no event for less than the last five years. Except as set forth in such biographical affidavits, no such occupation, position, office or employment required licensing by or registration with any federal, state, county or municipal governmental agency. None of such persons has been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years. Additional affidavits will be supplied for Jane G. Pisano, Alice D. Rosenblatt, John A. O'Rourke and Ronald G. Ponder as soon as they become available.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION.

(a) The aggregate consideration payable by WellPoint in connection with the Merger is One Billion Three Hundred Million Dollars ($1,300,000,000) (the "Merger Consideration"). The Merger Consideration will consist of cash in an amount not less than Four Hundred Fifty Million Dollars ($450,000,000) and WellPoint Common Stock with a value not to exceed Eight Hundred Fifty Million Dollars ($850,000,000). If the average of the daily closing price of the WellPoint Common Stock for the 20-trading day period ending on the fifth trading day prior to the Closing is below $70 per share, WellPoint has the right to calculate the number of shares to be issued for Merger Consideration as if WellPoint Common Stock were valued at $70 per share, and to make up the difference in Merger Consideration by issuing subordinated notes. The interest rate of the subordinated notes will be set such that the market value of the notes equals their face value at Closing. Provisions have been made in the Merger Agreement to assure that the WellPoint Common Stock issued as Merger Consideration may be sold immediately after Closing by the holder thereof in compliance with applicable securities laws. The description of the Merger Consideration contained herein is qualified in its entirety by reference to the full text of the Merger Agreement which is attached as Exhibit 1-A1 to this Acquisition Statement.

(b) The amount and nature of the Merger Consideration set forth in the Merger Agreement was the result of extensive arm's length negotiations conducted between WellPoint and CareFirst, Inc. The negotiation process, in which legal counsel and financial advisors from each side actively participated, resulted in what the parties and their financial advisors believe to

be fair consideration for the Merger. In determining such amount, the parties considered, among other factors, the value of CareFirst, Inc., BCBS-NCA, BCBS-MD and BCBSD and their respective subsidiaries, including, without limitation, their earnings and cash flows, the character and quality of their assets, and the extent of their liabilities.

CareFirst, Inc.'s Board of Directors obtained a written opinion from Credit Suisse First Boston regarding the fairness of the Merger Consideration from a financial point of view. Specifically, on November 20, 2001, Credit Suisse First Boston rendered an opinion to the CareFirst, Inc. Board of Directors that, as of that date and based on and subject to the assumptions made, matters considered and limitations described in that opinion, the Merger Consideration was fair from a financial point of view. The description of the Credit Suisse First Boston opinion contained herein is qualified in its entirety by reference to the full text of the opinion which is attached as Exhibit 4-B to this Acquisition Statement. Also included in Exhibit 4-B is a copy of the presentation made by Credit Suisse First Boston to CareFirst Inc.'s Board of Directors on November 20, 2001 in support of its opinion.

(c) The cash portion of the Merger Consideration in the amount of not less than $450 million will be paid from WellPoint's cash on hand, supplemented by borrowings under WellPoint's existing $1.0 billion revolving credit facility with a syndicate of banks led by Bank of America, N.A. and The Chase Manhattan Bank and/or borrowings under WellPoint's commercial paper program. A copy of the WellPoint Unsecured Revolving Credit Facility Agreements comprising its revolving credit facility is attached hereto as Exhibit 4-C.

ITEM 5. FUTURE PLANS FOR INSURER.

WellPoint has no present plans to cause CareFirst, Inc., BCBS-NCA, BCBS-MD, BCBSD or any other subsidiary of CareFirst, Inc. to declare any extraordinary dividend, to liquidate them, to sell any of their assets, or to merge or consolidate them with any person or persons, other than the Merger. There also are presently no plans to make any other material change in CareFirst, Inc., BCBS-NCA, BCBS-MD, BCBSD or any other subsidiary's business operations or corporate structure, other than as may be provided herein or as may arise in the ordinary course of business, and other than to achieve the synergies that normally arise in substantial acquisitions. No name changes of entities involved in the Proposed Transaction are anticipated. WellPoint has a proven expertise in the development of innovative and cost-effective health benefit products and, if appropriate after studying the local markets, may enhance the product portfolios of BCBS-NCA, BCBS-MD, BCBSD and their respective subsidiaries.

From and after the Merger, until successors are elected or appointed and qualified, the Board of Directors of CFAC shall become the Board of Directors of CareFirst, Inc. The officers of CareFirst, Inc. immediately prior to the Merger will remain the officers of CareFirst, Inc. following the Merger. The Merger Agreement provides that WellPoint will appoint one non-employee member of the existing Board of Directors of CareFirst, Inc. to serve on WellPoint's Board of Directors. In addition, an advisory board will be formed for each of BCBS-NCA,

BCBS-MD and BCBSD to which WellPoint will invite to become members each person who serves as a director of one of these companies at the time of Closing. Directors of CareFirst, Inc. at the time of Closing also will be invited to serve on one of the three advisory boards. Each advisory board will provide advice to its respective company regarding the company's relationship with subscribers, providers and the general public.

The Merger Agreement provides that from and after the Closing of the Merger, the headquarters of BCBS-NCA will be located in the District of Columbia and that the headquarters and principal executive offices of the WellPoint Southeast Business Region will be in Maryland. The Merger Agreement also provides that, at the Closing of the Merger, William Jews, CareFirst, Inc.'s President and Chief Executive Officer, shall become President of WellPoint's Southeast Business Region and other senior executives of CareFirst, Inc. shall be assigned significant responsibilities with respect to the business of CareFirst, Inc.

Information required by Item 3 will be filed for any proposed new directors (including the directors of CFAC who will become directors of CareFirst, Inc. at Closing) and new executive officers of CareFirst, Inc. or BCBS-NCA identified prior to the approval of this Acquisition Statement as a supplement to this Acquisition Statement and, after being filed, will be incorporated herein by reference as Exhibit 5-A hereto.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED.

WellPoint intends to acquire 100% of the outstanding shares of CareFirst, Inc. stock held by the tax-exempt Foundations as described more fully in Items 1 and 4(a) of this Acquisition Statement and in the Merger Agreement. No other person listed in Item 3 hereof plans to acquire directly any of the stock or any of the voting securities of CareFirst, Inc.

The fairness of the Merger Consideration was determined through arm's length negotiation among the parties to the Merger Agreement. As described above, CareFirst, Inc. received a written opinion dated November 20, 2001 from Credit Suisse First Boston to the effect that, as of that date, and based on and subject to various assumptions, matters considered and limitations described in that opinion, the Merger Consideration was fair from a financial point of view to the holders of CareFirst, Inc. common stock. The description of the Credit Suisse First Boston opinion contained herein is qualified in its entirety by reference to the full text of the opinion which is attached as Exhibit 4-B to this Acquisition Statement.

ITEM 7. OWNERSHIP OF VOTING SECURITIES.

No person listed in Item 3 hereof has any legal or beneficial interest in any voting security of CareFirst, Inc. or any Acquired Subsidiary. Other than the rights of WellPoint existing under the Merger Agreement, neither WellPoint, any of its affiliates, nor any person listed in Item 3

hereof has any right or has entered into any agreement to purchase or otherwise acquire any such voting security.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER.

Other than the Merger Agreement and the transactions contemplated thereby, there are no contracts, arrangements or understandings with respect to any voting security of CareFirst, Inc. or any Acquired Subsidiary, in which WellPoint, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or of profits, division of losses or profits or the giving or withholding of proxies of CareFirst, Inc. or any Acquired Subsidiary.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES.

Neither WellPoint nor any of its affiliates, nor any person listed in Item 3 hereof, has at any time during the twelve (12) calendar months preceding the filing of this Acquisition Statement made any purchase of the voting securities of CareFirst, Inc. or any Acquired Subsidiary.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE.

Neither WellPoint nor any of its affiliates, nor any person listed in Item 3 hereof, nor any other person as the result of an interview with or at the suggestion of WellPoint, any of its affiliates, or any person listed in Item 3 hereof, has, directly or indirectly, at any time during the twelve (12) calendar months preceding the filing of this Acquisition Statement, made to any person any recommendation to purchase any voting security or make any contract, arrangement or understanding with respect to any voting security, loan or option arrangement, put or call, guarantee of loans, guarantee against loss or of profits, division of losses or profits or the giving or withholding of proxies of CareFirst, Inc. or any Acquired Subsidiary.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS.

No agreement, arrangement or understanding has been made by WellPoint or CareFirst, Inc. with any broker-dealer as to solicitation of voting securities of CareFirst, Inc. or any Acquired Subsidiary for tender.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS.

(a) The Financial Statements of WellPoint and Exhibits relating to this Acquisition Statement are attached hereto and incorporated herein by reference, and are listed in Item 12(b) below. The Financial Statements of WellPoint are for the preceding six (6) fiscal years and most

recent calendar quarter, as provided in Exhibit 2-B1A through Exhibit 2-B11. These financial statements contain consolidated financial statements for WellPoint and for all of the WellPoint affiliates listed in Exhibit 2-C1.

(b) List of Financial Statements and Exhibits.

Exhibit Reference	**Description of Exhibit**
Exhibit 1-A1	Agreement and Plan of Merger dated November 20, 2001, between WellPoint, CFAC and CareFirst, Inc.
Exhibit 1-A2	Resolutions of the Board of Directors of CareFirst, Inc. Authorizing the Acquisition
Exhibit 1-A3	Resolutions of the Board of Directors of BCBS-NCA Authorizing the Acquisition
Exhibit 1-A4	Resolutions of the Board of Directors of BCBS-MD Authorizing the Acquisition
Exhibit 1-A5	Resolutions of the Board of Directors of BCBSD Authorizing the Acquisition
Exhibit 1-A6	Community Impact Statement Prepared by Accenture
Exhibit 1-A7	Resolutions of the Board of Directors of WellPoint Authorizing the Acquisition
Exhibit 1-A8	Resolutions of the Board of Directors of CFAC Authorizing the Acquisition
Exhibit 2-B1A	Annual Report on Form 10-K for WellPoint for the year ending December 31, 2001 and Amended Annual Report on Form 10-K/A for the year ending December 31, 2001
Exhibit 2-B1	Annual Report on Form 10-K for WellPoint for the year ending December 31, 2000
Exhibit 2-B2	Annual Report on Form 10-K for WellPoint for the year ending December 31, 1999

Exhibit 2-B3	Annual Report on Form 10-K for WellPoint for the year ending December 31, 1998
Exhibit 2-B4	Annual Report on Form 10-K for WellPoint for the year ending December 31, 1997
Exhibit 2-B5	Annual Report on Form 10-K for WellPoint for the year ending December 31, 1996
Exhibit 2-B6A	Annual Report to Stockholders for WellPoint for the year ending December 31, 2001
Exhibit 2-B6	Annual Report to Stockholders for WellPoint for the year ending December 31, 2000
Exhibit 2-B7	Annual Report to Stockholders for WellPoint for the year ending December 31, 1999
Exhibit 2-B8	Annual Report to Stockholders for WellPoint for the year ending December 31, 1998
Exhibit 2-B9	Annual Report to Stockholders for WellPoint for the year ending December 31, 1997
Exhibit 2-B10	Annual Report to Stockholders for WellPoint for the year ending December 31, 1996
Exhibit 2-B11A	Quarterly Report on Form 10-Q for WellPoint for the period ending June 30, 2002
Exhibit 2-B11	Quarterly Report on Form 10-Q for WellPoint for the period ending September 30, 2001
Exhibit 2-C1	PreAcquisition Organizational Chart of WellPoint and its Affiliates
Exhibit 2-C2	PostAcquisition Organizational Chart of WellPoint and its Affiliates
Exhibit 3-A	Biographical Affidavits for Directors and Executive Officers of WellPoint
Exhibit 4-B	Fairness Opinion Issued by Credit Suisse First Boston to the Board of Directors of CareFirst, Inc. and Presentation to the Board of Directors of CareFirst, Inc. on November 20, 2001

Exhibit 4-C	WellPoint Unsecured Revolving Credit Facility Agreements
Exhibit 5-A	Biographical Information for the Proposed Directors and Executive Officers of CareFirst, Inc. and BCBS-NCA (to be provided by supplemental filing, as necessary)
Exhibit 6-A1A	Annual Report for CareFirst, Inc. for the year ending December 31, 2001
Exhibit 6-A1	Annual Report for CareFirst, Inc. for the year ending December 31, 2000
Exhibit 6-A2	Annual Report for CareFirst, Inc. for the year ending December 31, 1999
Exhibit 7	Expert Opinion Issued by New Directions for Policy entitled Identifying Options for Using Assets To Improve Health In The District of Columbia

(c) The Merger Agreement is the only agreement between WellPoint and CareFirst, Inc. for the Proposed Transaction and there are no other tender offers for, requests or invitations for, tenders of, exchange offers for, or other agreements involving WellPoint or its affiliates to acquire or exchange any voting securities of CareFirst, Inc. Attached as Exhibits 6-A1A, 6-A1 and 6-A2 are the CareFirst, Inc. annual reports for the last three years. WellPoint's annual reports to stockholders for the last three years are attached as Exhibits 2-B6A, 2-B6 and 2-B7.

ITEM 13. SIGNATURE AND CERTIFICATION.

SIGNATURE

Pursuant to the requirements of Section 31-703 and 31-3427 of the D.C. Code Annotated, WellPoint Health Networks Inc. has caused this application to be duly signed on its behalf in the City of Thousand Oaks and State of California, on the 19th day of August, 2002.

WellPoint Health Networks Inc.

(SEAL)

By: _____
(Name)

Executive Vice President
(Title)

Attest:

_____
(Signature of Officer)

Assistant Secretary
Title

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached application dated August 19, 2002, for and on behalf of WellPoint Health Networks Inc., that he is the Assistant Secretary of WellPoint Health Networks Inc. and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

_____
(Signature)

Robert A. Kelly
(Type or print name)

Date: August 19, 2002

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10−Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2002

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number 001−13083

WELLPOINT HEALTH NETWORKS INC.
(Exact name of registrant as specified in its charter)

Delaware	**95−4635504**
(State or other jurisdiction of incorporation or organization)	(IRS Employer Identification No.)
1 WellPoint Way, Thousand Oaks, California	**91362**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code **(818) 234−4000**

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date:

Title of each class	**Outstanding at August 8, 2002**
Common Stock, $0.01 par value	145,680,559 shares

WellPoint Health Networks, Inc.
Quarterly Report on Form 10−Q for the Quarter Ended June 30, 2002
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ITEM 1. ***Financial Statements***

WellPoint Health Networks Inc.
Consolidated Balance Sheets

(In thousands, except share data)	June 30, 2002	December 31, 2001
	(Unaudited)	
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 882,705	$ 1,028,476
Investment securities, at market value	4,718,000	3,832,982
Receivables, net	1,303,089	841,722
Deferred tax assets, net	141,404	79,063
Other current assets	123,672	90,398
Total Current Assets	7,168,870	5,872,641
Property and equipment, net	341,280	222,080
Intangible assets, net	757,050	430,488
Goodwill, net	1,690,368	661,346
Long−term investments, at market value	131,000	124,611
Deferred tax assets, net	—	54,486
Other non−current assets	159,494	106,481
Total Assets	$ 10,248,062	$ 7,472,133
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Medical claims payable	$ 2,312,703	$ 1,934,620
Reserves for future policy benefits	80,204	62,739
Unearned premiums	395,665	332,813
Accounts payable and accrued expenses	1,032,724	783,026
Experience rated and other refunds	256,480	255,570
Income taxes payable	57,055	64,654
Other current liabilities	837,515	632,383

Total Current Liabilities	4,972,346	4,065,805
Accrued postretirement benefits	124,319	94,124
Reserves for future policy benefits, non−current	218,974	222,406
Long−term debt	1,152,013	837,957
Deferred tax liabilities	37,696	—
Other non−current liabilities	167,354	119,262
Total Liabilities	6,672,702	5,339,554
Stockholders' Equity:		
Preferred Stock—$0.01 par value, 50,000,000 shares authorized, none issued and outstanding	—	—
Common Stock—$0.01 par value, 300,000,000 shares authorized, 146,995,980 and 135,307,637 issued at June 30, 2002 and December 31, 2001, respectively	1,470	714
Treasury stock, at cost, 1,346,975 and 7,474,305 shares at June 30, 2002 and December 31, 2001, respectively	(77,390)	(465,805)
Additional paid−in capital	1,689,517	1,002,193
Retained earnings	1,924,021	1,548,941
Accumulated other comprehensive income	37,742	46,536
Total Stockholders' Equity	3,575,360	2,132,579
Total Liabilities and Stockholders' Equity	$ 10,248,062	$ 7,472,133

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.
Consolidated Income Statements
(Unaudited)

(In thousands, except earnings per share)	Quarter Ended June 30, 2002	Quarter Ended June 30, 2001	Six Months Ended June 30, 2002	Six Months Ended June 30, 2001
Revenues:				
Premium revenue	$ 4,025,094	$ 2,926,067	$ 7,723,753	$ 5,359,195
Management services and other revenue	207,831	158,491	392,268	288,015
Investment income	66,148	60,848	126,062	113,649
	4,299,073	3,145,406	8,242,083	5,760,859
Operating Expenses:				
Health care services and other benefits	3,282,003	2,388,224	6,264,607	4,353,697
Selling expense	167,465	124,763	323,190	236,500
General and administrative expense	538,586	430,869	1,080,675	788,456
	3,988,054	2,943,856	7,668,472	5,378,653
Operating Income	311,019	201,550	573,611	382,206
Interest expense	16,973	13,563	33,458	21,742
Other expense, net	13,978	18,606	24,901	31,932
Income before Provision for Income Taxes and Extraordinary Items	280,068	169,381	515,252	328,532
Provision for income taxes	112,105	69,452	206,189	132,100
Income before Extraordinary Items	167,963	99,929	309,063	196,432
Extraordinary Items:				
Gain from negative goodwill on acquisition	4,042	—	4,042	—
Loss on early extinguishment of debt, net of tax benefit of $838	(1,258)	—	(1,258)	—
	2,784	—	2,784	—
Net Income	$ 170,747	$ 99,929	$ 311,847	$ 196,432
Earnings Per Share:				
Income before Extraordinary Items	$ 1.16	$ 0.79	$ 2.18	$ 1.55
Extraordinary gain from negative goodwill on acquisition	0.03	—	0.03	—
Extraordinary loss on early extinguishment of debt, net of tax benefit	(0.01)	—	(0.01)	—
Net Income	$ 1.18	$ 0.79	$ 2.20	$ 1.55
Earnings Per Share Assuming Full Dilution:				
Income before Extraordinary Items	$ 1.10	$ 0.76	$ 2.08	$ 1.50
Extraordinary gain from negative goodwill on acquisition	0.03	—	0.03	—
Extraordinary loss on early extinguishment of debt, net of tax benefit	(0.01)	—	(0.01)	—
Net Income	$ 1.12	$ 0.76	$ 2.10	$ 1.50
Weighted Average Shares Outstanding	144,852	126,719	141,986	126,347
Fully Diluted Weighted Average Shares Outstanding	152,566	131,628	149,230	131,525

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.

Consolidated Statement of Changes in Stockholders' Equity

(Unaudited)

(In thousands)	Preferred Stock	Common Stock Issued Shares	Common Stock Issued Amount	Common Stock In Treasury Shares	Common Stock In Treasury Amount	Additional Paid−in Capital	Retained Earnings	Accumulated Other Comprehensive Income
Balance as of December 31, 2001	$ —	71,391	$ 714	7,474	$ (465,805)	$ 1,002,193	$ 1,548,941	$ 46,536
Stock grants to employees and directors				(29)	1,571			
Stock issued for employee stock option and stock purchase plans				(2,562)	150,132	45,742		
Stock repurchased, at cost				2,000	(122,265)			
Stock issued in connection with acquisition of RightCHOICE Managed Care, Inc.		2,718	27	(5,536)	358,977	687,105	62,979	
100% Stock Dividend on March 15, 2002		72,887	729			(729)		
Net losses from treasury stock reissued						(44,794)	254	
Comprehensive income (loss)								
Net income							311,847	
Other comprehensive income, net of tax								
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								(8,794)
Total comprehensive income (loss)							311,847	(8,794)
Balance as of June 30, 2002	$ —	146,996	$ 1,470	1,347	$ (77,390)	$ 1,689,517	$ 1,924,021	$ 37,742

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.
Consolidated Statements of Cash Flows
(Unaudited)

(In thousands)	Six Months Ended June 30, 2002	2001
Cash flows from operating activities:		
Income before extraordinary items	$ 309,063	$ 196,432
Adjustments to reconcile income before extraordinary items to net cash provided by operating activities:		
Depreciation and amortization, net of accretion	56,562	50,079
Loss on sales of assets, net	6,533	18,968
Provision (benefit) for deferred income taxes	(58,548)	90,232
Amortization of deferred gain on sale of building	(2,213)	(2,213)
Fair value adjustment of interest rate swaps on notes payable	2,413	—
Accretion of interest on zero coupon convertible subordinated debentures and 6 3/8% Notes due 2012 and 6 3/8% Notes due 2006	1,665	1,508
(Increase) decrease in certain assets:		
Receivables, net	(104,912)	(63,289)
Other current assets	(18,159)	(8,905)
Other non−current assets	(26,600)	618
Increase (decrease) in certain liabilities:		
Medical claims payable	200,247	(17,642)
Reserves for future policy benefits	12,029	(5,116)
Unearned premiums	(24,479)	37,199
Accounts payable and accrued expenses	145,730	45,645
Experience rated and other refunds	910	6,676
Income taxes payable	18,975	(32,555)
Other current liabilities	62,497	49,253
Accrued postretirement benefits	4,249	2,468
Other non−current liabilities	10,606	(89,038)
Net cash provided by operating activities	596,568	280,320
Cash flows from investing activities:		
Investments purchased	(3,251,028)	(1,797,741)
Proceeds from investments sold	2,614,967	1,739,105
Property and equipment purchased	(55,885)	(43,696)
Proceeds from property and equipment sold	4,355	123
Acquisition of new businesses, net of cash acquired	(347,616)	(555,211)
Net cash used in investing activities	(1,035,207)	(657,420)
Cash flows from financing activities:		
Net (repayment) borrowing of long−term debt under the revolving credit facility	(235,000)	85,000
Net borrowing of commercial paper	199,813	—
Net borrowing of long−term debt under 6 3/8% Notes due 2006	—	448,981
Net borrowing of long−term debt under 6 3/8% Notes due 2012	348,905	—
Cash paid on redemption of zero coupon convertible subordinated debentures	(5,747)	—
Proceeds from issuance of common stock	107,162	41,204
Common stock repurchased	(122,265)	—
Net cash provided by financing activities	292,868	575,185
Net (decrease) increase in cash and cash equivalents	(145,771)	198,085
Cash and cash equivalents at beginning of period	1,028,476	566,889
Cash and cash equivalents at end of period	$ 882,705	$ 764,974

See the accompanying notes to the consolidated financial statements.

1. Organization

WellPoint Health Networks Inc. (the "Company" or "WellPoint") is one of the nation's largest publicly traded managed health care companies. As of June 30, 2002, WellPoint had approximately 13.0 million medical members and approximately 45.3 million specialty members. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), point−of−service ("POS") plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial service, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products and services including pharmacy, dental, utilization management, vision, life insurance, preventive care, disability, behavioral health, medicare supplements, COBRA and flexible benefits account administration. The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in various parts of the country under the name UNICARE or HealthLink. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks. The Company's customer base is diversified, with extensive membership among large and small employer groups and individuals and a growing presence in the Medicare and Medicaid markets.

2. Basis of Presentation

The accompanying unaudited consolidated financial statements of WellPoint, in the opinion of management, reflect all material adjustments (which are of a normal recurring nature) necessary for a fair statement of its financial position as of June 30, 2002, the results of its operations for the quarter and six months ended June 30, 2002 and 2001, cash flows for the six months ended June 30, 2002 and 2001 and its changes in stockholders' equity for the six months ended June 30, 2002. The results of operations for the interim periods presented are not necessarily indicative of the operating results for the full year.

Stock Split

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint stock for each share held. Share and per share data for all periods presented herein have been adjusted to give effect to the stock split.

3. Acquisitions

In 1996, the Company began pursuing a nationwide expansion strategy through selective acquisitions and start−up activities in key geographic areas. More recently, the Company has focused on acquiring businesses that provide significant concentrations of members in strategic locations outside of California. In connection with this strategy, the Company completed its acquisitions of MethodistCare, Inc. ("MethodistCare") and RightCHOICE Managed Care, Inc. ("RightCHOICE") in 2002 and Cerulean Companies, Inc. ("Cerulean") in 2001.

On April 30, 2002, the Company completed the acquisition of MethodistCare serving over 70,000 members in the Houston, Texas area. This acquisition is intended to enable UNICARE, WellPoint's national operating unit, to expand its product line by offering HMO products along with other open−access products in MethodistCare's service area. As a result of the acquisition, the Company recognized an extraordinary gain of $4.0 million, or $0.03 per share assuming full dilution, for both the quarter and six months ended June 30, 2002 due to an excess of the fair value of net assets over acquisition costs.

On January 31, 2002, WellPoint completed its merger, through its wholly owned subsidiary, RWP Acquisition Corp., with RightCHOICE, the parent company of Blue Cross and Blue Shield of Missouri, which served approximately 2.2 million medical members as of January 31, 2002. Under the terms of the transaction, total consideration paid to all holders of RightCHOICE common stock and holders of employee stock options in the merger was approximately $379.1 million in cash and 16.5 million shares of WellPoint Common Stock. The Company issued approximately 11.1 million shares from treasury stock and the remaining 5.4 million shares from newly issued shares of WellPoint Common Stock. The total purchase price of approximately $1,442.1 million was used to purchase net assets with a fair value of approximately $303.9 million. This acquisition was accounted for under the purchase method of accounting and, accordingly, the consolidated results of operations of the Company include the results of RightCHOICE from the date of acquisition. As a result of the acquisition of RightCHOICE, the Company estimates that it will incur $113.8 million in expenses primarily related to change−in−control payments to RightCHOICE management and transaction costs. Generally accepted accounting principles require that these expenses, which are not associated with the generation of future revenues and have no future economic benefit, be reflected as assumed liabilities in the allocation of the purchase price to the net assets acquired. Goodwill and other intangibles totaling $1,337.0 million includes $104.1 million of deferred and current tax liabilities relating to identified intangibles. With the adoption of Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"), goodwill and other intangible assets with indefinite useful lives are no longer amortized, but instead subject to impairment tests. Identified intangibles with definite useful lives are being amortized on a straight−line basis or the timing of related cash flows depending upon the expected amortization pattern over 15 to 20 years. The valuation process is not yet complete and, as a result, the useful lives and method of amortization are only preliminary estimates. The current estimated purchase price allocation between goodwill and identifiable intangible assets is $1,070.9 million and $266.1 million, respectively.

On March 15, 2001, the Company completed its acquisition of Cerulean, the parent company of Blue Cross Blue Shield of Georgia, Inc., which served approximately 1.9 million medical members in the state of Georgia as of March 31, 2001. This acquisition was accounted for under the purchase method of accounting and, accordingly, the consolidated results of operations of the Company include the results of Cerulean from the date of acquisition. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company incurred $134.5 million in expenses primarily related to change in control payments to Cerulean management and transaction costs. Generally accepted accounting principles require that these expenses, which are not associated with the generation of future revenues and have no future economic benefit, be reflected as assumed liabilities in the allocation of the purchase price to the net assets acquired. Cash of $200.0 million and debt of $500.0 million were used to purchase net assets with a fair value of approximately $334.8 million. Goodwill and other intangibles totaling $602.9 million includes $149.1 million of deferred and current tax liabilities relating to identified intangibles. Other intangibles with definite useful lives are being amortized using a straight−line basis or the timing of related cash flows depending upon the expected amortization pattern over five to 25 years. The purchase price allocation between goodwill and identifiable intangible assets is $235.3 million and $367.6 million, respectively.

In accordance with the requirements of Statement of Financial Accounting Standards No. 141, "Business Combinations," ("SFAS No. 141") the following unaudited pro forma summary presents revenues, net income and per share data of WellPoint as if the acquisitions of Cerulean, RightCHOICE and MethodistCare had occurred on January 1, 2001. The pro forma information includes the results of operations for each acquired entity for the period prior to its acquisition, adjusted for interest expense on long−term debt incurred to fund the acquisitions, amortization of goodwill and intangible assets and the related income tax effects. The pro forma financial information for the quarter and six months ended June 30, 2001 is presented under the requirements of APB Opinion No. 16, "Business Combinations," which allows for amortization of goodwill and other intangible assets with indefinite useful lives. The pro forma financial information for the quarter and six months ended June 30, 2002 is presented under the requirements of SFAS No. 141, which disallows the amortization of goodwill and other intangible assets with indefinite useful lives. For comparability purposes, the pro forma financial information for the quarter and six months ended June 30, 2001 have also been presented under the requirements of SFAS No. 141.

The pro forma financial information is presented for informational purposes only and may not be indicative of the results of operations had the Company been a single entity during the quarter and six months ended June 30, 2002 and 2001, nor is it necessarily indicative of future results of operations. Pro forma earnings per share is based on 144.9 million and 143.2 million weighted average shares outstanding for the quarter ended June 30, 2002 and 2001, respectively. Pro forma earnings per share assuming full dilution is based on 152.6 million and 149.3 million weighted average shares outstanding for the quarter ended June 30, 2002 and 2001, respectively. Pro forma earnings per share is based on 144.7 million and 142.9 million weighted average shares outstanding for the six months ended June 30, 2002 and 2001, respectively. Pro forma earnings per share assuming full dilution is based on 152.2 million and 149.2 million weighted average shares outstanding for the six months ended June 30, 2002 and 2001, respectively.

	Quarter Ended June 30,			Six Months Ended June 30,		
(In thousands, except per share data)	2002 (SFAS 142)	2001 (APB 16)	2001 (SFAS 142)	2002 (SFAS 142)	2001 (APB 16)	2001 (SFAS 142)
Revenues	$ 4,311,749	$ 3,480,597	$ 3,480,597	$ 8,403,558	$ 6,909,931	$ 6,909,931
Adjusted Pro forma Income before Extraordinary Items	$ 168,949	$ 96,927	$ 128,832	$ 300,905	$ 201,189	$ 247,561
Adjusted Pro forma Net Income	$ 171,733	$ 96,927	$ 128,832	$ 303,689	$ 201,189	$ 247,561
Earnings Per Share:						
Adjusted Pro forma Income before Extraordinary Items	$ 1.17	$ 0.68	$ 0.90	$ 2.08	$ 1.41	$ 1.73
Adjusted Pro forma Net Income	$ 1.19	$ 0.68	$ 0.90	$ 2.10	$ 1.41	$ 1.73
Diluted Earnings Per Share:						
Adjusted Pro forma Income before Extraordinary Items	$ 1.11	$ 0.65	$ 0.87	$ 1.98	$ 1.35	$ 1.67
Adjusted Pro forma Net Income	$ 1.13	$ 0.65	$ 0.87	$ 2.00	$ 1.35	$ 1.67

For the quarter and six months ended June 30, 2001, the adjusted pro forma income before extraordinary items and net income includes a $13.1 million after−tax gain resulting from MethodistCare's sale of its investment in a limited liability partnership operating in a large multi−practice medical group.

4. Goodwill and Other Intangible Assets

In June 2001, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards No. 141, "Business Combinations" ("SFAS No. 141"), and Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 141 requires all business combinations initiated after June 30, 2001 be accounted for using the purchase method. The provisions of SFAS No. 141 also apply to all business combinations consummated after June 30, 2001. SFAS No. 142, effective for fiscal years beginning after December 15, 2001, eliminates amortization of goodwill and other intangible assets with indefinite useful lives. Rather, these assets are subject to the impairment tests at least annually.

The Company adopted SFAS No. 142 on January 1, 2002 and no longer amortizes goodwill and other intangible assets with indefinite useful lives. The Company also completed the evaluation of its goodwill and other intangible assets and determined that there was no impairment loss. The following table shows net income and earnings per share adjusted to reflect the adoption of the non−amortization provisions of SFAS No. 142 as of the beginning of the respective periods:

(In thousands, except per share amounts)	Three Months Ended June 30, 2002	Three Months Ended June 30, 2001	Six Months Ended June 30, 2002	Six Months Ended June 30, 2001
Reported net income	$ 170,747	$ 99,929	$ 311,847	$ 196,432
Add back: Amortization of goodwill and other intangibles with indefinite useful lives, net of tax effect	—	9,467	—	13,707
Adjusted net income	$ 170,747	$ 109,396	$ 311,847	$ 210,139
Reported earnings per share	$ 1.18	$ 0.79	$ 2.20	$ 1.55
Add back: Amortization of goodwill and other intangibles with indefinite useful lives, net of tax effect	—	0.07	—	0.11
Adjusted earnings per share	$ 1.18	$ 0.86	$ 2.20	$ 1.66
Reported earnings per share assuming full dilution	$ 1.12	$ 0.76	$ 2.10	$ 1.50
Add back: Amortization of goodwill and other intangibles with indefinite useful lives, net of tax effect	—	0.07	—	0.10
Adjusted earnings per share assuming full dilution	$ 1.12	$ 0.83	$ 2.10	$ 1.60

The changes in the carrying amount of goodwill by reportable segment for the six months ended June 30, 2002 are as follows:

(In thousands)	Health Care	Specialty	Consolidated
Balance as of January 1, 2002	$ 646,375	$ 14,971	$ 661,346
Goodwill acquired during 2002	1,072,919	—	1,072,919
Final allocation of Cerulean goodwill and acquired intangibles	(47,361)	—	(47,361)
Reclassification from other intangible assets	3,464	—	3,464
Balance as of June 30, 2002	$ 1,675,397	$ 14,971	$ 1,690,368

Upon adoption of SFAS No. 141, the Company reclassified $3.5 million of other intangible assets to goodwill since they did not meet the criteria for recognition apart from goodwill. The reclassification is for the assembled workforce intangible assets acquired from previous acquisitions.

On January 31, 2002, WellPoint completed its merger with RightCHOICE as discussed in Note 3—Acquisitions. As a result of the acquisition of RightCHOICE, the Company recorded $1,070.9 million of goodwill and $266.1 million of identifiable intangible assets. The valuation process is not yet

complete and, therefore, the allocation between goodwill and other intangible assets recorded as of June 30, 2002 represents an estimate. Based on the information currently available, the following table presents details of the acquired amortized and non−amortized intangible assets of RightCHOICE at cost as of June 30, 2002:

(In thousands)	Estimated Value	Useful Life (in years)
Amortized intangible assets:		
Provider Contracts with physicians	$ 4,377	20
Customer Contracts and Related Customer Relationships	90,613	15
Total amortized intangible assets	94,990	
Non−amortized intangible assets:		
Provider Contracts with hospitals and ancillary facilities	$ 5,072	Indefinite
Trade Name and Service Marks	166,000	Indefinite
Total non−amortized intangible assets	171,072	
Total other intangible assets	$ 266,062	

The gross carrying value, accumulated amortization and net carrying value of other intangible assets as of June 30, 2002 and December 31, 2001 are as follows (amounts in thousands):

As of June 30, 2002	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Amortization Period (in years)
Amortized intangible assets:				
Provider Contracts with physicians	$ 29,974	$ 3,212	$ 26,762	10 to 25 years
Customer Contracts and Related Customer Relationships	352,699	55,839	296,860	18 months to 20 years
Other	21,967	6,921	15,046	5 to 20 years
Total amortized intangible assets	404,640	65,972	338,668	
Non−amortized intangible assets:				
Provider Contracts with hospitals and ancillary facilities	17,122	98	17,024	Indefinite
Trade Name and Service Marks	404,000	2,642	401,358	Indefinite
Total non−amortized intangible assets	421,122	2,740	418,382	
Total other intangible assets	$ 825,762	$ 68,712	$ 757,050	

As of December 31, 2001	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Amortization Period (in years)
Amortized intangible assets:				
Provider Contracts	$ 23,547	$ 2,509	$ 21,038	10 to 40 years
Customer Contracts and Related Customer Relationships	285,819	39,285	246,534	18 months to 20 years
Trade Name and Service Marks	135,000	2,642	132,358	40 years
Other	38,477	7,919	30,558	5 to 20 years
Total amortized intangible assets	$ 482,843	$ 52,355	$ 430,488	

For the three months and six months ended June 30, 2002, amortization expense relating to intangible assets was $9.6 million and $18.4 million, respectively. For the three months and six months ended June 30, 2001, amortization expense relating to intangible assets was $17.3 million and $28.6 million, respectively. The following table presents the Company's estimated annual amortization expense for amortized intangible assets for each of the years ending December 31, 2002, 2003, 2004, 2005 and 2006 (amounts in thousands). These estimates were calculated based on the gross carrying value of amortized intangible assets as of June 30, 2002 using the applicable amortization period.

For year ending December 31, 2002	$ 37,952
For year ending December 31, 2003	36,258
For year ending December 31, 2004	33,839
For year ending December 31, 2005	31,657
For year ending December 31, 2006	27,318

5. Long−Term Debt

$6\frac{3}{8}$% Notes due 2012

On January 16, 2002, the Company issued $350.0 million aggregate principal amount at maturity of $6\frac{3}{8}$% Notes due January 15, 2012 (the "2002 Notes"). The net proceeds of this offering totaled approximately $348.9 million. The net proceeds from the sale of the 2002 Notes were used to finance the RightCHOICE merger discussed in Note 3. The 2002 Notes bear interest at a rate of $6\frac{3}{8}$% per annum, payable semi−annually in arrears on January 15 and July 15 of each year commencing July 15, 2002. Interest is computed on the basis of a 360−day year of twelve 30−day months. At June 30, 2002, the Company had $348.9 million (based upon the principal amount of $350.0 million less discount) of 2002 Notes outstanding. The related interest expense and amortization of discount for the quarter and six months ended June 30, 2002 totaled $5.7 million and $10.5 million, respectively.

The 2002 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2002 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2002 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2002 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (J.P. Morgan Securities Inc. or

Deutsche Banc Alex Brown or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2002 Notes to the redemption date.

6 3/8% Notes due 2006

On June 15, 2001, the Company issued $450.0 million aggregate principal amount at maturity of 6 3/8% Notes due June 15, 2006 (the "2001 Notes"). The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities. The 2001 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest is computed on the basis of a 360−day year of twelve 30−day months. At June 30, 2002, the Company had $449.2 million (based upon the principal amount of $450.0 million less discount) of 2001 Notes outstanding. The related interest expense and amortization of discount for the quarter and six months ended June 30, 2002 totaled $7.5 million and $14.9 million, respectively.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semi−annual basis at the Treasury rate as determined by the designated Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

In order to mitigate interest rate fluctuations associated with its 2001 Notes, the Company, on January 15, 2002, entered into a $200 million notional amount interest rate swap agreement. The swap agreement is a contract to exchange a fixed 6 3/8% rate for a LIBOR−based floating rate. The swap agreement expires June 15, 2006. As of June 30, 2002, the Company recognized a fair value liability adjustment to the $450.0 million 2001 Notes of $2.4 million. (See Note 10. Hedging Activities).

The 2002 and 2001 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2002 and 2001 Notes. The indenture governing the 2002 and 2001 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2002 and 2001 Notes.

Revolving Credit Facility

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities (which are generally referred to collectively in this Quarterly Report on Form 10−Q as the Company's "revolving credit facility") bear interest at rates determined by reference to the bank's base rate or to the London InterBank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, expires on March 28, 2003. Any amount

outstanding under this facility as of March 28, 2003 may be converted into a one−year term loan at the option of the Company.

Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control. During the six months ended June 30, 2002, the Company repaid its entire indebtedness under the revolving credit facility of $235.0 million at December 31, 2001, which had an effective interest rate at the time of 2.76%. This repayment was funded in part by the Company's incurrence of short−term indebtedness described below under the heading "Commercial Paper Program."

The agreement provides for interest on committed advances at rates determined by reference to the bank's base rate or to the London InterBank Offered Rate ("LIBOR") plus a margin determined by reference to the Company's senior unsecured long−term debt rating by specified rating agencies. Interest is determined using whichever of these methods is the most favorable to the Company.

Borrowings under the credit facility are made on a committed basis or pursuant to an auction−bid process. A facility fee based on the facility amount, regardless of utilization, is payable quarterly. The facility fee rate is also determined by the senior unsecured debt ratings or the leverage ratio of the Company.

Zero Coupon Convertible Subordinated Debentures

On July 2, 1999, the Company issued $299.0 million aggregate principal amount at maturity of zero coupon convertible subordinated debentures due 2019 (the "Debentures"). The proceeds totaled approximately $200.8 million. The Debentures accrue interest at a yield to maturity of 2.0% per year compounded semi−annually. Holders have the option to convert the Debentures into the Company's common stock at any time prior to maturity at a rate of 13.594 shares per $1,000 principal amount at maturity. In lieu of delivering shares of common stock upon conversion of any Debentures, the Company may elect to pay cash for the Debentures in an amount equal to the last reported sales price of its common stock on the trading day preceding the conversion date. The Debentures are subordinate in right of payment to all existing and future senior indebtedness.

On October 6, 1999, the Board of Directors authorized the repurchase of some or all of the Company's Debentures for cash. The Company did not repurchase any Debentures during the six months ended June 30, 2002 and year ended December 31, 2001.

As of June 30, 2002 and December 31, 2001, the Company had $151.7 million and $153.9 million (based upon the original issue price plus accrued interest), respectively, of Debentures outstanding. The reduction in the balance from December 31, 2001 to June 30, 2002 resulted from holders exercising their option to convert the Debentures into the Company's common stock. In lieu of delivering shares of common stock upon conversion of these Debentures, the Company elected to pay cash. During the six months ended June 30, 2002, holders converted $5.1 million in aggregate principal amount at maturity of the Company's Debentures with a carrying value (including accrued interest) of $3.6 million. The total purchase price paid by the Company of $5.7 million resulted in an extraordinary after−tax loss of $1.3 million, as shown on the Company's Consolidated Income Statements.

Accrued interest related to the Debentures was $9.0 million and $7.5 million, as of June 30, 2002 and December 31, 2001, respectively.

Commercial Paper Program

In April 2002, the Company commenced a commercial paper program providing for the issuance of up to $1.0 billion in aggregate maturity value of short−term indebtedness (known generally as "commercial paper"). The commercial paper is being issued by the Company without registration under the Securities Act of 1933 (the "1933 Act") in reliance upon the exemption from registration contained in Section 4(2) of the 1933 Act. The commercial paper is issued in denominations of $100,000 or integral multiples of $1,000 in excess thereof, will bear such interest rates, if interest−bearing, or will be sold at such discount from their face amounts, as agreed upon by the Company and the dealer or dealers acting in connection with the commercial paper program. The commercial paper may be issued with varying maturities up to a maximum of 270 days from the date of issuance. As of June 30, 2002, outstanding commercial paper totaled approximately $199.8 million, with an average maturity of 29 days. The weighted average yield on the outstanding commercial paper as of June 30, 2002 was 2.03%. At the time that the Company entered into the revolving credit facility in March 2001, the Company contemplated that the proceeds of any borrowings under the revolving credit facility could be used to repay commercial paper borrowings. The Company has the intent to maintain commercial paper borrowings of at least the amount outstanding at June 30, 2002 for more than one year. For financial reporting purposes, the commercial paper has been classified under non−current liabilities in the accompanying Consolidated Balance Sheets based on the terms of the revolving credit facility.

6. Earnings Per Share

The following is an illustration of the dilutive effect of the Company's potential common stock on earnings per share ("EPS"). There were no antidilutive securities in any of the periods presented.

(In thousands, except per share data)	Quarter Ended June 30, 2002	Quarter Ended June 30, 2001	Six Months Ended June 30, 2002	Six Months Ended June 30, 2001
Basic Earnings Per Share Calculation:				
Numerator				
Income before extraordinary items	$ 167,963	$ 99,929	$ 309,063	$ 196,432
Extraordinary gain from negative goodwill on acquisition	4,042	—	4,042	—
Extraordinary loss on early extinguishment of debt, net of tax benefit of $838	(1,258)	—	(1,258)	—
Net Income	$ 170,747	$ 99,929	$ 311,847	$ 196,432
Denominator				
Weighted average shares outstanding	144,852	126,719	141,986	126,347
Earnings Per Share				
Income before extraordinary items	$ 1.16	$ 0.79	$ 2.18	$ 1.55
Extraordinary gain from negative goodwill on acquisition	0.03	—	0.03	—
Extraordinary loss on early extinguishment of debt, net of tax benefit	(0.01)	—	(0.01)	—
Net Income	$ 1.18	$ 0.79	$ 2.20	$ 1.55
Earnings Per Share Assuming Full Dilution Calculation:				
Numerator				
Income before extraordinary items	$ 167,963	$ 99,929	$ 309,063	$ 196,432
Interest expense on zero coupon convertible subordinated debentures, net of tax	483	466	966	946
Adjusted income before extraordinary items	168,446	100,395	310,029	197,378
Extraordinary gain from negative goodwill on acquisition	4,042	—	4,042	—
Extraordinary loss on early extinguishment of debt, net of tax benefit of $838	(1,258)	—	(1,258)	—
Adjusted Net Income	$ 171,230	$ 100,395	$ 312,813	$ 197,378
Denominator				
Weighted average shares outstanding	144,852	126,719	141,986	126,347
Net effect of dilutive stock options	4,758	1,946	4,284	2,215
Assumed conversion of zero coupon convertible subordinated debentures	2,956	2,963	2,960	2,963
Fully diluted weighted average shares outstanding	152,566	131,628	149,230	131,525
Earnings Per Share Assuming Full Dilution				
Income before extraordinary items	$ 1.10	$ 0.76	$ 2.08	$ 1.50
Extraordinary gain from negative goodwill on acquisition	0.03	—	0.03	—
Extraordinary loss on early extinguishment of debt, net of tax benefit	(0.01)	—	(0.01)	—
Net Income	$ 1.12	$ 0.76	$ 2.10	$ 1.50

7. Comprehensive Income

The following summarizes comprehensive income reclassification adjustments for the six months ended June 30, 2002 and 2001:

(In thousands)	Six Months Ended June 30, 2002	2001
Investment Securities:		
Net holding (loss) gain on investment securities arising during the period, net of tax benefit (expense) of $9,394 and $(11,361)	$ (14,364)	$ 17,770
Reclassification adjustment for realized gain (loss) on investment securities, net of tax (expense) benefit of $(3,607) and $4,238	5,410	(6,628)
	(8,954)	11,142
Fair Value Hedges:		
Holding loss related to foreign exchange transactions, net of tax benefit of $363	—	(568)
Transition adjustment, net of tax expense of $167	—	262
Reclassification adjustment related to foreign exchange gain on investment securities, net of tax expense of $31	—	48
	—	(258)
Cash Flow Hedges:		
Holding gain related to swap transactions, net of tax expense of $111 and $893	160	1,397
Transition adjustment, net of tax benefit of $4,442	—	(6,948)
	160	(5,551)
Net (loss) gain recognized in other comprehensive income, net of tax benefit (expense) of $5,676 and $(2,397)	$ (8,794)	$ 5,333

8. Contingencies

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California

Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which was to be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The hearing was held in January 2002 and, in March 2002, the Court of Appeals panel issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration. The Company filed a motion requesting a rehearing of the matter before the entire 11thCircuit Court of Appeals, which motion was denied by the 11th Circuit Court of Appeals in June 2002. On July 29, 2002, Judge Moreno issued an order providing that discovery in the case would be allowed to re−commence on September 30, 2002.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status. The Company filed a motion (which was granted in July 2002) with the federal Judicial Panel on Multidistrict Litigation requesting that the proceedings in this case be consolidated with a similar action brought against other managed care companies that has previously been consolidated with the *Shane* lawsuit.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. Discovery in the matter is currently being conducted and a hearing regarding class certification has been scheduled for December 16, 2002. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

Prior to the Company's acquisition of the GBO, John Hancock Mutual Life Insurance Company ("John Hancock") entered into a number of reinsurance arrangements with respect to personal accident insurance and the occupational accident component of workers' compensation insurance, a portion of which was originated through a pool managed by Unicover Managers, Inc. Under these arrangements, John Hancock assumed risks as a reinsurer and transferred certain of such risks to other companies. These arrangements have become the subject of disputes, including a number of legal

proceedings to which John Hancock is a party. The Company believes that it has a number of defenses to avoid any ultimate liability with respect to these matters and believes that such liabilities were not transferred to the Company as part of the GBO acquisition. However, if the Company were to become subject to such liabilities, the Company could suffer losses that might have a material adverse effect on its financial condition, results of operations or cash flows.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown. Certain of such legal proceedings are or may be covered under insurance policies or indemnification agreements. Based upon information presently available, management of the Company believes that the final outcome of all such proceedings should not have a material adverse effect on the Company's results of operations, cash flows or financial condition.

9. Business Segment Information

As of December 31, 2001, the Company's primary internal business divisions were focused on large employer group business, individual and small employer group business, and senior and specialty business. As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002. As a result of these changes, the Company now has the following two reportable segments: Health Care business and Specialty business. The Health Care segment is managed geographically and continues to provide a broad spectrum of network−based health plans, including HMOs, PPOs, POS plans, other hybrid plans and traditional indemnity products to large and small employers and individuals. The Specialty business is maintained as a separate segment providing an array of other products, including pharmacy, dental, workers' compensation managed care services, life insurance, preventive care, disability insurance and behavioral health. Corporate includes net investment income, general and administrative expense and interest expense not allocable to the reportable segments.

The following tables present segment information for the Health Care and Specialty segments for the quarter and six months ended June 30, 2002 and 2001, respectively, as if the Company's new organizational structure had been effective on January 1, 2001.

Quarter Ended June 30, 2002

(In thousands)	Health Care	Specialty	Corporate	Consolidated
Premium revenue	$ 3,898,013	$ 127,081	$ —	$ 4,025,094
Management services revenue	170,240	37,591	—	207,831
Total revenue from external customers	4,068,253	164,672	—	4,232,925
Segment net income (loss)	$ 166,747	$ 5,222	$ (1,222)	$ 170,747
Segment assets	$ 7,656,269	$ 588,377	$ 2,003,416	$ 10,248,062

Quarter Ended June 30, 2001

(In thousands)	Health Care	Specialty	Corporate	Consolidated
Premium revenue	$ 2,802,730	$ 123,337	$ —	$ 2,926,067
Management services revenue	132,543	25,948	—	158,491
Total revenue from external customers	2,935,273	149,285	—	3,084,558
Segment net income	$ 94,943	$ 3,902	$ 1,084	$ 99,929
Segment assets	$ 4,864,803	$ 657,259	$ 1,441,488	$ 6,963,550

Six Months Ended June 30, 2002

(In thousands)	Health Care	Specialty	Corporate	Consolidated
Premium revenue	$ 7,473,738	$ 250,015	$ —	$ 7,723,753
Management services revenue	323,956	68,312	—	392,268
Total revenue from external customers	7,797,694	318,327	—	8,116,021
Segment net income (loss)	$ 312,399	$ 9,498	$ (10,050)	$ 311,847

Six Months Ended June 30, 2001

(In thousands)	Health Care	Specialty	Corporate	Consolidated
Premium revenue	$ 5,134,810	$ 224,385	$ —	$ 5,359,195
Management services revenue	233,361	54,654	—	288,015
Total revenue from external customers	5,368,171	279,039	—	5,647,210
Segment net income	$ 185,403	$ 9,669	$ 1,360	$ 196,432

10. Hedging Activities

The Company maintains an interest rate risk management strategy that uses derivative instruments to minimize significant, unanticipated earnings fluctuations caused by interest rate volatility. The Company's goal is to maintain a balance between fixed and floating interest rates on its long−term debt.

By using derivative financial instruments to hedge exposures to changes in exchange rates and interest rates, the Company exposes itself to credit risk and market risk. Market risk is the adverse effect on the value of a financial instrument that results from a change in currency exchange rates or interest rates. The Company manages exposure to market risk associated with interest rate and foreign exchange contracts by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

The Company uses interest rate swap agreements to manage interest rate exposures. The principal objective of such contracts is to minimize the risks and/or costs associated with financial and investing activities. The Company does not use derivative financial instruments for speculative purposes. The

counterparties to these contractual arrangements are major financial institutions with which the Company also has other financial relationships. These counterparties expose the Company to credit loss in the event of non−performance. However, the Company does not anticipate non−performance by the other parties. As of June 30, 2002, the Company reported a net derivative liability of $11.4 million of which a derivative liability of $13.8 million was related to the cash flow hedges and a derivative asset of $2.4 million was related to the fair value hedge.

Fair Value Hedges

In order to mitigate interest rate fluctuations associated with its $450 million aggregate principal amount at maturity of 6 3/8% Notes due June 15, 2006, the Company, on January 15, 2002, entered into a $200 million notional amount interest rate swap agreement. The swap agreement is a contract to exchange a fixed 6 3/8% rate for a LIBOR−based floating rate. The swap agreement expires June 15, 2006. For the six months ended June 30, 2002, the Company recognized $2.8 million of income from this swap which was recorded as a reduction to interest expense. As of June 30, 2002, the Company recognized a derivative asset of $2.4 million related to this swap agreement.

During 2001, the Company entered into foreign currency forward exchange contracts for each of the fixed maturity securities on hand denominated in foreign currencies in order to hedge asset positions with respect to currency fluctuations related to these securities. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and as a result entered into a hedge to offset the remaining currency hedge. Both hedges expired during the quarter ended June 30, 2002. Subsequent to the implementation of Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"), all gains and losses from both effective and ineffective forward exchange contracts have been reported in investment income offset by the related gains and losses on the Company's available−for−sale foreign securities.

Cash Flow Hedges

The Company uses interest rate swap agreements to reduce the impact of changes in interest rates on its floating rate debt under its revolving credit facility. The swap agreements are contracts to exchange variable−rate for fixed−rate interest payments without the exchange of the underlying notional amounts. During the six months ended June 30, 2002, the Company recognized a net loss of approximately $8,000 reported in interest expense in the Consolidated Income Statements, which represents the total ineffectiveness of all cash flow hedges.

As of June 30, 2002, the Company had the following interest rate swap agreements in effect (notional amount in thousands) in addition to the swap agreement referred to under "Fair Value Hedges":

Notional Amount	Strike Rate	Expiration Date
$ 150,000	6.99%	October 17, 2003
$ 50,000	7.06%	October 17, 2006

As of June 30, 2002, the Company had recognized a derivative liability related to these swap agreements of $13.8 million, which was included in other non−current liabilities of the Consolidated Balance Sheets.

11. New Pronouncements

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 142 addresses financial accounting and reporting for acquired goodwill and other intangible assets and supersedes APB Opinion No. 17, "Intangible Assets." The new rules change the accounting methodology for goodwill from a model that amortizes goodwill to one which evaluates it for impairment. Amortization of goodwill, including previously recorded goodwill, ended upon adoption of the new rules. The new rules also eliminate amortization of other intangibles with indefinite useful lives, but these assets are also subject to the impairment tests. SFAS No. 142 is effective for fiscal years beginning after December 15, 2001. Upon adoption of SFAS No. 142 on January 1, 2002, the Company's evaluation of its goodwill and other intangible assets resulted in no impairment loss. Amortization of goodwill and other intangibles for the quarter ended June 30, 2002 and 2001, totaled $9.6 million and $17.3 million, respectively. Amortization of goodwill and other intangibles for the six months ended June 30, 2002 and 2001, totaled $18.4 million and $28.6 million, respectively. SFAS No. 142 accounted for $11.2 million of the amortization decrease for the quarter ended June 30, 2002, partially offset by a net increase in amortization of intangible assets with definite useful lives of $3.5 million, primarily due to recent acquisitions. SFAS No. 142 accounted for $18.3 million of the amortization decrease for the six months ended June 30, 2002, partially offset by a net increase in amortization of intangible assets with definite useful lives of $8.1 million, primarily due to recent acquisitions.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 143, "Accounting for Asset Retirement Obligations" ("SFAS No. 143"). SFAS No. 143 is effective for financial statements issued for fiscal years beginning after June 15, 2002. The Company will adopt SFAS No. 143 on January 1, 2003. The provisions of SFAS No. 143 require companies to record an asset and related liability for the costs associated with the retirement of a long−lived tangible asset if a legal liability to retire the asset exists. The Company is in the process of analyzing the provisions of SFAS No. 143; however, the effect of adoption is not expected to have a significant impact on the Company's financial condition and results of operations.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long−Lived Assets" ("SFAS No. 144"). SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001. The Company adopted SFAS No. 144 on January 1, 2002. This statement addresses financial accounting and reporting for the impairment or disposal of long−lived assets and supersedes SFAS No. 121, "Accounting for the Impairment of Long−Lived Assets and for Long−Lived Assets to be Disposed of" and the accounting and reporting provisions of APB 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," for the disposal of a segment of business (as previously defined in that opinion). SFAS No. 144 retains the basic principles of SFAS No. 121 for long−lived assets to be disposed of by sale or held and used and broadens discontinued operations presentation to include a component of an entity that is held for sale or that has been disposed. Components must have operations and cash flows that can be clearly distinguished from the rest of the entity. The adoption of this standard did not have any impact on the Company's financial results.

In May 2002, the FASB issued Statement of Financial Accounting Standards No. 145, "Rescission of FASB statements No. 4, 44 and 64, Amendment of FASB statement No. 13 and Technical Corrections as of April 2002," ("SFAS No. 145"). With the rescission of SFAS No. 4, gains and losses from the extinguishment of debt should be classified as extraordinary items only if they meet the criteria in APB 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 Opinion No. 30"). Applying the provisions of APB Opinion No. 30 will distinguish transactions that are part of an entity's recurring operations from those that are unusual or infrequent

or that meet the criteria for classification as an extraordinary item. The provisions of SFAS No. 145 related to the rescission of SFAS No. 4 shall be applied for fiscal years beginning after May 15, 2002. The Company has determined that the extinguishment of debt under its Zero Coupon Convertible Subordinated Debentures does not meet the requirements of unusual or infrequent and therefore would not be included as an extraordinary item with the rescission of SFAS No. 4. The Company does not believe the other provisions within SFAS No. 145 will have a material effect on the Company's financial statements.

In July 2002, the FASB issued Statement of Financial Accounting Standards No. 146, "Accounting for Costs Associated with Exit or Disposal Activities" ("SFAS No. 146"). SFAS No. 146 replaces current accounting literature and requires the recognition of costs associated with exit or disposal activities when they are incurred rather than at the date of a commitment to an exit or disposal plan. SFAS No. 146 is to be applied prospectively to exit or disposal activities initiated after December 31, 2002. The Company does not believe the adoption of SFAS No. 146 will have a material effect on the Company's financial statements.

12. Pending Transactions

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to approximately 3.1 million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that the gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

In April 2002, the Maryland legislature adopted legislation that would, among other things, require that the consideration paid by the Company in the CareFirst transaction consist entirely of cash, prohibit certain change−in−control payments to CareFirst management previously approved by the CareFirst's Board of Directors and delay for 90 days the effectiveness of any decision by the Maryland Insurance Administration regarding CareFirst's for−profit conversion and consummation of the CareFirst transaction in order to allow the Maryland legislature to review the decision. The Company is currently assessing the effects of this legislation on the proposed transaction. The Maryland Insurance Administration has engaged an independent consultant to provide a preliminary valuation analysis regarding CareFirst, which the Company currently expects will be completed during the third quarter of 2002. Once this analysis has been received, the Company also expects to assess the analysis' impact on the proposed transaction.

13. Related Party Transactions

In December 2000, the Company formed The WellPoint Foundation ("Foundation"), a non−profit organization exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code. The purpose of the Foundation is to improve the health and well−being of individuals in the communities served by the Company. The Foundation Board of Directors is comprised solely of persons who are also officers of the Company. For the quarter and six months ended June 30, 2002, the Company contributed $15.0 million and $30.0 million, respectively, to the Foundation on a committed basis. No commitments were made to the Foundation for the quarter and six months ended June 30, 2001. The Company had an outstanding commitment payable to the Foundation of $15 million as of June 30, 2002 and December 31, 2001. These commitments were paid in the subsequent quarter for each respective period. The Company has no legal obligations for any future commitments to the Foundation.

14. Extraordinary Items

During the quarter ended June 30, 2002, the Company recorded two extraordinary items, a gain related to the acquisition of MethodistCare, which was due to an excess of the fair value of net assets over acquisition costs and a loss related to the early redemption of certain of the Debentures. The acquisition on April 30, 2002 of MethodistCare resulted in an extraordinary gain of $4.0 million, or $0.03 per share assuming full dilution, for both the quarter and six months ended June 30, 2002. During the second quarter of 2002, Debenture holders converted $5.1 million in aggregate principal amount at maturity of the Debentures with a carrying value (including accrued interest) of $3.6 million. The total purchase price paid by the Company of $5.7 million resulted in an extraordinary loss of $2.1 million, net of tax expense totaling $1.3 million, or $0.01 per share assuming full dilution, for both the quarter and six months ended June 30, 2002.

15. Subsequent Events

In July 2002, one of the Company's wholly owned subsidiaries, Blue Cross of California ("BCC"), agreed to pay $9.25 million to the U.S. Treasury to settle allegations brought by a former employee under the Civil False Claims Act against BCC in its former role as a Medicare Part A fiscal intermediary. Under the settlement, BCC expressly denied the allegations made by the plaintiff.

Part A fiscal intermediaries act as third−party administrators of claims filed by hospitals, nursing homes and certain other health care providers for medical services rendered to Medicare−eligible individuals. The lawsuit alleged that in the 1990s, BCC incorrectly entered dates into a tracking system that monitored the process of auditing cost reports submitted by health care providers to BCC.

The Company was sued in its capacity as the parent organization of BCC. The settlement agreement contains no allegations that the Company engaged in any wrongdoing. The settlement did not have a material adverse impact on the Company's statement of financial position and results of operations.

Report of Independent Accountants

To the Stockholders and Board of Directors
WellPoint Health Networks Inc.

We have reviewed the accompanying consolidated balance sheet of WellPoint Health Networks Inc. and its subsidiaries ("the Company") as of June 30, 2002, and the related consolidated income statements for each of the three−month and six−month periods ended June 30, 2002 and 2001, and the related consolidated statement of changes in stockholders' equity for the six month period ended June 30, 2002 and the consolidated statements of cash flows for the six month periods ended June 30, 2002 and 2001. These financial statements are the responsibility of the Company's management.

We conducted our review in accordance with standards established by the American Institute of Certified Public Accountants. A review of interim financial information consists principally of applying analytical procedures to financial data and making inquiries of persons responsible for financial and accounting matters. It is substantially less in scope than an audit conducted in accordance with generally accepted auditing standards, the objective of which is the expression of an opinion regarding the financial statements taken as a whole. Accordingly, we do not express such an opinion.

Based on our review, we are not aware of any material modifications that should be made to the accompanying consolidated interim financial statements for them to be in conformity with accounting principles generally accepted in the United States of America.

We previously audited in accordance with auditing standards generally accepted in the United States of America, the consolidated balance sheet as of December 31, 2001, and the related consolidated income statement and consolidated change in stockholders' equity and cash flows for the year then ended (not presented herein), and in our report dated January 31, 2002 except for Note 3 as to which the date is March 15, 2002, and Note 22 as to which the date is March 18, 2002, we expressed an unqualified opinion on those consolidated financial statements. Our report included an explanatory paragraph, that effective January 1, 1999, the Company changed its method of accounting for start−up costs. In our opinion, the information set forth in the accompanying consolidated balance sheet information as of December 31, 2001, is fairly stated in all material respects in relation to the consolidated balance sheet from which it has been derived.

/s/ PricewaterhouseCoopers LLP

Los Angeles, California
July 23, 2002

ITEM 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

This discussion contains forward−looking statements, which involve risks and uncertainties. The Company's actual results may differ materially from those anticipated in these forward−looking statements as a result of certain factors including, but not limited to, those set forth under "Factors That May Affect Future Results of Operations."

General

The Company is one of the nation's largest publicly traded managed health care companies. As of June 30, 2002, WellPoint had approximately 13.0 million medical members and approximately 45.3 million specialty members. As a result of the January 31, 2002 closing of the RightCHOICE transaction, the Company's medical membership increased by approximately 2.2 million members. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include HMOs, PPOs, POS plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial services, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products, including pharmacy, dental, life insurance, preventive care, disability insurance, behavioral health, COBRA and flexible benefits account administration. The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in other states primarily under the name UNICARE or HealthLink. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks.

As of December 31, 2001, the Company's primary internal business divisions were focused on large employer group business, individual and small employer group business, and senior and specialty business. As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002 to reflect the following reportable segments: Health Care business and Specialty business.

Acquisition of MethodistCare

On April 30, 2002, the Company completed the acquisition of MethodistCare (See Note 3 to the Consolidated Financial Statements), serving over 70,000 members in the Houston, Texas area.

Acquisition of RightCHOICE

On October 17, 2001, the Company entered into an Agreement and Plan of Merger with RightCHOICE, through its wholly owned subsidiary, RWP Acquisition Corp. (See Note 3 to the Consolidated Financial Statements). On January 31, 2002, the Company completed this transaction, pursuant to which RightCHOICE became a wholly owned subsidiary of the Company. The acquisition was valued at approximately $1.4 billion on the closing date, which was paid with $379.1 million in cash and approximately 16.5 million shares of WellPoint common stock. RightCHOICE, through its exclusive license to use the Blue Cross and Blue Shield names and service marks, is the largest provider of managed health care benefits in the state of Missouri based on number of members. RightCHOICE, through its HealthLink subsidiary, also provides network rental, administrative services, workers' compensation managed care services and other non−underwritten health benefit programs. As of January 31, 2002, RightCHOICE served approximately 2.2 million medical members in Missouri, Arkansas, Illinois, Indiana, Iowa, Kentucky and West Virginia. RightCHOICE has historically

experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. For the quarter and six months ended June 30, 2002, the RightCHOICE business experienced a higher administrative expense ratio than the Company's core businesses.

Acquisition of Cerulean

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross Blue Shield of Georgia, Inc. (See Note 3 to the Consolidated Financial Statements). Cerulean, principally through its Blue Cross and Blue Shield of Georgia subsidiary, offers insured and administrative services products primarily in the State of Georgia. Cerulean has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. Cerulean has also historically experienced a higher medical loss ratio than the Company's core businesses due to its higher percentage of Large Employer Group business and fewer managed care offerings. Accordingly, Cerulean's higher loss and administrative expense ratios have contributed to an increase in those ratios for the Company. The acquisition increased the Company's Georgia medical membership by approximately 1.9 million members as of March 31, 2001. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company also incurred $134.5 million in expenses, primarily related to change in control payments to Cerulean management and transaction costs. This acquisition was accounted for under the purchase method of accounting.

Pending Acquisition of CareFirst

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to approximately 3.1 million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that the gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

In April 2002, the Maryland legislature adopted legislation that would, among other things, require that the consideration paid by the Company in the CareFirst transaction consist entirely of cash, prohibit certain change−in−control payments to CareFirst management previously approved by CareFirst's Board of Directors and delay for 90 days the effectiveness of any decision by the Maryland Insurance Administration regarding CareFirst's for−profit conversion and consummation of the CareFirst transaction in order to allow the Maryland legislature to review the decision. The Company is currently assessing the effects of this legislation on the proposed transaction. The Maryland Insurance Administration has engaged an independent consultant to provide a preliminary valuation analysis

regarding CareFirst, which the Company currently expects will be completed during the third quarter of 2002. Once this analysis has been received, the Company also expects to assess the analysis' impact on the proposed transaction.

National Expansion and Other Recent Developments

In an effort to pursue the expansion of the Company's business outside the state of California, the Company acquired two businesses in 1996 and 1997, the Life and Health Benefits Management Division ("MMHD") of Massachusetts Mutual Life Insurance Company and the Group Benefits Operations (the "GBO") of John Hancock Mutual Life Insurance Company. The acquisitions of Rush Prudential Health Plans and a mail−order pharmacy which now does business as PrecisionRx in 2000 and the acquisition of Cerulean in 2001 were also components of this expansion strategy. In 2001, the Company entered into definitive agreements to expand into the Midwest with its acquisition of RightCHOICE, which closed on January 31, 2002, and into the Mid−Atlantic region with the pending acquisition of CareFirst, which is expected to close in 2003. On April 30, 2002, the Company completed its acquisition of MethodistCare.

As a result of these various acquisitions, the Company has significantly expanded its operations outside of California. In order to integrate its acquired businesses and implement the Company's regional expansion strategy, the Company will need to develop satisfactory networks of hospitals, physicians and other health care service providers, develop distribution channels for its products and successfully convert acquired books of business to the Company's existing information systems, which will require continued investments by the Company.

In response to rising medical and pharmacy costs, the Company has from time to time implemented premium increases with respect to certain of its products. The Company will continue to evaluate the need for further premium increases, plan design changes and other appropriate actions in the future in order to maintain or restore profit margins. There can be no assurances, however, that the Company will be able to take subsequent pricing or other actions or that any actions previously taken or implemented in the future will be successful in addressing any concerns that may arise with respect to the performance of certain businesses.

Legislation

Federal legislation enacted during the last several years seeks, among other things, to insure the portability of health coverage and mandates minimum maternity hospital stays. California legislation enacted since 1999, among other things, establishes an explicit duty on managed care entities to exercise ordinary care in arranging for the provision of medically necessary health care services and establishes a system of independent medical review. In 1997, Texas adopted legislation purporting to make managed care organizations such as the Company liable for their failure to exercise ordinary care when making health care treatment decisions. Similar legislation has also been enacted in Georgia. These and other proposed measures may have the effect of dramatically altering the regulation of health care and of increasing the Company's loss ratio and administrative costs or decreasing the affordability of the Company's products.

Consolidated Results of Operations

The Company's revenues are primarily generated from premiums earned for risk−based health care and specialty services provided to its members, fees for administrative services, including claims processing and access to provider networks for self−insured employers, and investment income. Operating expenses include health care services and other benefits expenses, consisting primarily of payments for physicians, hospitals and other providers for health care and specialty products claims;

selling expenses for broker and agent commissions; general and administrative expenses; interest expense; depreciation and amortization expense; and income taxes.

The Company's results of operations for the quarter ended June 30, 2002 include its acquired operations of Cerulean and RightCHOICE for the full quarter and operating results for MethodistCare for the period from April 30, 2002, its date of acquisition. The Company's consolidated results of operations for the six months ended June 30, 2002 include six months of earnings for Cerulean, five months of earnings for RightCHOICE and two months of earnings for MethodistCare. The results of operations for the quarter ended June 30, 2001 include a full quarter of earnings for Cerulean and the results of operations for the six months ended June 30, 2001 include the results of Cerulean for the period from March 15, 2001, its date of acquisition.

The following table sets forth selected operating ratios. The loss ratio for health care services and other benefits is shown as a percentage of premium revenue. All other ratios are shown as a percentage of premium revenue and management services revenue combined.

	Quarter Ended June 30,		Six Months Ended June 30,	
	2002	2001	2002	2001
Operating Revenues:				
Premium revenue	95.1%	94.9%	95.2%	94.9%
Management services revenue	4.9%	5.1%	4.8%	5.1%
	100.0%	100.0%	100.0%	100.0%
Operating Expenses:				
Health care services and other benefits (loss ratio)	81.5%	81.6%	81.1%	81.2%
Selling expense	4.0%	4.0%	4.0%	4.2%
General and administrative expense	12.7%	14.0%	13.3%	14.0%

Membership

The following table sets forth membership data and the percent change in membership:

Medical Membership (a)(b)(c)(d)

	June 30,		
	2002(e)	**2001 (e)**	**Percent Change**
California			
Large Group	4,492,189	3,959,472	13.5%
Individual and Small Group	1,607,429	1,561,767	2.9%
Senior	237,505	209,353	13.4%
Total California	6,337,123	5,730,592	10.6%
Central Region (f)			
Missouri			
Large Group	1,146,113	27,694	N/A
Individual and Small Group	232,340	632	N/A
Senior	43,056	117	N/A
Total Missouri	1,421,509	28,443	N/A
Illinois			
Large Group	746,843	434,634	71.8%
Individual and Small Group	120,832	76,260	58.4%
Senior	12,589	11,261	11.8%
Total Illinois	880,264	522,155	68.6%
Texas			
Large Group	381,785	310,171	23.1%
Individual and Small Group	196,291	162,867	20.5%
Senior	521	326	59.8%
Total Texas	578,597	473,364	22.2%
Other States			
Large Group	1,665,506	1,403,663	18.7%
Individual and Small Group	92,088	78,923	16.7%
Senior	21,907	15,436	41.9%
Total Other States	1,779,501	1,498,022	18.8%
Georgia			
Large Group	1,583,767	1,508,004	5.0%
Individual and Small Group	391,211	317,888	23.1%
Senior	70,396	77,614	−9.3%
Total Georgia	2,045,374	1,903,506	7.5%
Total Medical Membership	**13,042,368**	**10,156,082**	28.4**%**
ASO Membership (g)			
California	1,446,309	1,354,284	6.8%
Central Region	2,800,553	1,498,333	86.9%
Georgia	875,697	889,202	−1.5%
Total ASO Membership	**5,122,559**	**3,741,819**	36.9**%**
Risk Membership			
California	4,890,814	4,376,308	11.8%
Central Region	1,859,318	1,023,651	81.6%
Georgia	1,169,677	1,014,304	15.3%
Total Risk Membership	7,919,809	6,414,263	23.5%
Total Medical Membership	**13,042,368**	**10,156,082**	28.4**%**

Medical Membership Footnotes

(a)

Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by the contract.

(b)

Classification between states for employer groups is determined by the zip code of the subscriber.

(c)

Medical membership includes management services and network services members, which are primarily included in the Large Group for each respective state.

(d)

Senior membership includes members covered under both Medicare risk and Medicare supplement products.

(e)

Membership numbers as of June 30, 2001 have been adjusted to include members from two Company−owned or Company−controlled rental networks as well as the Company's proportionate share of members associated with a joint venture providing Medicaid services in Puerto Rico. Membership numbers as of June 30, 2002 also include members from these entities. As of June 30, 2002 and June 30, 2001, total members associated with these entities were 344,767 and 320,991, respectively. Membership numbers as of June 30, 2002 reflect members resulting from the Company's January 2002 merger with RightCHOICE Managed Care, Inc. ("RightCHOICE"). In order to reflect consistent membership numbers across the Company's various operating subsidiaries, the Company has excluded certain members for which RightCHOICE provides workers' compensation managed care services, which RightCHOICE previously reflected as members. There were approximately 975,007 and 789,439 such members as of June 30, 2002 and June 30, 2001, respectively. The membership numbers as of

June 30, 2002 have also been adjusted to eliminate approximately 135,449 shared members that are enrolled in UNICARE plans using the HealthLink networks. Finally, the Company has also excluded certain members participating in a national Blue Cross and Blue Shield Association program that were previously included as medical members by RightCHOICE. There were approximately 125,344 and 85,472 members in this program in the former RightCHOICE business as of June 30, 2002 and June 30, 2001, respectively.

(f)

Central Region Large Group membership includes network access services members, primarily from HealthLink, of 1,405,499 as of June 30, 2002 and 320,191 as of June 30, 2001.

(g)

ASO Membership represents members for which the Company provides administrative services only and does not assume full insurance risk.

Specialty Membership (a)

	June 30,		Percent Change
	2002	2001	
Pharmacy	32,912,985	30,471,062	8.0%
Dental	2,704,078	2,675,216	1.1%
Life	2,366,670	2,114,968	11.9%
Disability	517,811	544,705	−4.9%
Behavioral Health	6,813,440	5,004,274	36.2%

(a)

Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by the contract.

Comparison of Results for the Quarter Ended June 30, 2002 to the Quarter Ended June 30, 2001

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint Common Stock for each share held. Share and per share data for all periods presented below have been adjusted to give effect to the stock split.

The operating results for the quarter ended June 30, 2002 compared to the quarter ended June 30, 2001 were significantly affected by the RightCHOICE acquisition, which was consummated on January 31, 2002.

As discussed in Note 9 to the Consolidated Financial Statements, effective February 1, 2002 the Company effected a change in its organizational structure and now has two reportable segments—Health Care and Specialty. The Health Care segment includes all managed care plans and managed care services. The Specialty segment includes specialty managed health care and other services. The following table depicts premium revenue by reportable segment:

	Quarter Ended June 30,	
(In thousands)	**2002**	**2001**
Health Care	$ 3,898,013	$ 2,802,730
Specialty	127,081	123,337
Consolidated	$ 4,025,094	$ 2,926,067

Premium revenue increased 37.6%, or $1,099.0 million, to $4,025.1 million for the quarter ended June 30, 2002 from $2,926.1 million for the quarter ended June 30, 2001. The increase was primarily due to $312.1 million of premium revenue related to the RightCHOICE acquisition, representing 28.4% of the increase. Of the $312.1 million increase related to the RightCHOICE acquisition, $311.3 million was attributable to the Health Care segment and $0.8 million to the Specialty segment. Excluding the RightCHOICE acquisition, premium revenue would have increased 26.9% for the quarter ended June 30, 2002. The increase, excluding the RightCHOICE acquisition, was primarily due to an increase of insured member months of approximately 9.1% and the implementation of premium increases overall.

The following table depicts management services revenue by business segment:

	Quarter Ended June 30,	
(In thousands)	**2002**	**2001**
Health Care	$ 170,240	$ 132,543
Specialty	37,591	25,948
Consolidated	$ 207,831	$ 158,491

Management services revenue increased 31.1%, or $49.3 million, to $207.8 million for the quarter ended June 30, 2002 from $158.5 million for the quarter ended June 30, 2001. The increase was due to $38.0 million of management services revenue from the RightCHOICE acquisition. Of the $38.0 million increase related to the RightCHOICE acquisition, $35.3 million was attributable to the Health Care segment and $2.7 million to the Specialty segment. Excluding the RightCHOICE acquisition, management services revenue would have increased 7.2% for the quarter ended June 30, 2002. The increase was due to an increase in pharmacy benefit management services revenues of $7.0 million and the implementation of price increases overall.

Investment income was $66.1 million for the quarter ended June 30, 2002 compared to $60.8 million for the quarter ended June 30, 2001, an increase of $5.3 million or 8.7%. Gross investment income increased by $6.5 million or 10.5% in 2002 over 2001 as a result of higher average

investment balances for the quarter ended June 30, 2002 versus the quarter ended June 30, 2001. As a partial offset to this increase, net investment expenses increased by $1.2 million for the quarter ended June 30, 2002, due primarily to higher investment manager fees. Net realized losses remained relatively unchanged from the quarter ended June 30, 2001 to quarter ended June 30, 2002.

The loss ratio for the quarter ended June 30, 2002 was 81.5% compared to 81.6% for the same quarter in 2001. The loss ratio attributable to the Health Care segment was 81.8% for the quarter ended June 30, 2002 compared to 82.0% for the same quarter in 2001. The loss ratio attributable to the Specialty segment was 72.9% for the quarter ended June 30, 2002 compared to 73.9% for the same quarter in 2001. The RightCHOICE business has a lower loss ratio than the Company's core businesses. Excluding RightCHOICE, the loss ratio for both segments combined remained constant at 81.6% for the quarters ended June 30, 2002 and 2001. The health care services and other benefits expense includes an estimate of claims incurred during the period but which have not been reported to the Company. This estimate is actuarially determined based on a variety of factors and is inherently subject to a number of higher variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Selling expense consists of commissions paid to outside brokers and agents representing the Company. The selling expense ratio remained constant at 4.0% for the quarters ended June 30, 2002 and 2001. The RightCHOICE business has a slightly lower selling expense ratio of 3.9% than the Company's core businesses. The exclusion of RightCHOICE had no impact on the Company's selling expense ratio for the quarter ended June 30, 2002.

The administrative expense ratio decreased to 12.7% for the quarter ended June 30, 2002 from 14.0% for the quarter ended June 30, 2001. The acquired RightCHOICE business experienced a higher administrative expense ratio than the Company's core businesses for the quarter ended June 30, 2002, due to integration expenses along with certain other transaction−related expenses. Excluding RightCHOICE, the administrative expense ratio decreased to 12.5% in the second quarter of 2002 compared to 14.0% in the second quarter of 2001, due to merger synergies and fixed administrative costs spread over a larger membership base.

Interest expense increased $3.4 million to $17.0 million for the quarter ended June 30, 2002, compared to $13.6 million for the quarter ended June 30, 2001. The increase in interest expense was related to the higher average debt balance for the quarter ended June 30, 2002 in comparison to the quarter ended June 30, 2001, primarily due to the RightCHOICE acquisition. The weighted average interest rate for all debt for the quarter ended June 30, 2002, including the fees associated with the Company's borrowings and interest rate swap agreements, was 5.9%.

Other expense decreased $4.6 million to $14.0 million for the quarter ended June 30, 2002, compared to $18.6 million for the quarter ended June 30, 2001. The decrease resulted from lower amortization of goodwill and other intangible assets due to the implementation of SFAS No. 142, which accounted for $11.2 million of the amortization decrease. This decrease was partially offset by the following items: i) an increase in amortization of intangible assets with definite useful lives of $3.5 million, primarily due to recent acquisitions, ii) an increase in losses on the disposition of fixed assets of $1.3 million and iii) an increase in operating expenses of $1.6 million from an insurance general agency subsidiary owned by the Company.

The Company's net income for the quarter ended June 30, 2002 was $170.7 million, compared to $99.9 million for the quarter ended June 30, 2001. Net income for the quarter ended June 30, 2002 includes a net gain for two extraordinary items, a gain related to the acquisition of MethodistCare partially offset by a loss on early redemption of debt. The extraordinary gain amounted to $4.0 million, or $0.03 per diluted share, and was due to an excess of the fair value of net assets over acquisition costs. The extraordinary loss was $1.3 million, net of tax, or $0.01 per diluted share, which resulted

from the early redemption of the Company's Zero Coupon Convertible Subordinated Debentures (the "Debentures").

Earnings per share including the extraordinary items totaled $1.18 for the quarter ended June 30, 2002 and $0.79 for the quarter ended June 30, 2001. Earnings per share assuming full dilution including the extraordinary items totaled $1.12 for the quarter ended June 30, 2002 and $0.76 for the quarter ended June 30, 2001.

Earnings per share for the quarter ended June 30, 2002 is based upon weighted average shares outstanding of 144.9 million shares, excluding potential common stock, and 152.6 million shares, assuming full dilution. Earnings per share for the quarter ended June 30, 2001 is based on 126.7 million shares, excluding potential common stock, and 131.6 million shares, assuming full dilution. The increase in weighted average shares outstanding primarily resulted from the issuance of shares related to the RightCHOICE acquisition and Company's employee stock option and purchase plans.

Comparison of Results for the Six Months Ended June 30, 2002 to the Six Months Ended June 30, 2001

The following table depicts premium revenue by reportable segment:

	Six Months Ended June 30,	
(In thousands)	**2002**	**2001**
Health Care	$ 7,473,738	$ 5,134,810
Specialty	250,015	224,385
Consolidated	$ 7,723,753	$ 5,359,195

Premium revenue increased 44.1%, or $2,364.6 million, to $7,723.8 million for the six months ended June 30, 2002 from $5,359.2 million for the six months ended June 30, 2001. The increase was primarily due to $1,216.4 million of premium revenue related to the RightCHOICE and Cerulean acquisitions, representing 51.4% of the increase. Of the $1,216.4 million increase related to the RightCHOICE and Cerulean acquisitions, $1,192.4 million was attributable to the Health Care segment and $24.0 million to the Specialty segment. Excluding acquisitions, premium revenue would have increased 24.3% for the six months ended June 30, 2002. The increase, excluding acquisitions, was primarily due to an increase of insured member months of approximately 7.6% and the implementation of premium increases overall.

The following table depicts management services revenue by business segment:

	Six Months Ended June 30,	
(In thousands)	**2002**	**2001**
Health Care	$ 323,956	$ 233,361
Specialty	68,312	54,654
Consolidated	$ 392,268	$ 288,015

Management services revenue increased 36.2%, or $104.3 million, to $392.3 million for the six months ended June 30, 2002 from $288.0 million for the six months ended June 30, 2001. The increase was due to $102.1 million of management services revenue from the RightCHOICE and Cerulean acquisitions. Of the $102.1 million increase related to the RightCHOICE and Cerulean acquisitions, $98.6 million was attributable to the Health Care segment and $3.5 million to the Specialty segment. Excluding acquisitions, management services revenue would have increased 0.9% for the six months ended June 30, 2002.

Investment income was $126.1 million for the six months ended June 30, 2002 compared to $113.6 million for the six months ended June 30, 2001, an increase of $12.5 million or 11.0%. Gross investment income increased $9.2 million or 7.4% in 2002 over 2001 as a result of higher average investment balances during the six months ended June 30, 2002 versus the six months ended June 30, 2001. Lower net realized losses for the six months ended June 30, 2002 of $1.4 million as compared to net realized losses in 2001 of $7.1 million also contributed to the increase. As a partial offset to these increases, net investment expenses increased by $2.4 million for the six months ended June 30, 2002, due primarily to higher investment manager fees.

The loss ratio for the six months ended June 30, 2002 was 81.1% compared to 81.2% for the same period in 2001. The loss ratio attributable to the Health Care segment was 81.4% for the six months ended June 30, 2002 compared to 81.7% for the same period in 2001. The loss ratio attributable to the Specialty segment was 71.3% for the six months ended June 30, 2002 compared to 71.6% for the same period in 2001. The RightCHOICE business has a lower loss ratio than the Company's core businesses while the acquired Cerulean business has experienced a higher loss ratio than the Company's core businesses due to its higher percentage of large employer group business and fewer managed care offerings. Excluding the RightCHOICE and Cerulean acquisitions, the loss ratio for both segments combined would have been 80.2% for the six months ended June 30, 2002 and 80.6% for the same period in 2001. The health care services and other benefits expense includes an estimate of claims incurred during the period but which have not been reported to the Company. This estimate is actuarially determined based on a variety of factors and is inherently subject to a number of higher variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The selling expense ratio for the six months ended June 30, 2002 decreased to 4.0% compared to 4.2% for the six months ended June 30, 2001. The acquired Cerulean business has experienced a lower selling expense ratio due primarily to its lower percentage of individual and small employer group business. The acquired RightCHOICE business also experienced a slightly lower selling expense ratio than the Company's core businesses. Excluding acquisitions, the selling expense ratio would have decreased slightly to 4.3% for the six months ended June 30, 2002 from 4.4% for the same period in 2001.

The administrative expense ratio decreased to 13.3% for the six months ended June 30, 2002 from 14.0% for the six months ended June 30, 2001. The acquired RightCHOICE business experienced a higher administrative expense ratio than the Company's core businesses for the six months ended June 30, 2002 due to integration expenses along with certain other transaction−related expenses. Excluding acquisitions, the administrative expense ratio decreased to 13.0% in the six months ended June 30, 2002 compared to 14.0% a year ago, due to merger synergies and fixed administrative costs spread over a larger membership base.

Interest expense increased $11.8 million to $33.5 million for the six months ended June 30, 2002, compared to $21.7 million for the six months ended June 30, 2001. The increase in interest expense was related to the higher average debt balance for the six months ended June 30, 2002 in comparison to the six months ended June 30, 2001, primarily due to the RightCHOICE acquisition. The weighted average interest rate for all debt for the six months ended June 30, 2002, including the fees associated with the Company's borrowings and interest rate swap agreements, was 5.9%.

Other expense decreased $7.0 million to $24.9 million for the six months ended June 30, 2002, compared to $31.9 million for the six months ended June 30, 2001. The decrease resulted from lower amortization of goodwill and other intangible assets due to the implementation of SFAS No. 142, which accounted for $18.4 million of the amortization decrease. This decrease was partially offset by the following items: i) an increase in amortization of intangible assets with definite useful lives of $8.1 million, primarily due to recent acquisitions, ii) an increase in losses on the disposition of fixed

assets of $2.1 million and iii) an increase in operating expenses of $2.6 million from an insurance general agency subsidiary owned by the Company.

The Company's net income for the six months ended June 30, 2002 was $311.8 million, compared to $196.4 million for the six months ended June 30, 2001. Net income for the six months ended June 30, 2002 includes a net gain for two extraordinary items, a gain related to the acquisition of MethodistCare partially offset by a loss on early redemption of debt. The extraordinary gain amounted to $4.0 million, or $0.03 per diluted share, and was due to an excess of the fair value of net assets over acquisition costs. The extraordinary loss was $1.3 million, net of tax, or $0.01 per diluted share, which resulted from the early redemption of certain of the Debentures.

Earnings per share including the extraordinary items totaled $2.20 for the six months ended June 30, 2002 and $1.55 for the six months ended June 30, 2001. Earnings per share assuming full dilution including the extraordinary items totaled $2.10 for the six months ended June 30, 2002 and $1.50 for the six months ended June 30, 2001.

Earnings per share for the six months ended June 30, 2002 is based upon weighted average shares outstanding of 142.0 million shares, excluding potential common stock, and 149.2 million shares, assuming full dilution. Earnings per share for the six months ended June 30, 2001 is based on 126.3 million shares, excluding potential common stock, and 131.5 million shares, assuming full dilution. The increase in weighted average shares outstanding primarily resulted from the issuance of shares related to the RightCHOICE acquisition and Company's employee stock option and purchase plans.

Financial Condition

The Company's consolidated assets increased by $2,776.0 million, or 37.2%, to $10,248.1 million as of June 30, 2002 from $7,472.1 million as of December 31, 2001. The increase in total assets was primarily due to the acquisition of RightCHOICE, which accounted for $2,015.0 million or 72.6% of the increase. Excluding RightCHOICE, the increase in total assets was primarily due to growth in cash and investments of $388.4 million and an increase in receivables of $309.9 million. Cash and investments totaled $5.7 billion as of June 30, 2002, or 55.9% of total assets.

Overall claims liabilities increased $392.1 million, or 17.7%, to $2,611.9 million as of June 30, 2002 from $2,219.8 million as of December 31, 2001. This increase is due to claims liabilities associated with the RightCHOICE acquisition of $156.5 million and an increase in the claims liabilities associated with the Company's core businesses of $235.6 million.

As of June 30, 2002, the Company's long−term indebtedness was $1,152.0 million, of which $151.7 million was related to the Debentures, $451.6 million was related to the Company's 6 3/8% Notes due 2006, which includes a fair value adjustment of $2.4 million, $348.9 million was related to the Company's 6 3/8% Notes due 2012 and $199.8 million of commercial paper. The 6 3/8% Notes due 2012, with an aggregate principal amount at maturity of $350.0 million, were issued to finance the RightCHOICE acquisition. The Company's revolving credit facility indebtedness of $235.0 million at December 31, 2001 was repaid during the six months ended June 30, 2002 with $200.0 million obtained through the commercial paper program and operating cash of $35.0 million. (See Note 5 to the Consolidated Financial Statements).

Stockholders' equity totaled $3,575.4 million as of June 30, 2002, an increase of $1,442.8 million from $2,132.6 million as of December 31, 2001. The increase was primarily due to the issuance of the Company's Common Stock of $1,109.1 million in connection with the RightCHOICE acquisition, net income of $311.8 million for the six months ended June 30, 2002 and a $152.9 million net increase from the reissuance of treasury stock related to the Company's employee 401(k) Plan, stock option and stock purchase plans. Partially offsetting these increases were the repurchase of two million shares of its common stock for $122.3 million and a decrease in unrealized gains of $8.7 million, net of taxes, due primarily to investment securities.

Liquidity and Capital Resources

The Company's primary sources of cash are premium and management services revenues received and investment income. The primary uses of cash include health care claims and other benefits, capitation payments, income taxes, repayment and repurchases of long−term debt, interest expense, broker and agent commissions, administrative expenses, Common Stock repurchases and capital expenditures. In addition to the foregoing, other uses of cash include costs of provider networks and systems development, and costs associated with the integration of acquired businesses.

The Company generally receives premium revenue in advance of anticipated claims for related health care services and other benefits. The Company's investment policies are designed to provide safety and preservation of capital, sufficient liquidity to meet cash flow needs, the integration of investment strategy with the business operations and objectives of the Company, and attainment of a competitive after−tax total return.

The Company's strategy for achieving its investment goals is broad diversification of its investments, both across and within asset classes. As of June 30, 2002, the Company's investment portfolio consisted primarily of investment grade fixed−maturity securities. The Company's portfolio also included large capitalization and small capitalization domestic equities, foreign equities, tax−exempt municipal bonds and a small amount of non−investment grade debt securities. The fixed−income assets include both short and long−duration securities with an attempt to match the Company's funding needs.

The investment policy contains limitations regarding concentration in individual securities and industries and generally prohibits speculative and leveraged investments. Cash and investment balances maintained by the Company are sufficient to meet applicable regulatory financial stability and net worth requirements, including license requirements of the Blue Cross Blue Shield Association.

Cash flow provided by operating activities was $596.6 million for the six months ended June 30, 2002, compared with $280.3 million for the six months ended June 30, 2001. Cash flow from operations for the six months ended June 30, 2002 was due primarily to net income before extraordinary items of $309.1 million, an increase in medical claims payable of $200.2 million due to membership growth and higher provider contract rates and an increase in accounts payable and accrued expenses of $145.7 million resulting from the timing of liability payments. Partially offsetting these increases was a decrease in receivables of $104.9 million due to revenue growth and timing of cash receipts.

Net cash used in investing activities for the six months ended June 30, 2002 totaled $1,035.2 million, compared with $657.4 million for the six months ended June 30, 2001. The cash used in the six months ended June 30, 2002 was attributable primarily to the purchase of investments of $3.3 billion, and of property and equipment, net of sales proceeds, of $51.5 million and the purchases of RightCHOICE and MethodistCare, net of acquired cash, of $347.6 million. Proceeds from investments sold and matured totaled $2.6 billion, partially offsetting the aforementioned purchases.

Net cash provided by financing activities totaled $292.9 million for the six months ended June 30, 2002 compared with $575.2 million for the six months ended June 30, 2001. The net cash provided in the six months ended June 30, 2002 was primarily related to additional debt of $350.0 million incurred to finance the RightCHOICE acquisition, in addition to the receipt of proceeds of $107.2 million from the issuance of stock related to the Company's employee stock option and purchase programs less $122.3 million in Company stock repurchases. During the six months ended June 30, 2002, the Company repaid its entire indebtedness under the revolving credit facility of $235.0 million at December 31, 2001. The net borrowings of commercial paper totaled $199.8 million for the six months ended June 30, 2002. The net proceeds of this commercial paper program and operating cash were used to repay the revolving credit facility.

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities (which are generally referred to collectively in this Quarterly Report on Form 10−Q as the Company's "revolving credit facility") bear interest at rates determined by reference to the bank's base rate or to the London InterBank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's senior unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million, expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, originally expired as of March 30, 2002. In March 2002, the Company amended this facility to provide for an expiration date of March 28, 2003. Any amount outstanding under this facility as of March 28, 2003 may be converted into a one−year term loan at the option of the Company. Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control (See Note 5 to the Consolidated Financial Statements). As mentioned above, during the six months ended June 30, 2002 the Company repaid its entire outstanding revolving credit facility balance at December 31, 2001 of $235.0 million.

In April 2002, the Company commenced a commercial paper program providing for the issuance of up to $1.0 billion in aggregate maturity value of short−term indebtedness (known generally as "commercial paper"). The commercial paper is being issued by the Company without registration under the 1933 Act in reliance upon the exemption from registration contained in Section 4(2) of the 1933 Act. The commercial paper is issued in denominations of $100,000 or integral multiples of $1,000 in excess thereof, will bear such interest rates, if interest−bearing, or will be sold at such discount from their face amounts, as agreed upon by the Company and the dealer or dealers acting in connection with the commercial paper program. The commercial paper may be issued with varying maturities up to a maximum of 270 days from the date of issuance. The commercial paper ranks equally with all other unsecured and unsubordinated indebtedness of the Company. As of June 30, 2002, the outstanding commercial paper borrowings totaled $199.8 million with various maturity dates and had interest rates ranging from 2.00% to 2.08%. The weighted average yield on the outstanding commercial paper as of June 30, 2002 was 2.03%.

As a part of a hedging strategy to limit its exposure to variable interest rate increases, the Company entered into interest rate swap agreements in order to reduce the volatility of interest expense resulting from changes in interest rates. The swap agreements are contracts to exchange variable−rate interest payments (weighted average rate for the six months ended June 30, 2002 of 2.25%) for fixed−rate interest payments (weighted average rate for the six months ended June 30, 2002 of 7.37%) without the exchange of the underlying notional amounts. As of September 30, 2001, the Company had entered into $200.0 million of fixed rate swap agreements, which consisted of a $150.0 million notional amount swap agreement at 6.99% maturing on October 17, 2003 and a $50.0 million notional amount swap agreement at 7.06% maturing on October 17, 2006.

In order to mitigate interest rate fluctuations associated with its $450 million aggregate principal amount at maturity of 6 3/8% Notes due June 15, 2006 (the "2001 Notes"), the Company, on January 15, 2002 entered into a $200 million notional amount interest rate swap agreement which matures on June 15, 2006. The swap agreement is a contract to exchange a fixed 6 3/8% rate for a LIBOR−based floating rate (weighted average variable rate of 5.96% for the six months ended June 30, 2002).

During 2001, the Company entered into foreign currency forward exchange contracts for each of the fixed maturity securities on hand denominated in foreign currencies in order to hedge asset positions with respect to currency fluctuations related to these securities. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and as result entered into a hedge to offset the remaining currency hedge. Subsequent to the implementation of SFAS No. 133, all gains and losses from both effective and ineffective forward exchange contracts have been reported in investment income offset by the related gains and losses on the Company's available−for−sale foreign securities.

Certain of the Company's subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory agencies, including the California Department of Managed Health Care and the Departments of Insurance in various states. As of June 30, 2002 (or the most recent date with respect to which compliance is required), those subsidiaries of the Company were in compliance with all minimum capital requirements.

On June 15, 2001, the Company issued the 2001 Notes. The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities, which indirectly financed a portion of the Cerulean acquisition. The 2001 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest will be computed on the basis of a 360−day year of twelve 30−day months.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts:

1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

With the anticipated acquisition of RightCHOICE on January 31, 2002, the Company on January 16, 2002 issued $350.0 million aggregate principal amount at maturity of $6^{3}/_{8}$% Notes due January 15, 2012 (the "2002 Notes"). The net proceeds of this offering totaled approximately $348.9 million. The 2002 Notes bear interest at a rate of $6^{3}/_{8}$% per annum, payable semi−annually in arrears on January 15 and July 15 of each year commencing July 15, 2002. Interest is computed on the basis of a 360−day year of twelve 30−day months.

The 2002 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2002 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2002 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2002 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (J.P. Morgan Securities Inc. or Deutsche Banc Alex Brown or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2002 Notes to the redemption date.

The 2001 and 2002 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2001 and 2002 Notes. The indenture governing the 2001 and 2002 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2001 and 2002 Notes.

The Company believes that cash flow generated by operations and its cash and investment balances, supplemented by the Company's ability to borrow under its existing revolving credit facility, commercial paper program or through public or private financing sources, will be sufficient to fund continuing operations and expected capital requirements for the foreseeable future.

Critical Accounting Policies

The preparation of financial statements in conformity with generally accepted accounting principles requires the Company's management to make a variety of estimates and assumptions. These estimates and assumptions affect, among other things, the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Actual results can differ from the amounts previously estimated, which were based on the information available at the time the estimates were made.

The critical accounting policies described below are those that the Company believes are important to the portrayal of the Company's financial condition and results, and which require management to make difficult, subjective and/or complex judgments. Critical accounting policies cover accounting matters that are inherently uncertain because the future resolution of such matters is unknown. The Company believes that critical accounting policies include medical claims payable, reserves for future policy benefits and intangible assets and goodwill.

Medical Claims Payable

Medical claims payable includes claims in process and a provision for the Company's estimate of incurred but not reported claims. Such estimates are developed using actuarial principles and assumptions which consider, among other things, contractual requirements, historical utilization trends and payment patterns, medical inflation, product mix, seasonality, membership and other relevant factors. Claim processing expenses are also accrued based on an estimate of expenses necessary to process such claims. Such reserves are continually monitored and reviewed with any adjustments reflected in current operations. Capitation costs represent monthly fees paid one month in advance to physicians, certain other medical service providers and hospitals in the Company's HMO networks as retainers for providing continuing medical care. The Company maintains various programs that provide incentives to physicians, certain other medical service providers and hospitals participating in its HMO networks through the use of risk−sharing agreements and other programs. Payments under such agreements are made based on the providers' performance in controlling health care costs while providing quality health care. Expenses related to these programs, which are based in part on estimates, are recorded in the period in which the related services are rendered. Management believes that its reserves for medical claims payable are adequate to satisfy its ultimate claim liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The Company's future results of operations will depend in part on its ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. WellPoint's ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above−listed or other factors may adversely affect the Company's future profitability.

Reserves for Future Policy Benefits

The estimated reserves for future policy benefits relate to life and disability insurance policies written in connection with health care contracts. Reserves for future life benefit coverage are based on projections of past experience. Reserves for future policy and contract benefits for certain long−term disability products and group paid−up life products are based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon the Company's experience. Reserves are continually monitored and reviewed, and as settlements are made or reserves adjusted, differences are reflected in current operations. The current portion of reserves for future policy benefits relates to the portion of such reserves which management expects to pay within one year. Management believes that its reserves for future policy benefits are adequate to satisfy its ultimate benefit liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Intangible Assets and Goodwill

The Company has made several acquisitions in the past several years that included a significant amount of intangible assets and goodwill. Under generally accepted accounting principles in effect through December 31, 2001, these assets were amortized over their useful lives, and were tested periodically to determine if they were recoverable from operating earnings on an undiscounted basis over their useful lives.

The Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable

intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, such potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity.

Effective January 1, 2002, intangible assets and goodwill are accounted for under SFAS No. 142, "Goodwill and Other Intangible Assets." The new rules eliminate amortization of goodwill and other intangibles with indefinite lives, but these assets are subject to the impairment tests. (See "New Accounting Pronouncements" and Note 11 to the Consolidated Financial Statements for a more complete discussion of the Company's intangible assets and goodwill). Management is required to make assumptions and estimates, such as the discount factor, in determining estimated fair value. Such estimated fair values might produce significantly different results if other reasonable assumptions and estimates were to be used.

Factors That May Affect Future Results of Operations

Certain statements contained herein, such as statements concerning potential or future loss ratios, pending acquisitions and other statements regarding matters that are not historical facts, are forward−looking statements (as such term is defined in the Securities Exchange Act of 1934). Such statements involve a number of risks and uncertainties that may cause actual results to differ from those projected. Factors that can cause actual results to differ materially include, but are not limited to, those discussed below and those discussed from time to time in the Company's various filings with the Securities and Exchange Commission, including the Company's Annual Report on Form 10−K.

The Company's operations are subject to substantial regulation by federal, state and local agencies in all jurisdictions in which the Company operates. Many of these agencies have increased their scrutiny of managed health care companies in recent periods or are expected to increase their scrutiny, as newly passed legislation becomes effective. From time to time, the Company and its subsidiaries receive requests for information from regulatory agencies or are notified that such agencies are conducting reviews, investigations or other proceedings with respect to certain of the Company's activities. The Company also provides insurance products to Medi−Cal beneficiaries in various California counties under contracts with the California Department of Health Services (or delegated local agencies) and provides administrative services to the Centers for Medicare and Medicaid Services ("CMS") in various capacities. There can be no assurance that acting as a government contractor in these circumstances will not increase the risk of heightened scrutiny by such government agencies or that such scrutiny will not have a material adverse effect on the Company, either through negative publicity about the Company or through an adverse impact on the Company's results of operations. In addition, profitability from this business may be adversely affected through inadequate premium rate increases due to governmental budgetary issues. Future actions by any regulatory agencies may have a material adverse effect on the Company's business.

In connection with the RightCHOICE and Cerulean transactions, the Company incurred significant additional indebtedness to fund the cash payments made to the acquired companies' stockholders. In addition, the Company currently expects to incur additional indebtedness to fund some or all of the cash payments to be made in connection with the pending CareFirst transaction. This existing or new indebtedness may result in a significant percentage of the Company's cash flow being applied to the payment of interest, and there can be no assurance that the Company's operations will generate sufficient future cash flow to service this indebtedness. The Company's current indebtedness, as well as any indebtedness that the Company may incur in the future (such as indebtedness incurred to fund repurchases of its Common Stock or to fund the CareFirst or other transactions), may adversely affect the Company's ability to finance its operations and could limit the Company's ability to pursue business opportunities that may be in the best interests of the Company and its stockholders.

Completion of the Company's pending transaction with CareFirst is subject to the satisfaction of a number of conditions, including approval of the insurance regulators in each of Maryland, Delaware and the District of Columbia. In addition, one of CareFirst's operating affiliates must have its federal charter amended or repealed by the United States Congress (subject to presidential approval) and must obtain approval from the Washington D.C. Corporation Counsel. There can be no assurances that the required approvals will be obtained. If all conditions to closing are not met on or before November 20, 2004, each of WellPoint and CareFirst will have the right to terminate the CareFirst Merger Agreement. As a result, there can be no assurances that the transaction will be consummated.

As a condition to approval of the transaction, regulatory agencies may seek to impose requirements or limitations on the way that the combined company conducts it business. Although neither WellPoint nor CareFirst is obligated to agree to any material requirements or limitations in order to obtain approval, if either or both companies were to agree to any such conditions, such requirements or limitations or additional costs associated therewith could adversely affect WellPoint's

ability to integrate the operations of CareFirst with those of WellPoint. Accordingly, a material adverse effect on WellPoint's revenue, results of operations and cash flows following the CareFirst transaction could result.

As part of the Company's business strategy, the Company has acquired substantial operations in new geographic markets over the last six years. These businesses, some of which include substantial indemnity−based insurance operations, have experienced varying profitability or losses in recent periods. Since the relevant dates of acquisition of Rush Prudential and Cerulean, the Company has continued to work extensively on the integration of these businesses. The Company has also begun its integration of the RightCHOICE business. However, there can be no assurances regarding the ultimate success of the Company's integration efforts or regarding the ability of the Company to maintain or improve the results of operations of the businesses of completed or pending transactions. The Company has incurred and will, among other things, need to continue to incur considerable expenditures for provider networks, distribution channels and information systems in addition to the costs associated with the integration of these acquisitions. The integration of these complex businesses may result in, among other things, temporary increases in claims inventory or other service−related issues that may negatively affect the Company's relationship with its customers and contribute to increased attrition of such customers. The Company's results of operations could be adversely affected in the event that the Company experiences such problems or is otherwise unable to implement fully its expansion strategy.

The Company and certain of its subsidiaries are subject to capital surplus requirements by the California Department of Managed Health Care, the Georgia Department of Insurance, the Missouri Department of Insurance, various other state Departments of Insurance and the Blue Cross Blue Shield Association. Although the Company believes that it is currently in compliance with all applicable requirements, there can be no assurances that such requirements will not be increased in the future.

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO

claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which was to be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The hearing was held in January 2002 and, in March 2002, the Court of Appeals panel issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration. The Company filed a motion requesting a rehearing of the matter before the entire 11 thCircuit Court of Appeals, which motion was denied by the 11th Circuit Court of Appeals in June 2002. On July 29, 2002, Judge Moreno issued an order providing that discovery in the case would be allowed to re−commence on September 30, 2002.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status. The Company filed a motion (which was granted in July 2002) with the federal Judicial Panel on Multidistrict Litigation requesting that the proceedings in this case be consolidated with a similar action brought against other managed care companies that has previously been consolidated with the *Shane* lawsuit.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. Discovery in the matter is currently being conducted and a hearing regarding class certification has been scheduled for December 16, 2002. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The Company's future results will depend in large part on accurately predicting health care costs incurred on existing business and upon the Company's ability to control future health care costs through product and benefit design, underwriting criteria, utilization management and negotiation of favorable provider contracts. Changes in mandated benefits, utilization rates, demographic characteristics, health care practices, provider consolidation, inflation, new pharmaceuticals/technologies, clusters of high−cost cases, the regulatory environment and numerous other factors are beyond the control of any health plan provider and may adversely affect the Company's ability to predict and control health care costs and claims, as well as the Company's financial condition, results of operations or cash flows. Periodic renegotiations of hospital and other provider contracts coupled with continued consolidation of physician, hospital and other provider groups may result in increased health care costs and limit the Company's ability to negotiate favorable rates. In recent years, large physician practice management companies have experienced extreme financial difficulties, including bankruptcy, which may subject the Company to increased credit risk related to provider groups and cause the

Company to incur duplicative claims expense. Additionally, the Company faces competitive pressure to contain premium prices. Fiscal concerns regarding the continued viability of government−sponsored programs such as Medicare and Medicaid may cause decreasing reimbursement rates for these programs. Any limitation on the Company's ability to increase or maintain its premium levels, design products, implement underwriting criteria or negotiate competitive provider contracts may adversely affect the Company's financial condition or results of operations.

Managed care organizations, both inside and outside California, operate in a highly competitive environment that has undergone significant change in recent years as a result of business consolidations, new strategic alliances, aggressive marketing practices by competitors and other market pressures. Additional increases in competition (including competition from market entrants offering Internet−based products and services), could adversely affect the Company's financial condition, cash flows or results of operations.

As a result of the Company's acquisitions, the Company operates on a select geographic basis nationally and offers a spectrum of health care and specialty products through various risk−sharing arrangements. The Company's health care products include a variety of managed care offerings as well as traditional fee−for−service coverage. With respect to product type, fee−for−service products are generally less profitable than managed care products. A component of the Company's expansion strategy is to transition over time the traditional insurance members of the Company's acquired businesses to more managed care products.

With respect to the risk−sharing nature of products, managed care products that involve greater potential risk to the Company generally tend to be more profitable than management services products and those managed care products where the Company is able to shift risks to employer groups. Individuals and small employer groups are more likely to purchase the Company's higher−risk managed care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government−sponsored programs involve the Company's higher−risk managed care products. Over the past few years, the Company has experienced a slight decline in margins in its higher−risk managed care products and to a lesser extent on its lower−risk managed care and management services products. This decline is primarily attributable to product mix change, product design, competitive pressure and greater regulatory restrictions applicable to the small employer group market. From time to time, the Company has implemented price increases in certain of its managed care businesses. While these price increases are intended to improve profitability, there can be no assurance that this will occur. Subsequent unfavorable changes in the relative profitability between the Company's various products could have a material adverse effect on the Company's results of operations and on the continued merits of the Company's geographic expansion strategy.

One of the Company's wholly owned subsidiaries operates as a pharmacy benefit manager ("PBM") under the trade name WellPoint Pharmacy Management. The PBM industry faces a number of risks and uncertainties in addition to those facing the Company's health plan business. Such risks and uncertainties include the application of federal and state anti−remuneration laws (generally known as "anti−kickback" laws), whether PBMs operate as fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA") and are in compliance with their fiduciary obligations under ERISA in connection with the development and implementation of items such as formularies, preferred drug listings and therapeutic intervention programs, and potential liability regarding the use of patient identifiable medical information. In addition, a number of federal and state legislative proposals are being considered that could affect a variety of PBM industry practices, such as the receipt of rebates from pharmaceutical manufacturers. The Company believes that its PBM business is currently being conducted in compliance in all material respects with applicable legal requirements. However, there can be no assurance that the Company's PBM business will not be subject to challenge under various laws and regulations, or that any such challenge will not have a material adverse effect upon the Company's results of operations or financial condition. In addition, future legislative enactments affecting the PBM

industry could also have a material adverse effect upon the Company's results of operations and financial condition.

Substantially all of the Company's investment assets are in interest−yielding debt securities of varying maturities or equity securities. The value of fixed income securities is highly sensitive to fluctuations in short− and long−term interest rates, with the value decreasing as such rates increase and increasing as such rates decrease. In addition, the value of equity securities can fluctuate significantly with changes in market conditions. Changes in the value of the Company's investment assets, as a result of interest rate fluctuations, can affect the Company's results of operations and stockholders' equity. There can be no assurances that interest rate fluctuations will not have a material adverse effect on the results of operations or financial condition of the Company.

The Company's operations are dependent on retaining existing employees, attracting additional qualified employees and achieving productivity gains from the Company's investment in technology. The Company faces intense competition for qualified information technology personnel and other skilled professionals. There can be no assurances that an inability to retain existing employees or attract additional employees will not have a material adverse effect on the Company's results of operations.

Prior to the Company's acquisition of the GBO, John Hancock Mutual Life Insurance Company ("John Hancock") entered into a number of reinsurance arrangements with respect to personal accident insurance and the occupational accident component of workers' compensation insurance, a portion of which was originated through a pool managed by Unicover Managers, Inc. Under these arrangements, John Hancock assumed risks as a reinsurer and transferred certain of such risks to other companies. These arrangements have become the subject of disputes, including a number of legal proceedings to which John Hancock is a party. The Company believes that it has a number of defenses to avoid any ultimate liability with respect to these matters and believes that such liabilities were not transferred to the Company as part of the GBO acquisition. However, if the Company were to become subject to such liabilities, the Company could suffer losses that might have a material adverse effect on its financial condition, results of operations or cash flows.

In December 2000, a wholly owned subsidiary of the Company completed its acquisition of certain mail order pharmaceutical service assets and now conducts business as a mail order pharmacy. The pharmacy business is subject to extensive federal, state and local regulations which are in many instances different from those under which the Company's core health plan business currently operates. The failure to properly adhere to these and other applicable regulations could result in the imposition of civil and criminal penalties, which could adversely affect the Company's results of operations or financial condition. In addition, pharmacies are exposed to risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Although the Company intends to maintain professional liability and errors and omissions liability insurance, there can be no assurances that the coverage limits under such insurance programs will be adequate to protect against future claims or that the Company will be able to maintain insurance on acceptable terms in the future.

Following the terrorist attacks of September 11, 2001, there have been various incidents of suspected bioterrorist activity in the United States. To date, these incidents have resulted in related isolated incidents of illness and death. However, federal and state law enforcement officials have issued public warnings about additional potential terrorist activity involving biological weapons. If the United States were to experience more widespread bioterrorist attacks, the Company's covered medical expenses could rise and the Company could experience a material adverse effect on its results of operations, financial condition and cash flow.

In April and May 2002, one of the Company's wholly owned subsidiaries acting as a pharmacy benefit management business under the tradename WellPoint Pharmacy Management received two administrative subpoenas duces tecum issued by the U.S. Attorney's Office in Boston Massachusetts. The Company does not believe that its pharmacy benefit management business is presently a target of

investigation by the U.S. Attorney. The subpoenas appear to focus primarily on WellPoint Pharmacy Management's relationship with TAP Pharmaceuticals, including TAP's drugs Lupron and Prevacid. The Company has responded to the subpoenas by producing certain requested documents. The Company believes that it is in compliance in all material respects with all laws and regulations applicable to the pharmacy benefit management business.

As a result of the general economic downturn throughout the country, California is currently experiencing a significant state budget deficit. California legislators are exploring a variety of alternatives to address this situation. In order to address the budget shortfall, there may be proposed a reduction in the fixed per member per month payments received by Medi−Cal managed care providers such as the Company. Alternatively, state legislators may seek to impose greater state taxes. Any significant reduction in payments received by the Company in connection with its Medi−Cal managed care business could have a material adverse effect on the Company's results of operations or financial condition. Additionally, any increase in state taxes could prolong or exacerbate the state's economic downturn, which could in turn have a material adverse effect on the Company results of operations or financial condition.

Review by Independent Accountants

With respect to the unaudited consolidated financial information of WellPoint Health Networks Inc. for the three−month and six−month periods ended June 30, 2002 and 2001, PricewaterhouseCoopers LLP ("PricewaterhouseCoopers") reported that they have applied limited procedures in accordance with professional standards for a review of such information. However, their separate report dated July 23, 2002 appearing herein, states that they did not audit and they do not express an opinion on that unaudited consolidated financial information. Accordingly, the degree of reliance on their report on such information should be restricted in light of the limited nature of the review procedures applied. PricewaterhouseCoopers is not subject to the liability provisions of Section 11 of the Securities Act of 1933 for their report on the unaudited consolidated financial information because that report is not a "report" or a "part" of the registration statement prepared or certified by PricewaterhouseCoopers within the meaning of Sections 7 and 11 of the Act.

ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk***

The Company is exposed to market rate risks associated with its investments and borrowings. Market risk represents the risk of loss in value of a financial instrument resulting from changes in interest rates and equity prices. The Company regularly evaluates its assets and liabilities as well as the appropriateness of investments relative to its internal investment guidelines.

As of June 30, 2002, the Company's investment securities at market value totaled $4.7 billion, of which 90.0% was invested in fixed income securities with intermediate durations and the remaining 10.0% in equity securities. The Company has evaluated the net impact to the fair value of its fixed income investments from a hypothetical change in all interest rates of 100, 200 and 300 basis points ("bps"). In doing so, optionality was addressed through Monte Carlo simulation of the price behavior of securities with embedded options. In addressing prepayments on mortgage−backed securities, the model follows the normal market practice of estimating a non−interest rate sensitive component (primarily related to relocations) and an interest−sensitive component (primarily related to refinancings) separately. The model is based on statistical techniques applied to historical prepayment and market data, and then incorporates forward−looking mortgage market research and judgments about future prepayment behavior. Changes in the fair value of the investment portfolio are reflected in the balance sheet through stockholders' equity. Assuming increases of 100, 200 and 300 bps in market interest rates, the fair value of the Company's investment in fixed maturities as of June 30, 2002 would have decreased by $146.3 million, $290.1 million and $427.4 million, respectively.

As of June 30, 2002, the Company's equity securities were comprised primarily of domestic stocks. Assuming an immediate decrease of 10% in market value, as of June 30, 2002, the hypothetical loss in fair value of stockholders' equity is estimated to be approximately $47.1 million.

The Company has from time to time entered into interest rate swap agreements primarily by exchanging the floating debt payments due under its outstanding indebtedness for fixed rate payments. The Company has also entered into interest rate swap agreement by exchanging the fixed payments due under the 2001 Notes for a LIBOR−based floating rate. The Company believes that this allows it to better anticipate its interest payments while helping to manage the asset−liability relationship. As of June 30, 2002, assuming increases of 100, 200 and 300 bps in market interest rates, the fair value of the interest rate swap agreements would have, on a net basis, increased by $4.3 million and $1.1 million, and decreased by $2.0 million, respectively.

PART II OTHER INFORMATION

ITEM 1. ***Legal Proceedings***

See "Factors That May Affect Future Results of Operations" for a discussion of various pending legal matters involving the Company. The Company's Annual Report on Form 10−K/A for the year ended December 31, 2001 also contains a discussions of various pending legal matters.

ITEM 2. ***Changes in Securities and Use of Proceeds***

In June 2002, the Company inadvertently sold approximately 4,900 shares without registration under the Securities Act of 1933 to certain of its employees participating in the Blue Cross Blue Shield of Missouri 401(k) Savings Program. These shares were sold for an aggregate of approximately $428,000.

ITEM 4. ***Submission of Matters to a Vote of Security Holders***

On June 27, 2002, the annual meeting of stockholders of the Company was held. The agenda items for such meeting are shown below along with the vote of the Company's Common Stock with respect to such agenda items.

1.

Election of three Class III Directors to serve until the 2003 Annual Meeting of Stockholders and one Class II director to serve until the 2004 Annual Meeting of Stockholders; or in each case until the election of their successors.

Class III Nominees:

Nominee:	W. Toliver Besson Votes FOR: 119,348,904 Votes WITHHELD AUTHORITY: 5,553,909
Nominee:	Julie A. Hill Votes FOR: 123,217,638 Votes WITHHELD AUTHORITY: 1,685,175
Nominee:	Leonard D. Schaeffer Votes FOR: 123,217,638 Votes WITHHELD AUTHORITY: 1,685,175

Class II Nominee:

Nominee:	Jane G. Pisano Votes FOR: 122,594,441 Votes WITHHELD AUTHORITY: 2,308,372

The terms of Roger E. Birk, Sheila P. Burke, William H.T. Bush, Warren Y. Jobe and Elizabeth A. Sanders continued after the meeting.

2.

Ratification of the selection of PricewaterhouseCoopers LLP as the Company's independent public accountants for the fiscal year ending December 31, 2002.

Votes FOR:	117,655,318
Votes AGAINST:	6,716,145
Votes WITHHELD AUTHORITY:	531,350
Broker non−votes:	0

ITEM 6. ***Exhibits and Reports on Form 8−K***

(a)

Exhibits

2.01 Amended and Restated Recapitalization Agreement dated as of March 31, 1995 by and among the Registrant, Blue Cross of California, Western Health Partnership and Western Foundation for Health Improvement, incorporated by reference to Exhibit 2.1 of the Registrant's Registration Statement on Form S−4 dated April 8, 1996

2.02 Amended and Restated Agreement and Plan of Merger dated as of November 29, 2000, by and among Cerulean Companies, Inc., the Registrant and Water Polo Acquisition Corp., incorporated by reference to Exhibit 2.01 of the Registrant's Current Report on Form 8−K dated March 15, 2001

2.03 Agreement and Plan of Merger dated as of October 17, 2001 by and among the Registrant, RightCHOICE Managed Care, Inc. and RWP Acquisition Corp., incorporated by reference to Exhibit 2.01 to the Registrant's Registration Statement on Form S−4 (Registration No. 333−73382)

2.04 Agreement and Plan of Merger dated as of November 20, 2001 by and among the Registrant, CareFirst, Inc. and Congress Acquisition Corp., incorporated by reference to Exhibit 99.1 to the Registrant's Current Report on Form 8−K dated November 20, 2001

3.01 Restated Certificate of Incorporation of the Registrant, incorporated by reference to Exhibit 3.1 of the Registrant's Current Report on Form 8−K filed on August 5, 1997.

3.02 Bylaws of the Registrant, incorporated by reference to Exhibit 4.2 of the Registrant's Registration Statement on Form S−8, Registration No. 333−90791

4.01 Specimen of common stock certificate of WellPoint Health Networks Inc., incorporated by reference to Exhibit 4.4 of Registrant's Registration Statement on Form 8−B, Registration No. 001−13083

4.02 Restated Certificate of Incorporation of the Registrant (included in Exhibit 3.01)

4.03 Bylaws of the Registrant (included in Exhibit 3.02)

4.04 Indenture dated as of July 2, 1999 by and between the Registrant and The Bank of New York, as trustee (including the form of Debenture attached as Exhibit A thereto), incorporated by reference to Exhibit 4.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 2000.

4.05 Amended and Restated Indenture dated as of June 8, 2001 by and between the Registrant and The Bank of New York, as trustee, incorporated by reference to Exhibit 4.05 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 2001.

4.06 Form of $6^{3}/_{8}$% Note due 2006, incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8−K dated June 12, 2001.

4.07 Form of $6^{3}/_{8}$% Note due 2012, incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8−K dated January 12, 2002.

10.01	Amendment to the WellPoint 401(k) Retirement Savings Plan effective as of April 30, 2002
15.01	Letter regarding unaudited interim financial information
99.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350
99.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350

(b)

Reports on Form 8−K

On April 10, 2002, the Company filed a Current Report on Form 8−K which reported that the Company had received a letter from the Internal Revenue Service (the "IRS") notifiying the Company that a private letter ruling received by the Company on September 1998 would not be revoked on a retroactive basis. Previously, in March 2002, the Company had received a letter from the IRS notifying the Company that the IRS was considering revoking the September 1998 private letter ruling. The letter further stated that the IRS was withdrawing the private letter ruling and that the Company could no longer rely on the private letter ruling. In March 2002, the Company had submitted a written request for relief from retroactive affect of the revocation under Section 7805(b) of the Internal Revenue Code.

On May 3, 2002, the Company filed a Current Report on Form 8−K disclosing the medical membership of the Company as of December 31, 1999 and 2000, as of each calendar quarter end in the year ended December 31, 2001 and as of March 31, 2002. As a result of the Company's acquisition of RightCHOICE Managed Care, Inc. in January 2002 and in order to reflect consistent membership numbers across the Company's various operating subsidiaries, the Company had adopted certain revisions to its medical membership accounting methodology.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

WELLPOINT HEALTH NETWORKS INC.
Registrant

Date: August 13, 2002

By: /s/ LEONARD D. SCHAEFFER

Leonard D. Schaeffer
Chairman of the Board of Directors and Chief Executive Officer

Date: August 13, 2002

By: /s/ DAVID C. COLBY

David C. Colby
Executive Vice President and Chief Financial Officer

Date: August 13, 2002

By: /s/ KENNETH C. ZUREK

Kenneth C. Zurek
Senior Vice President, Controller and Taxation

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EXHIBIT 10.01

AMENDMENT
TO THE
WELLPOINT 401(k) RETIREMENT SAVINGS PLAN

The WellPoint 401(k) Retirement Savings Plan (the "Plan"), as amended through January 1, 2001, is hereby further amended, effective as of April 30, 2002.

1. A new Section 3.17 providing for prior service credit for employees of RightCHOICE Managed Care, Inc. and HealthLink, Inc. is added at the end of Article III.

3.17 *RightCHOICE/HealthLink.* Each individual employed by RightCHOICE Managed Care, Inc. ("RightCHOICE") on April 30, 2002, and each individual employed by HealthLink,Inc. ("HealthLink") on May 5, 2002 who becomes an Eligible Employee on May 1, 2002 (with respect to an individual employed by RightCHOICE) or on May 6, 2002 (with respect to an individual employed by HealthLink) in connection with the authorization of RightCHOICE and HealthLink as Participating Companies will receive credit under the Plan for all service completed prior to May 1, 2002 (with respect to an individual employed by RightCHOICE) and May 6, 2002 (with respect to an individual employed by HealthLink), as described in Appendices XII (RightCHOICE) and XIII (HealthLink), provided, however, that no such Eligible Employee will be eligible for the Grandfathered Match implemented in 1997 regardless of his or her aggregated service.

2. A new Section 3.18 providing for prior service credit for employees of Texas Managed Care Administrative Services, Inc. is added at the end of Article III.

3.18 *Texas Managed Care Administrative Services, Inc.* Each individual employed by Texas Managed Care Administrative Services, Inc. ("TMCAS") on April 30, 2002 who becomes an Eligible Employee on May 1, 2002 in connection with the authorization of TMCAS as a Participating Company will receive credit under the Plan for all service completed prior to May 1, 2002 for TMCAS, provided, however, that no such Eligible Employee will be eligible for the Grandfathered Match implemented in 1997 regardless of his or her aggregated service.

3. Section 5.01 governing Salary Deferral Contributions is amended, effective as of January 1, 2002, to increase the maximum contribution per payroll period to 20% from 15% and, effective as of May 1, 2002, to decrease the minimum contribution per payroll period to 1% from 2%.

4. Appendix VII: Participating Companies is amended to reflect the authorization of RightCHOICE Managed Care, Inc. as a Participating Company effective as of May 1, 2002 and to reflect the authorization of HealthLink, Inc. as a Participating Company effective as of May 6, 2002.

5. A new Appendix XII: *Special Provisions Applicable to RightCHOICE Employees* is added at the end of the Plan effective as of May 1, 2002.

APPENDIX XII: SPECIAL PROVISIONS APPLICABLE TO RIGHTCHOICE EMPLOYEES

The Blue Cross and Blue Shield of Missouri 401(k) Savings Program (the "RightCHOICE Plan") will be merged into the Plan effective as of 11:59 p.m. on July 14, 2002. Assets and liabilities of the RightCHOICE Plan, together with the assets and liabilities of this Plan, will constitute a single plan within the meaning of Code Section 414(l) as of July 15, 2002 (the "Plan Merger Date"). Unless otherwise expressly provided herein, the rights and benefits of a participant in the RightCHOICE Plan (each a "RightCHOICE Participant") who terminates employment with RightCHOICE Managed Care, Inc. ("RightCHOICE") on or prior to July 15, 2002 are determined in accordance with the provisions of the RightCHOICE Plan as in effect prior to July 15, 2002. References in the Plan to "Participant" as defined in Article II include each RightCHOICE Participant with an interest in the RightCHOICE Plan on July 14, 2002 without regard to his or her status as a current or former employee of RightCHOICE. This Appendix XII is designed to describe special provisions that apply specifically to individuals employed by

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RightCHOICE on and after May 1, 2002 (each a "RightCHOICE Employee") and to preserve under the Plan any benefits that are accrued by RightCHOICE Employees under the RightCHOICE Plan prior to July 15, 2002 to the extent such benefits are protected under Code Section 411(d)(6). The provisions of the Plan apply to the benefits of RightCHOICE Employees described in this Appendix subject to the restriction applicable to protected benefits and except to the extent modified by the terms of this Appendix. In the event of a conflict, the provisions of this Appendix will control.

1.01 *Eligibility.* Notwithstanding anything to the contrary in the Plan, each individual who is, or becomes, an Employee of RightCHOICE on or after May 1, 2002 is eligible to participate in the Plan as described in Article IV and make Salary Deferral Contributions as described in Article V, provided that he or she otherwise satisfies the Plan's eligibility requirements. In no event will any such individual's Salary Deferral Contribution election described in Article V apply to Compensation earned prior to May 1, 2002.

1.02 *Matching Contributions.* For purposes of determining the six percent (6%) limit on Matching Contributions, only Compensation that a RightCHOICE Employee earns after April 30, 2002 while eligible for Matching Contributions under the Plan will be taken into account. If the RightCHOICE Employee has accrued service prior to May 1, 2002 that is recognized under the RightCHOICE Plan at April 30, 2002, such service, as well as service accrued under this Plan, will be taken into account for purposes of determining eligibility for a Matching Contribution under Section 5.02(g).

1.03 *Restoration of Forfeitures.* If the nonvested part of a former RightCHOICE Participant's account under the RightCHOICE Plan was forfeited following a distribution of the vested part of such account upon termination of employment prior to the Plan Merger Date, such nonvested part will be restored as follows: If the former RightCHOICE Participant becomes an Eligible Employee within the applicable time limit on or after the Plan Merger Date, and repays the amount of the prior distribution within the applicable time limit, the nonvested part that was previously forfeited will be restored (without interest) under this Plan, and the entire Account will be fully vested. The former RightCHOICE Participant must become an Eligible Employee before incurring five consecutive one−year breaks in service and make the repayment within five years of the date of his or her employment as an Eligible Employee. If a former RightCHOICE Participant who terminated employment prior to the Plan Merger Date becomes an Eligible Employee prior to incurring five consecutive one−year breaks−in−service, and did not receive a distribution at his or her prior termination of employment, any nonvested part of his or her Account that was previously forfeited will automatically be restored under this Plan, and the entire Account will be fully vested. Funds for restoring forfeited amounts under this Section will be drawn from a special contribution to the Plan to be made by the appropriate Participating Company, as determined by the Committee. The special contribution will not be subject to the limitations under the

Internal Revenue Code Section 415.

1.04 *Use of Forfeitures.* Any forfeitures existing under the RightCHOICE Plan at the Plan Merger Date will be applied against Matching Contributions under this Plan.

1.05 *In−Service Withdrawals.* In addition to the amounts described in Section 9.04, a RightCHOICE Employee participating in the Plan may make an in−service withdrawal of all amounts attributable to assets transferred from the RightCHOICE Plan to the Plan on his or her behalf (other than earnings on elective deferrals made after 1988), subject to the hardship withdrawal provisions in Section 9.04.

1.06 *Loan Repayments.* As soon as administratively practicable after May 1, 2002, each participant loan in a RightCHOICE Participant's account under the RightCHOICE Plan with an outstanding balance at May 1, 2002 will be transferred to such participant's Account in this Plan,

and repayment on such loans will commence under this Plan. Any participant loan made on or after May 2, 2002 under the RightCHOICE Plan (each a "New Loan") will be transferred to this Plan as of the Plan Merger Date. Repayment on each such New Loan will be amortized over the remaining term of the loan, taking into account repayment amounts that were suspended under the RightCHOICE Plan prior to the Plan Merger Date.

1.07 *Previous Authorizations.* All distributions in progress, outstanding loans and hardship distributions initiated under the RightCHOICE Plan, except as provided to the contrary in this Appendix, will be administered under the Plan as of the Plan Merger Date.

6. A new Appendix XIII: *Special Provision Applicable to HealthLink Employees* is added at the end of the Plan effective as of May 6, 2002.

APPENDIX XIII: SPECIAL PROVISIONS APPLICABLE TO HEALTHLINK EMPLOYEES

The HealthLink,Inc. Savings Incentive Profit Sharing Plan (401(k)) (the "HealthLink Plan") will be merged into the Plan effective as of 11:59 p.m. on July 14, 2002. Assets and liabilities of the HealthLink Plan, together with the assets and liabilities of this Plan, will constitute a single plan within the meaning of Code Section 414(l) as of July 15, 2002 (the "Plan Merger Date"). Unless otherwise expressly provided herein, the rights and benefits of a participant in the HealthLink Plan (each a "HealthLink Participant") who terminates employment with HealthLink, Inc. ("HealthLink") on or prior to July 15, 2002 are determined in accordance with the provisions of the HealthLink Plan as in effect prior to July 15, 2002. References in the Plan to "Participant" as defined in Article II include each HealthLink Participant with an interest in the HealthLink Plan on July 14, 2002 without regard to his or her status as a current or former employee of HealthLink. This Appendix XIII is designed to describe special provisions that apply specifically to individuals employed by HealthLink on and after May 6, 2002 (each a "HealthLink Employee") and to preserve under the Plan any benefits that are accrued by HealthLink Employees under the HealthLink Plan prior to July 15, 2002 to the extent such benefits are protected under Code Section 411(d)(6). The provisions of the Plan apply to the benefits of HealthLink Employees described in this Appendix subject to the restriction applicable to protected benefits and except to the extent modified by the terms of this Appendix. In the event of a conflict, the provisions of this Appendix will control.

1.01 *Eligibility.* Notwithstanding anything to the contrary in the Plan, each individual who is, or becomes, an Employee of HealthLink on or after May 6, 2002 is eligible to participate in the Plan as described in Article IV and make Salary Deferral Contributions as described in Article V, provided that he or she otherwise satisfies the Plan's eligibility requirements. In no event will any such individual's Salary Deferral Contribution election described in Article V apply to Compensation earned prior to May 6, 2002.

1.02 *Matching Contributions.* For purposes of determining the six percent (6%) limit on Matching Contributions, only Compensation that a HealthLink Employee earns after May 5, 2002 while eligible for Matching Contributions under the Plan will be taken into account. If the HealthLink Employee has accrued service prior to May 6, 2002 that is recognized under the HealthLink Plan at May 5, 2002, such service, as well as service accrued under this Plan, will be taken into account for purposes of determining eligibility for a Matching Contribution under Section 5.02(g).

1.03 *Restoration of Forfeitures.* If the nonvested part of a former HealthLink Participant's account under the HealthLink Plan was forfeited following a distribution of the vested part of such account upon termination of employment prior to the Plan Merger Date, such nonvested part will be restored as follows: If the former HealthLink Participant becomes an Eligible Employee within the applicable time limit on or after the Plan Merger Date, and repays the amount of the prior

distribution within the applicable time limit, the nonvested part that was previously forfeited will be restored (without interest) under this Plan, and the entire Account will be fully vested. The former HealthLink Participant must become an Eligible Employee before incurring five consecutive one−year breaks in service and make the repayment within five years of the date of his or her employment as an Eligible Employee. If a former HealthLink Participant who terminated employment prior to the Plan Merger Date becomes an Eligible Employee prior to incurring five consecutive one−year breaks−in−service, and did not receive a distribution at his or her prior termination of employment, any nonvested part of his or her Account that was previously forfeited will automatically be restored under this Plan, and the entire Account will be fully vested. Funds for restoring forfeited amounts under this Section will be drawn from a special contribution to the Plan to be made by the appropriate Participating Company, as determined by the Committee. The special contribution will not be subject to the limitations under the Internal Revenue Code Section 415.

1.04 *Use of Forfeitures.* Any forfeitures existing under the HealthLink Plan at the Plan Merger Date will be applied against Matching Contributions under this Plan.

1.05 *Distribution Forms.* In addition to the single sum distribution form provided for in Section 11.08, a HealthLink Employee may elect to take amounts in his or her Account attributable to assets transferred from the HealthLink Plan in installments payable in cash or in kind over a period that does not exceed the life or life expectancy of the HealthLink Employee or the HealthLink Employee and his or her Beneficiary.

1.06 *In−Service Withdrawals.* In addition to the amounts described in Section 9.04, a HealthLink Employee participating in the Plan may make an in−service withdrawal of all amounts attributable to assets transferred from the HealthLink Plan to the Plan on his or her behalf (other than earnings on elective deferrals made after 1988), subject to the hardship withdrawal provisions in Section 9.04.

1.07 *Loan Repayments.* As soon as administratively practicable after May 21, 2002, each participant loan in a HealthLink Participant's account under the HealthLink Plan with an outstanding balance at May 21, 2002 will be transferred to such participant's Account in this Plan, and repayment on each such loan will commence under this Plan. Any participant loan made after May 21, 2002 under the HealthLink Plan (each a "New Loan") will be transferred to this Plan as of the Plan Merger Date. Repayment on each such New Loan will be amortized over the remaining term of the loan, taking into account repayment amounts that were suspended under the HealthLink Plan prior to the Plan Merger Date.

1.08 *Previous Authorizations.* All distributions in progress, outstanding loans and hardship distributions initiated under the HealthLink Plan, except as provided to the contrary in this Appendix, will be administered under the Plan as of the Plan Merger Date.

IN WITNESS WHEREOF, WellPoint Health Networks Inc. has cause this Amendment to be executed this 30th day of April, 2002.

WELLPOINT HEALTH NETWORKS INC.

By: /s/ J. THOMAS VAN BERKEM

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AMENDMENT TO THE WELLPOINT 401(k) RETIREMENT SAVINGS PLAN

EXHIBIT 15.01

August 13, 2002

Securities and Exchange Commission
450 Fifth Street, N.W.
Washington, D.C. 20549

Commissioners:

We are aware that our report dated July 23, 2002 on our review of interim financial information of WellPoint Health Networks Inc. (the "Company") as of and for the period ended June 30, 2002 and included in the Company's quarterly report on Form 10−Q for the quarter then ended is incorporated by reference in the Registration Statements on Form S−8 (File Nos. 333−05111, 333−33013, 333−42073, 333−81687, 333−90791, 333−37958, 333−55314, 333−81872 and 333−83462), Form S−3 (File No. 333−08519) and Form S−4 (File No. 333−73382).

Very truly yours,

/s/ PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

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EXHIBIT 99.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES−OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10−Q of WellPoint Health Networks Inc. (the "Company") for the period ending June 30, 2002 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Leonard D. Schaeffer, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes−Oxley Act of 2002, that:

1. The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ LEONARD D. SCHAEFFER

Leonard D. Schaeffer
Chief Executive Officer
August 13, 2002

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EXHIBIT 99.1
CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES−OXLEY ACT OF 2002

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EXHIBIT 99.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES−OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10−Q of WellPoint Health Networks Inc. (the "Company") for the period ending June 30, 2002 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, David C. Colby, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes−Oxley Act of 2002, that:

1. The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ DAVID C. COLBY

David C. Colby
Chief Financial Officer
August 13, 2002

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EXHIBIT 99.2
CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES−OXLEY ACT OF 2002

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934

FORM 10−K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2001

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number 001−13083

WELLPOINT HEALTH NETWORKS INC.
(Exact name of Registrant as specified in its charter)

Delaware (State of incorporation)	**95−4635504** (I.R.S. Employer Identification No.)
1 WellPoint Way **Thousand Oaks, CA** (Address of principal executive offices)	**91362** (Zip Code)

Registrant's telephone number, including area code: (818) 234−4000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, $0.01 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S−K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of the Form 10−K or any amendment to this Form 10−K. ☒

State the aggregate market value of the voting stock held by non−affiliates of the Registrant as of March 18, 2002: $8,895,428,927 (based on the last reported sale price of $62.48 per share on March 18, 2002, on the New York Stock Exchange).

Common Stock, $0.01 par value of Registrant outstanding as of March 18, 2002: 143,239,794 shares.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10−K incorporates by reference information from the Registrant's definitive proxy statement for its 2002 Annual Meeting of Stockholders.

WELLPOINT HEALTH NETWORKS INC.

FORM 10−K ANNUAL REPORT

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PART I

Item 1. Business

General

WellPoint Health Networks Inc. (the "Company" or "WellPoint") is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. As a result of the January 31, 2002 completion of the Company's merger with RightCHOICE Managed Care, Inc. ("RightCHOICE"), the Company's medical membership has increased to approximately 12.5 million members as of January 31, 2002. The Company offers a broad spectrum of quality network−based managed care plans. WellPoint provides these plans to the large and small employer, individual, Medicaid and senior markets. The Company's managed care plans include preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs") and point−of−service ("POS") and other hybrid plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial services, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products, including pharmacy, dental, workers' compensation managed care services, utilization management, life insurance, preventive care, disability insurance, behavioral health, COBRA and flexible benefits account administration.

The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in various parts of the country under the name UNICARE or HealthLink. Historically, the Company's primary market for its managed care products has been California. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks. The Company's customer base is diversified, with extensive membership among large and small employer groups and individuals and a growing presence in the Medicare and Medicaid markets.

In 1996, the Company began pursuing a nationwide expansion strategy through selective acquisitions and start−up activities in key geographic areas. With the acquisitions in March 1996 of the Life & Health Benefits Management division ("MMHD") of Massachusetts Mutual Life Insurance Company (the "MMHD Acquisition") and in March 1997 of certain portions of the health and related life group benefit operations (the "GBO") of John Hancock Mutual Life Insurance Company (the "GBO Acquisition"), the Company significantly expanded its operations outside of California. The Company's acquisition strategy during this period was primarily focused on large employer group plans that offered indemnity and other health insurance products that were less intensively managed than the Company's products in California. From 1987 until 1996, the Company transitioned substantially all of its California indemnity insurance customers to managed care products. An element of the Company's geographic expansion strategy during this period was to replicate its experience in California in motivating traditional indemnity members to transition to the Company's broad range of managed care products.

More recently, the Company has focused on acquiring businesses that provide significant concentrations of members in strategic locations outside of California. In connection with this strategy, the Company completed its acquisitions of RightCHOICE in January 2002, Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross and Blue Shield of Georgia ("Georgia Blue"), in March 2001 and Rush Prudential Health Plans ("Rush Prudential") in March 2000. The Company's pending acquisition of CareFirst, Inc. ("CareFirst") is also an element of this strategy.

As of December 31, 2001, the Company's primary internal business divisions were focused on large employer group business, individual and small employer group business, and senior and specialty business. Revenues (with sales to external customers and sales or transfers to other segments shown separately), operating profit or loss and identifiable assets attributable to each of the Company's reportable segments are set forth in Note 19 to the Consolidated Financial Statements, which are included elsewhere in this Annual Report on Form 10−K. As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002. As a result of these changes, the Company currently anticipates that its Quarterly Report on Form 10−Q for the quarterly period ending March 31, 2002 (and subsequent filings under the Securities Exchange Act of 1934) will reflect the following two reportable segments: Health Care business and Specialty business.

Recent Completed Transactions and Pending Transactions

Acquisition of RightCHOICE

On January 31, 2002, the Company completed its merger (the "RightCHOICE Merger") with RightCHOICE, pursuant to the Agreement and Plan of Merger dated October 17, 2001 (the "RightCHOICE Merger Agreement"), by and among the Company, RWP Acquisition Corp., a wholly owned subsidiary of the Company, and RightCHOICE. As a result of the merger, RightCHOICE has now become a wholly owned subsidiary of WellPoint, and WellPoint now holds the exclusive license to use the Blue Cross and Blue Shield names and marks in 85 counties in the state of Missouri.

Pursuant to the RightCHOICE Merger Agreement, each issued and outstanding share of RightCHOICE Common Stock at the closing of the RightCHOICE Merger was converted into the right to receive $66 in cash or 0.6161 shares of WellPoint Common Stock. Stockholders of RightCHOICE were given the option to elect to receive cash for any or all of the shares of RightCHOICE Common Stock that they owned as of the effective time of the RightCHOICE Merger, subject to a proration provision to ensure that 30% of the outstanding shares of RightCHOICE Common Stock were converted into cash and the remaining 70% were converted into WellPoint Common Stock. Total consideration paid to all holders of RightCHOICE Common Stock in the merger was approximately $379.0 million in cash and 8,255,052 shares of WellPoint Common Stock (prior to the Company's two−for−one stock split in the form of a stock dividend, which was effected on March 15, 2002). As of December 31, 2001, RightCHOICE had approximately 3.0 million members. During the year ended December 31, 2001, RightCHOICE had total revenues of $1.2 billion and net income of $66.4 million.

Acquisition of Cerulean

On March 15, 2001, the Company completed its acquisition of Cerulean. The Merger Agreement provided for the merger (the "Cerulean Merger") of Water Polo Acquisition Corp., a wholly owned subsidiary of WellPoint, with and into Cerulean. As a result of the Cerulean Merger, Cerulean has now become a wholly owned subsidiary of WellPoint. At the effective time of the Merger, the shareholders of Cerulean became entitled to receive aggregate cash consideration of $700 million. As of December 31, 2000, Cerulean, through Georgia Blue and its various other subsidiaries, served approximately 1.8 million medical members in the state of Georgia.

Pending Acquisition of CareFirst

On November 20, 2001, the Company entered into a definitive agreement (the "CareFirst Merger Agreement") to acquire CareFirst. CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services. As of December 31, 2001, CareFirst served approximately

3.1 million members in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware.

The CareFirst portfolio of products ranges from traditional fee−for−service health care insurance to fully managed care. CareFirst administers the largest Federal Employees Health Plan in the nation. CareFirst affiliate companies also offer third−party administrative services and claims processing for self−insured groups.

Under the terms of the CareFirst Merger Agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion.

The Company will pay at least $450 million of the purchase price in cash and the balance in shares of the Company's Common Stock based on its average closing price in the 20 trading day period ending the fifth trading day prior to the closing of the CareFirst transaction. In the event that the average closing price is below $35 per share, the Company may issue a five−year subordinated note in lieu of a portion of the purchase price to be paid in its Common Stock. The subordinated note will rank *pari passu* with the Company's Zero Coupon Convertible Subordinated Debentures due 2019.

Before the CareFirst transaction is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law.

The conversion will require the approval of insurance regulators in each of the areas where CareFirst and its affiliates are domiciled—Maryland, Delaware and the District of Columbia. In addition, Group Hospitalization and Medical Services, Inc., CareFirst's operating affiliate in the District of Columbia, must have its federal charter amended or repealed by the United States Congress (subject to presidential approval) and obtain approval from the Washington, D.C. corporation counsel. The acquisition of CareFirst will also be subject to regulatory approval in the States of Maryland and Delaware and in the District of Columbia, and to antitrust clearance by the U.S. Department of Justice and the Federal Trade Commission.

The transaction is subject to the receipt of a private letter ruling from the Internal Revenue Service (the "IRS") that the conversion of CareFirst will constitute a tax−free reorganization and that gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. Although there can be no assurances that WellPoint and CareFirst will obtain the necessary approvals, the conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the CareFirst Merger Agreement.

On the closing date, one non−employee member of the existing Board of Directors of CareFirst will be appointed to the Company's Board of Directors. The chief executive officer of CareFirst will be named the president of the Company's southeast business region. Other senior executives of CareFirst will be assigned significant responsibilities with respect to the business of the Company in that area.

Managed Health Care Overview

An increasing focus on costs by employers and consumers over the last decade has spurred the growth of HMO, PPO, POS and other forms of managed care plans as alternatives to traditional indemnity health insurance. Typically, HMOs and PPOs, as well as hybrid plans incorporating features of each (such as POS plans), develop health care provider networks by entering into contracts with hospitals, physicians and other health care professionals to deliver health care at favorable rates that incorporate health care utilization management and other measures that encourage the delivery of

medically necessary care as well as network credentialing and quality assurance. HMO, PPO and POS members generally are charged periodic, prepaid premiums, and copayments or deductibles. PPOs, POS plans and a number of HMOs allow out−of−network usage, typically at substantially higher out−of−pocket costs to members. HMO members generally select one primary care physician from a network who is responsible for coordinating health care services for the member, while PPOs and other "open access" plans generally allow members to select physicians without coordination through a primary care physician. Hybrid plans, such as POS plans, typically involve the selection of primary care physicians similar to HMOs, but allow members to choose non−network physicians at higher out−of−pocket costs similar to PPOs.

The California Market. The desire of California−based employers for a range of health care choices that promote effective cost controls and quality care has contributed to substantial market acceptance of managed health care in California, where the total penetration of managed health care companies is generally higher than the national average. Initial developments in California with respect to managed care were focused on HMOs and other tightly controlled plans. Over the last few years, this emphasis has decreased as consumers and media scrutiny have generally criticized the reduced choice typical of HMO plans and as greater regulatory restrictions have been placed on HMO offerings. The Company believes that this movement towards PPOs and other open access plans will continue in the future.

Other States. Outside of California, the past decade has seen significant transformations in the health care sector. Although market acceptance of the array of managed health care plans continues to grow throughout the United States, it still varies widely from state to state. In some states, especially larger population centers, members are offered health care choices focused on HMO or other closed−access plans. In other states, members are typically offered a spectrum of health care choices which are more focused on PPOs or traditional indemnity health models than in California. Indemnity insurance usually allows members substantial freedom of choice in selecting health care providers but without significant financial incentives or cost−control measures typical of managed care plans. Indemnity insurance plans typically require annual deductible obligations of members. Upon satisfaction of the deductible, the member is reimbursed for health care expenses on a full or partial basis of the indicated charges. Health plan reimbursement is often limited to the health plan's assessment of the reasonable and customary charges prevailing in a region for the particular health care procedure. As in California, initial developments in managed care in other states have generally focused on more restrictive plans. More recently, consumer and general public sentiment has shifted towards open access plans.

Customer Segmentation

WellPoint's products are generally developed and marketed with an emphasis on the differing needs of various customer groups. In particular, the Company's product development and marketing efforts take into account the differing characteristics between the various customer groups served by the Company, including individuals and small employers, large employers (generally with 51 or more employees), seniors and Medicaid recipients, as well as the unique needs of educational and public entities, federal employee health and benefit programs, national employers and state−run programs servicing high−risk and under−served markets. Individual business units are responsible for enrolling, underwriting and servicing customers in specific segments. The Company believes that one of the keys to its success has been its focus on distinct customer groups defined generally by employer size and geographic region, which better enables the Company to develop benefit plans and services that meet the needs of these distinct markets. Although the Company has experienced increased competition over the last several years, the Company has long been a market leader in the California individual and small employer group market.

Individual and Small Group Business

Marketing

Sales representatives are generally assigned to a specific geographic region to allow WellPoint to tailor its marketing efforts to the particular health care needs of each regional market. Individual and small employer group products are marketed in California primarily through independent agents and brokers, who are overseen by WellPoint's sales departments, and through WellPoint's direct sales staff. UNICARE's individual and small employer group products are generally distributed on a regional basis by independent sales agents in the various localized markets in which UNICARE operates. The Company's Blue Cross and Blue Shield products in Georgia and Missouri are also distributed by independent sales agents working in conjunction with the Company's internal sales staff. The Company expects that, over time, the development of Internet−based distribution methods may affect the sales and marketing process in the individual and small employer group market. In this regard, in 1999 the Company entered into sales distribution arrangements with certain Internet−based sales agents and introduced its Agent Connect program, which allows individual agents and brokers to create customized Internet websites and incorporate basic information regarding the Company's health plan offerings.

Products

PPO and Other Plans. The Company's PPO products are generally marketed in California under the name "Prudent Buyer," in Georgia under the name "Blue Choice PPO," in Missouri under the name "Alliance PPO" and in various parts of the country under the names "UNICARE" and "HealthLink" and are designed to address the specific needs of different customer groups. The Company's PPO plans generally require periodic, prepaid premiums and may have copayment obligations for services rendered by network providers that are often similar to the copayment obligations of its HMO plans. Unlike WellPoint's HMO and other "closed−access" plans, members are not required to select a primary care physician who is responsible for coordinating their care and may be subject to annual deductible requirements. PPO members have the option to receive health care services from non−network health care professionals, typically at substantially higher out−of−pocket costs to members. In 1998, the Company introduced its unique Employee Elect product, which allows small employers to offer their employees a menu of PPO and HMO options. In January 2001, the Company introduced its PlanScape family of individual PPO plans in California. The PlanScape plans are marketed towards purchasers with varying price preferences and offer a variety of coverage options and premium amounts. The Company's PPO members in California, Missouri and Georgia may also participate in the Blue Cross Blue Shield Association's Blue Card program, which allows members to access other Blue Cross Blue Shield plans' PPO providers throughout the nation.

The Company believes that an important growth opportunity in the individual market lies in the development of products that are priced attractively for previously uninsured people. In 2000, the Company introduced a new PPO product in California and selected other locations that offers significantly lower premiums in exchange for certain limited benefits while still offering primary care physician visits, preventive care benefits and catastrophic coverage. During 2001, the Company also introduced this product in Georgia.

HMO Plans. The Company offers a variety of HMO products to its HMO members in California, Georgia, Illinois and Missouri. HMO members are generally charged periodic, prepaid premiums that do not vary based on the amount of services rendered, as well as co−payments (per−visit charges). Members choose a primary care physician from the HMO network who is usually responsible for coordinating health care services for the member. Certain plans permit members to receive services from health care professionals that are not a part of the Company's HMO network at a substantial out−of−pocket cost to members which includes a deductible and higher copayment obligations.

Large Group Business

During the last several years, WellPoint's large employer group business has experienced considerable growth. The Company attributes this growth in California primarily to the strength of the California economy and, throughout the country, to the enhancement of the Company's reputation for customer service and value especially among large, established companies.

Marketing and Products

WellPoint's managed health care plans to large employers are generally sold by WellPoint sales personnel, in conjunction with an employer's broker or consultant, to develop a package of managed health care benefits specifically tailored to meet the employer's needs. WellPoint believes that a key component of its success in this market segment is the Company's strength in developing complex, highly customized benefits packages that respond to the diverse needs of larger employers and their employee population. For example, in 1999, the Company introduced its Blue Cross Preferred PPO product in California, which provides certain enhanced benefits desired by high−technology companies in competitive labor markets.

Many of WellPoint's HMO and PPO products offered to individuals and small employer groups are also offered to large employer groups. In addition to competitive pricing and exemplary customary service, a key competitive factor in the sale of large employer group products is the ability to offer a spectrum of health plan choices. With the completion of the Company's acquisitions of RightCHOICE, Cerulean and Rush Prudential, the Company is able to offer a mix of products, including HMO and PPO products, to customers in Missouri, Georgia and the greater Chicago area. One component of the Company's expansion strategy outside of California is to evaluate acquisition opportunities that will allow the Company to complement its product offerings in selected target areas.

Management Services

In addition to fully insured products, WellPoint provides administrative services to large group employers that maintain self−funded health plans. In California, the Company often has been able to capitalize on this relationship by subsequently introducing WellPoint's underwritten managed care products. The Company's managed care services revenues have expanded considerably during the last several years as a result of the MMHD, GBO and Cerulean acquisitions. These businesses are comprised of a higher percentage of administrative services business than the Company's traditional California business. Georgia Blue currently provides administrative services for several accounts sponsored by the state of Georgia. These accounts comprise in excess of 24% of Georgia Blue's membership.

WellPoint offers managed care services, including underwriting, actuarial services, medical cost management, claims processing and administrative services for self−funded employers. WellPoint also enables employers with self−funded health plans to use WellPoint's provider networks and to realize savings through WellPoint's favorable provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. As of December 31, 2001, WellPoint served self−insured health plans covering approximately 3.4 million medical members.

In connection with the RightCHOICE transaction, the Company has acquired RightCHOICE's subsidiary, HealthLink. HealthLink provides provider network contracting services and review, management and coordination of health care services used by members. HealthLink currently serves the states of Missouri, Illinois, Iowa, Arkansas, Indiana, Kentucky and West Virginia. HealthLink's services are provided to employers that fund their own health plans, commercial insurers, unions and Taft−Hartley trusts. HealthLink also derives a portion of its revenues from providers for support and administrative services. As of December 31, 2001, HealthLink had approximately 1.1 million group

health PPO administrative services members and 0.9 million workers' compensation members. In addition, one of HealthLink's wholly owned subsidiaries had approximately 12,000 HMO members. One of the Company's business strategies is to expand the HealthLink business in selected regions of the country.

Senior Plans

WellPoint offers numerous Medicare supplement plans, which typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. For example, WellPoint offers a PPO−based product that offers supplemental Medicare coverage and a hybrid product which allows seniors over the age of 65 to maintain their full Medicare benefits for any out−of−network benefits while enrolled in a supplemental plan that allows them to choose their own physician with a copayment. As of December 31, 2001, these Medicare supplemental plans served approximately 338,000 members. As of December 31, 2001, RightCHOICE's Medicare supplemental plans had approximately 47,000 members. These products are marketed under the "Blue Horizons" name.

WellPoint also offers an HMO plan under a Medicare + Choice contract in certain locations in California and Georgia. These contracts generally entitle WellPoint to a fixed per−member premium which is subject to adjustment annually by the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare program, based on certain demographic information relating to the Medicare population and the cost of providing health care in a particular geographic area. In addition to physician care, hospitalization and other benefits covered by Medicare, the benefits under these plans (which vary by county) typically include routine physical exams, hearing tests, immunizations, eye examinations, counseling and health education services. As of December 31, 2001, the Company's Medicare + Choice HMO plans served approximately 61,000 members.

Medicaid Plans and Other State−Sponsored Programs

The California Department of Health Services ("DHS") administers Medi−Cal, California's Medicaid program. WellPoint has been awarded contracts to offer Medi−Cal managed care programs in various California counties. Under these programs, WellPoint provides health care coverage to Medi−Cal program members and DHS (or a delegated local agency) pays WellPoint a fixed payment per member per month. As of December 31, 2001, approximately 941,000 members were enrolled in WellPoint's Medi−Cal managed care programs in various California counties and in other state−sponsored programs. The Company has also obtained contracts to serve Medicaid members in locations outside of California, including parts of Oklahoma, Virginia and Massachusetts. As of December 31, 2001, the plans serving these members had approximately 95,000 members. In 2000, the Company entered into a joint venture with Medical Card Systems, Inc., a Puerto Rico−based group health and life insurer, to pursue contracts under the Health Reform Program in Puerto Rico.

Managed Health Care Networks and Provider Relations

The Company's health care networks and provider relations reflect the different market positions of the Company's various operating subsidiaries and local market dynamics in the various jurisdictions in which the Company does business.

Blue Cross of California

WellPoint's extensive managed health care provider networks in California include its HMO, PPO and specialty managed care networks. WellPoint uses its large California membership to negotiate physician contracts at favorable rates that promote delivery of quality care and encourage effective utilization management. Under these contracts, physicians are paid either a fixed per member monthly amount (known as a capitation payment) or on the basis of a fixed fee schedule. In selecting physicians

for its networks, WellPoint uses its credentialing programs to evaluate the applicant's professional qualifications and experience, including license status, malpractice claims history and hospital affiliations.

The following is a more detailed description of the principal features of WellPoint's California PPO and HMO networks.

PPO Network. There were approximately 3.6 million members (including administrative services members) enrolled in WellPoint's California PPO health care plans as of December 31, 2001, approximately 35% of whom were individuals or employees of small groups.

WellPoint endeavors to manage and control costs for its PPO plans by negotiating favorable arrangements with physicians, hospitals and other health care professionals, and requiring participation in the Company's various medical management programs. In addition, WellPoint manages costs through pricing and product design decisions intended to influence the behavior of both members and health care professionals.

WellPoint's California PPO plans provide for the delivery of specified health care services to members by contracting with physicians, hospitals and other health care professionals. Hospital contracts are on a nonexclusive basis and generally provide for per diem payments (a fixed fee schedule where the daily rate is based on the type of service) that provide for rates that are below the hospitals' standard billing rates. Physician contracts are also on a nonexclusive basis and specify fixed fee schedules that are below standard billing rates. WellPoint is able to obtain prices for hospitals and physician services below standard billing rates because of the volume of business it offers to health care professionals that are part of its network. Rates are generally negotiated on an annual or multi−year basis with hospitals. Rates for physicians in the Company's PPO network are set from time to time by the Company.

HMO Network. Membership in the Company's California HMO was approximately 2.3 million members as of December 31, 2001.

The physician network of participating medical groups ("PMGs") is comprised of both multi−specialty medical group practices and individual practice associations ("IPAs"). Substantially all primary care physicians or PMGs in the Company's California HMO network are reimbursed on a capitated basis. These arrangements specify fixed per member per month payments to providers and may result in a marginally higher medical loss ratio than a non−capitated arrangement, but significantly reduce risk to WellPoint. Generally, HMO network hospital contracts are on a nonexclusive basis and provide for a per diem payment, which is below the hospitals' standard billing rates.

Contractual arrangements with PMGs typically include provisions under which WellPoint provides limited stop−loss protection. If the PMG's actual charges for medical services provided to a member exceed an agreed−upon threshold amount, WellPoint will pay the group a portion of the excess amount. Rates are generally negotiated with PMGs and hospitals on an annual or multi−year basis. To encourage PMGs to contain costs for claims for non−capitated services such as inpatient hospital, outpatient surgery, hemodialysis, emergency room, skilled nursing facility, ambulance, home health and alternative birthing center services, WellPoint's PMG agreements provide for a settlement payment to the PMG based upon the PMG's effective utilization of such non−capitated services. PMGs are also eligible for additional incentive payments based upon their satisfaction of quality criteria and management of outpatient prescription drugs. In 2001, BCC announced plans to modify the incentive compensation arrangements for PMGs serving the Company's California HMO members to place greater emphasis on assessment of health outcomes, patient satisfaction information and generic outpatient drug utilization. This information will be reflected in a Quality Score Card prepared by BCC with respect to a particular PMG. BCC will seek to implement this modification as agreements with PMGs are renewed over the next two to three years.

Blue Cross Blue Shield of Georgia

In 1995, Cerulean began using jointly owned integrated delivery systems for managed health care products, with community health partnership networks ("CHPNs") as the cornerstone of this strategy. CHPNs are locally based equity ventures between Georgia Blue and a local physician group or hospital. The physician or hospital joint ventures, as well as other health care professionals with which the CHPN maintains contracts, provide clinical services. Georgia Blue provides sales, management and administrative services, including information systems and data management services. Georgia Blue's HMO affiliate collects premium and fee revenues from subscribers and retains a flat percentage as a contribution to surplus. After deduction for premium taxes and administrative payments for Georgia Blue, the remaining premium revenue is used for payment of medical expenses and contributions to the CHPN's retained earnings. As of December 31, 2001, Georgia Blue had one active CHPN, in the greater Atlanta area. Outside of Atlanta, networks for Georgia Blue's HMO products are maintained without the use of a CHPN. The HMO membership in Atlanta that uses the CHPN Network accounts for a significant percentage of Georgia Blue's HMO membership.

Georgia Blue has developed extensive physician and hospital networks that serve Georgia Blue's PPO Plans and certain of its indemnity products. For these products, Georgia Blue uses a variety of reimbursement methods, including per diem payments, maximum allowable charge, case rates, discounted fee−for−service and fee schedules.

Blue Cross Blue Shield of Missouri

The health care services received by Blue Cross Blue Shield of Missouri members are provided primarily by physicians, hospitals and other health care professionals in proprietary provider networks. Blue Cross Blue Shield of Missouri maintains multiple managed care provider networks, including PPO and HMO networks. Networks are developed based upon the geographic locale of the provider, the appropriateness of the provider's specialty and the particular region for that network, as well as the convenience and accessibility of the membership. As with the Company's other networks, physicians' credentials and experience and other factors are evaluated. The managed care contracts with providers incorporate utilization management and quality improvement provisions. Network physicians receive either a monthly capitation payment or are paid on the basis on a fixed fee schedule which is generally lower than standard billing rates. PPO physicians are compensated on the basis of a fixed fee schedule. Most of the primary care physicians in the HMO provider networks are compensated on a capitated basis, while most specialist physicians are compensated on the basis on a fixed fee schedule. Hospital contracts generally provide for inpatient per diem payments, which provide for a reimbursement that is below the hospital's standard billing rates for an inpatient stay.

HealthLink

HealthLink has developed extensive PPO networks in Missouri, Illinois, Indiana and various other states in which it operates. HealthLink's current network expansion efforts are concentrated on developing and supplementing the HealthLink provider networks in existing and adjacent areas of regional Missouri, Illinois, Indiana, Arkansas and Kentucky. HealthLink has also developed an HMO network concentrated in eastern and central Missouri and southern and central Illinois. To serve its workers' compensation members, HealthLink has developed workers compensation PPO networks serving portions of Missouri, Illinois and Indiana. Physician and hospital representation in HealthLink's various networks takes into account a number of factors, including the particular specialty or offered services of a contracting physician or facility. Managed care contracts generally incorporate utilization management and quality improvement features. Many of these contracts also obligate contracting providers to pay HealthLink a monthly fee for administrative services provided by HealthLink.

UNICARE

Due to the more recent development of the Company's UNICARE national operations, UNICARE's relations with health care professionals are more varied than the Company's relations in California. Since 1996, the Company has conducted its network development efforts in various states, including Georgia, Illinois, Indiana, Maryland, Ohio, Texas and Virginia.

As a result of the Rush Prudential acquisition, UNICARE added Rush Prudential's existing networks to its proprietary networks in the greater Chicago area. As part of the MMHD acquisition, the Company also acquired a majority ownership interest in a PPO entity, UNICARE National Capital Preferred Provider Organization ("UNICARE NCPPO"), which operates in the Maryland/Virginia area and is a joint venture with local health care providers.

A large number of UNICARE members are served by third−party provider networks, which generally lack the selectivity and discounts typical of the Company's proprietary networks. One of the Company's strategies for the expansion of its UNICARE operations is to continue building and acquiring proprietary network systems in certain geographies similar to the Company's networks in California, which provide a continuum of managed care products to various customer segments. As UNICARE expands its operations, it intends to build or acquire such network operations and, as appropriate, to replace or supplement the current third−party network arrangements. During the last three years, UNICARE has consolidated its third−party network relationships in an effort to further contain its administrative expenses.

Ancillary Networks

WellPoint evaluates current and emerging high volume or high cost services to determine whether developing an ancillary service network will yield cost control benefits. In establishing these ancillary service networks, WellPoint seeks to enter into capitation or fixed−fee arrangements with providers of these services. WellPoint regularly collects and analyzes industry data on high cost or high volume unmanaged services to identify the need for specialty managed care networks. For example, WellPoint has created Centers of Expertise for certain transplant services.

Utilization Management

In order to better manage quality in its proprietary provider networks, WellPoint adopts utilization management processes and guidelines that are intended to reduce unnecessary or inappropriate procedures, admissions and other medical costs. The utilization management systems seek to provide access to quality care to WellPoint's members based on medical necessity where final decisions are made by physicians. In its California HMO, WellPoint permits PMGs to oversee most utilization management for their particular medical group under WellPoint's guidelines. Currently, substantially all of the PMGs in WellPoint's California HMO network have established committees to oversee utilization management. For its California PPO network, WellPoint uses treatment guidelines, requires pre−admission approvals of hospital stays and concurrent review of all admissions and retrospectively reviews physician practice patterns. Utilization management also includes an outpatient program, with pre−authorization and retrospective review, ongoing supervision of inpatient and outpatient care of members, case management and discharge planning capacity. Review of practice patterns may result in modifications and refinements to the PPO plan offerings and network contractual arrangements. In addition, WellPoint manages health care costs by periodically reviewing cost and utilization trends within its provider networks. Cases are reviewed in the aggregate to identify a high volume of a particular type of service to identify the most effective method of treatment while more effectively managing costs. In addition, the Company reviews high−cost procedures in an effort to provide new quality, cost−effective treatment by utilizing new technologies or by creating additional networks, such as its networks of home health agencies.

For the Company's UNICARE managed care health plans, utilization management is provided by UNICARE through the Company's subsidiary CostCare, Inc. ("CCI"). As part of the GBO acquisition, the Company acquired CCI, which provides medical management services. The Company has integrated CCI's traditional utilization management and case management services into UNICARE offerings. CCI products include a disease state management program, a high−risk pregnancy identification and management program and a nurse health information line. Certain of the Company's plans in California also feature similar programs. In September 2001, CCI (which operates as UNICARE/Cost Care) received a one−year accreditation for its utilization management program from the Utilization Review Accreditation Commission ("URAC"), a private organization providing voluntary accreditation of utilization review entities. Additionally, in February 2000, CCI received a two−year accreditation from URAC for its health information line program.

In 2000, the National Committee for Quality Assurance ("NCQA") awarded Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. its second full, three−year accreditation. Georgia Blue's PPO organization was the first PPO in Georgia to receive accreditation from URAC. In 1999, NCQA awarded the Company's subsidiary HMO Missouri, Inc. a three−year accreditation. Blue Cross Blue Shield of Missouri's Alliances PPO and the HealthLink PPO have also received accreditation from URAC.

In 1996, Blue Cross Blue Shield of Missouri developed its innovative Physician Group Partners Program, which is designed to increase collaborative managed care initiatives with primary care physicians in Blue Cross Blue Shield of Missouri's HMO and to provide those physicians with the opportunity to earn additional compensation by improving patient satisfaction and improving performance levels using nationally recognized health care industry standards. The program has subsequently been expanded to include a specialist program. The Physician Group Partners Program strives to establish long−term business relationships with physicians. Blue Cross Blue Shield of Missouri believes that this program has resulted in reduced integration and oversight of physicians, enhanced member satisfaction and improved quality measure scores. Blue Cross Blue Shield of Missouri has also implemented additional initiatives to enhance its business relationships with the physician community. As WellPoint begins its integration of the RightCHOICE operations, WellPoint intends to explore the various programs implemented by Blue Cross Blue Shield of Missouri and consider their applicability to other regions of the country in which WellPoint operates.

Underwriting

In establishing premium rates for its health care plans, WellPoint uses underwriting criteria based upon its accumulated actuarial data, with adjustments for factors such as claims experience, member mix and industry differences to evaluate anticipated health care costs. WellPoint's underwriting practices in the individual and small group market are subject to legislation in California, Georgia, Illinois, Missouri and other states affecting the individual and small employer group market. Because UNICARE's members are in every state, the Company's underwriting practices, especially in the individual and small group market, are subject to a variety of legislative and regulatory requirements and restrictions. See "Government Regulation."

Quality Management

Quality management for most of the Company's business is overseen by the Company's Quality Management Department and is designed to ensure that necessary care is provided by qualified personnel. Depending on the local markets, quality management encompasses plan level quality performance, provider credentialing, provider and member grievance monitoring and resolution, medical group auditing, monitoring medical group compliance with Company standards for medical records and medical offices, physician peer review and a quality management committee.

Specialty Managed Health Care and Other Plans and Services

WellPoint offers a variety of specialty managed health care and other services. WellPoint believes that these specialty networks and plans complement and facilitate the marketing of WellPoint's medical plans and help in attracting employer groups and other members that are increasingly seeking a wider variety of options and services. WellPoint also markets these specialty products on a stand−alone basis to other health plans and other payors.

Pharmacy Products

WellPoint offers pharmacy services and pharmacy benefit management services to its members. WellPoint's pharmacy services incorporate features such as drug formularies (a WellPoint−developed listing of preferred, cost−effective drugs), a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Pharmacy benefit management services provided by WellPoint include management of drug utilization through outpatient prescription drug formularies, retrospective review and drug education for physicians, pharmacists and members. In December 2000, the Company completed its acquisition of a mail−order pharmacy facility, which now operates under the name PrecisionRx. The Company believes that PrecisionRx will enhance the competitiveness of its pharmacy benefit management services. As of December 31, 2001, WellPoint had approximately 32.8 million pharmacy members.

Dental Plans

WellPoint's California dental plans include Dental Net, its California dental HMO, and Blue Cross Dental Select HMO, a hybrid plan, a dental PPO, and traditional indemnity plans. The Company's dental products outside of California currently include a dental PPO in Texas, Georgia and almost all of the other states in which the Company operates. As a result of the MMHD and GBO acquisitions, the Company has acquired significant additional dental membership outside of California. The Company's dental plans provide primary and specialty dental services, including orthodontic services, and as of December 31, 2001, served approximately 2.6 million dental members.

Life Insurance

The Company offers primarily term−life and accidental death and dismemberment ("AD&D") insurance to employers, generally in conjunction with the Company's health plans. The MMHD, GBO and Cerulean acquisitions have expanded the Company's life insurance business both inside and outside of California. As of December 31, 2001, the Company provided life insurance products to approximately 2.3 million persons.

Mental Health Plans

WellPoint offers specialized mental health and substance abuse programs. The plans cover mental health and substance abuse treatment services on both an inpatient and an outpatient basis. In addition, approximately 260 employee assistance and behavioral managed care programs have been implemented for a wide variety of businesses throughout the United States. As of December 31, 2001, there were approximately 5.1 million members covered under WellPoint's mental health plans.

Utilization Management

In connection with the GBO acquisition, the Company acquired CCI. CCI, which now operates under the trade name UNICARE/CostCare, provides stand−alone utilization management and other medical management services to other health plans and self−funded employers. CCI utilization management services are also integrated into UNICARE product offerings. As of December 31, 2001, the Company had approximately 1.7 million utilization management members.

Disability Plans

The Company offers short− and long−term disability programs, usually in conjunction with the Company's health plans. As of December 31, 2001, the Company provided long−term or short−term disability coverage to approximately 541,000 individuals.

Long−Term Care Insurance

In 1997, the Company began offering a group of long−term care insurance products to its California members through its indirect wholly owned subsidiary BC Life & Health Insurance Company ("BC Life"). These plans, which are marketed under the Blue Cross Long Term Care trade name, involve six different products. The Company's long−term care products include tax−qualified and non−tax qualified versions of a skilled nursing home care plan and comprehensive policies covering skilled, intermediate and custodial long−term care and home health care services.

Workers' Compensation Managed Care Services

In California, the Company offers workers' compensation managed care services, including bill review, network access, medical cost management and utilization management, to employers who self−insure their workers' compensation coverage, as well as to workers' compensation carriers. The Company's HealthLink subsidiary also provides workers' compensation managed care services to its clients in the central portion of the United States. See "Large Group Business—Management Services."

Market Research and Advertising

WellPoint conducts market research and advertising programs to develop products and marketing techniques tailored specifically to customer segments. WellPoint uses print and broadcast advertising to promote its health care plans. In addition, the Company engages in promotional activities with agents, brokers and consultants. WellPoint incurred costs of approximately $59.6 million, $61.8 million and $40.8 million on advertising for the years ended December 31, 2001, 2000 and 1999, respectively.

Competition

The managed health care industry in California is competitive on both a regional and statewide basis. In addition, in recent years there has been a trend of increasing consolidation among both national and California−based health care companies, which may further increase competitive pressures. WellPoint competes with other companies that offer similar managed health care plans, some of which have greater resources than WellPoint. In addition, the development and growth of companies offering Internet−based connections between health care professionals, employers and members, along with a variety of services, may create additional competitors. Currently, WellPoint is a market leader in offering managed health care plans to individuals and small employer groups in California. The medical loss ratio attributable to WellPoint's individual and small group business has historically been lower than that for its large employer group business. As a result, a larger portion of WellPoint's profitability on a per−member basis is due to the individual and small group business. WellPoint has experienced increased competition in this market over the last several years, which could adversely affect its medical loss ratio and future financial condition, cash flows or results of operations. See "Factors That May Affect Future Results of Operations."

The markets in which the Company operates outside of California are also highly competitive. Because of the many different markets in which the Company now serves members, the Company faces unique competitive pressures in regional markets as well as on a national basis. The Company competes with other companies that offer managed health care plans as well as traditional indemnity insurance products. Many of these companies have greater financial and other resources than the

Company or greater market share on either a regional or national basis. As the Company continues to geographically expand its operations, it will be subject to national competitive factors as well as unique competitive conditions that may affect the more localized markets in which the Company operates.

WellPoint believes that significant factors in the selection of a managed health care plan by employers and individual members include price, the extent and depth of provider networks, flexibility and scope of benefits, quality of services, market presence, reputation (which may be affected by public rankings or accreditation by voluntary organizations such as NCQA and URAC) and financial stability. WellPoint believes that it competes effectively against other health care industry participants.

Government Regulation

California

DMHC and DOI Regulation. WellPoint offers its managed health care products in California principally through its wholly owned indirect subsidiary Blue Cross of California, which is subject to regulation by the California Department of Managed Health Care (the "DMHC") under the Knox−Keene Health Care Service Plan Act of 1975 (the "Knox−Keene Act"). The insurance business conducted by the Company's subsidiary BC Life & Health Insurance Company ("BC Life") is regulated by the California Department of Insurance (the "California DOI"). Each entity is subject to various minimum capital and other requirements, such as restrictions on the payment of dividends or the issuance of capital stock, established by its respective regulatory authority. Blue Cross of California's managed health care programs are also subject to extensive DMHC regulation regarding benefit and coverage levels, relationships with health care providers, administrative capacity, marketing and advertising, procedures for quality assurance and subscriber and enrollee grievance resolution. Any material modifications to the organization or operations of Blue Cross of California are subject to prior review and approval by the DMHC. BC Life must obtain approval from the California DOI for all of its group insurance policies and certain aspects of its individual policies prior to issuing those policies, as well as certain other material actions which BC Life may propose to take. The failure to comply with applicable regulations can subject BCC or BC Life to various penalties, including fines or the imposition of restrictions on the conduct of its operations.

California Health Care Reform Legislation

Since September 1999, California Legislature has adopted a number of health care reform measures. The following is a summary of the material terms of the most significant of these laws.

The Managed Health Care Insurance Accountability Act of 1999 ("SB 21") established an explicit duty on managed care entities to exercise ordinary care in arranging for the provision of medically necessary health care services to their subscribers and imposed liability for all harm legally caused by the failure to exercise such ordinary care. Managed care entities may be held liable if their failure to exercise ordinary care results in the denial, delay or modification of a health care service recommended for or furnished to the subscriber and the subscriber suffers "substantial harm." For purposes of the statute, "substantial harm" is defined as the loss of life, loss of or significant impairment of a limb or bodily function, significant disfigurement, severe and chronic pain or significant financial loss. Liability may be established for health care services regardless of whether the recommending health care provider is a contracting provider with the managed care entity. Managed care plans may not seek indemnity from a health care provider for the liability imposed by the statute. A cause of action may not be maintained under the statute against a managed care entity unless the subscriber has exhausted independent medical review procedures, except in instances where substantial harm has occurred or will imminently occur prior to the completion of the independent medical review.

Assembly Bill 55 ("AB 55") established an independent medical review system. Every health plan enrollee, whether currently under the regulatory supervision of the DMHC or the California DOI, must

be provided with an opportunity to seek an independent medical review whenever health care services have been denied, modified or delayed by a managed care entity or one of its contracting physicians, if this decision was based on a finding that the proposed services are not medically necessary. There is no minimum dollar level for claims to be subject to the independent review process and the enrollee does not have any responsibility for the payment of any application or processing fee. An enrollee's provider may assist and advocate in the review. All health plan contracts must provide an opportunity to seek an independent review. The statute does not apply to decisions by a health plan that health care services are not covered under the plan issued to the subscriber.

Assembly Bill 88 ("AB 88") required that any health care service plan contract or disability insurance policy must provide coverage for the diagnosis and medically necessary treatment of severe mental illness under the same terms and conditions applied to other medical conditions.

Assembly Bill 78 ("AB 78") provided for the creation of the DMHC, which now regulates the health care service plan operations previously under the supervision of the California Department of Corporations. The DMHC is advised by an advisory committee consisting of 22 members, 11 of whom are appointed by the Governor, 10 of whom are appointed by the joint recommendation of the Governor, the Speaker of the California Assembly and the California Senate Committee on Rules and one of whom is the Director of the Department (who is appointed by the Governor). This advisory committee is required to issue an annual report, which will include a report card issued to the public on the comparative performance of managed care organizations. This bill also established an Office of Patient Advocate, who is appointed by the California Governor, to represent the interest of enrollees. The Office of Patient Advocate is charged with the responsibility of helping enrollees secure health care services and will have access to the records of the DMHC. Under the legislation, the new DMHC has been granted expanded powers, including the ability to order the discontinuance of "unsafe or injurious practices."

Senate Bill 260 ("SB 260") established a Financial Solvency Standards Board (the "Board") comprised of the Director of the Department of Managed Care (the "Director") and seven members appointed by the Director. The Board reviews financial solvency matters affecting the delivery of health care services and recommends financial solvency requirements relating to plan operations, plan−affiliate operations and transactions, plan−provider contractual relationships and provider−affiliate operations and transactions. Every contract between a health care service plan and a risk−bearing organization (i.e., any provider group that provides services in exchange for fixed capitation payments) must include a requirement that the risk−bearing organization furnish financial information to the health care service plan. In addition, the health care service plan must disclose information to the risk−bearing organization that enables the organization to be informed regarding its financial risk. Plans must provide payment of all risk arrangements, excluding capitation payments, within 180 days after the close of each fiscal year. Risk−bearing organizations may not be at financial risk for the provision of health care services unless a particular contract provision allocating such risk has first been negotiated and agreed to between the health care service plan and the risk−bearing organization. In addition, no contract between a health care service plan and a risk−bearing organization may include any provision that requires a health care provider to accept rates or methods of payments unless the provisions have first been negotiated and agreed to between the plan and the risk−bearing organization.

Senate Bill 559 ("SB 559") imposed certain disclosure obligations and other limitations on health care plans, such as the Company, that make their networks of contracted providers available to other entities. Under SB 559, health care plans must disclose to contracting providers that they intend to make their health care networks and the negotiated discounts available to other payors such as self−insured employers or workers' compensation insurance companies. Providers may decline to be included in any list of contracted providers made available to any payor entity that does not provide financial incentives to, or otherwise actively encourage, the payor's members to use the list of contracting providers when obtaining medical care.

Assembly Bill 1455 ("AB 1455") imposed new time limits for the payment of uncontested covered claims and required health care service plans to pay interest on uncontested claims not paid promptly within the required time period. AB 1455 also granted the DMHC additional authority to impose monetary penalties and other sanctions on health plans engaging in certain "unfair payment practices" (as defined in AB 1455).

The California Legislature has also adopted legislation that imposes restrictions on the categories of persons that may be involved in medical management activities and on the conduct of such activities. Various other newly adopted bills mandate coverage for certain benefits, such as the provision of oral contraceptives, and place further limitations on health plan operations.

Federal

A variety of federal laws have been adopted in the last several years effecting the Company's operations and a significant number of measures have also been proposed for future adoption. The following is a summary of the significant enacted measures as well as proposed measures.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the implementing regulations that have thus far been adopted impose new obligations for issuers of health insurance coverage and health benefit plan sponsors. HIPAA requires certain guaranteed issuance and renewability of health coverage for individuals and small groups (generally 50 or fewer employees) and limits exclusions based on preexisting conditions. Most of the insurance reform provisions of HIPAA became effective for "plan years" beginning July 1, 1997.

HIPAA also establishes new requirements regarding the confidentiality of patient health information and regarding standard formats for the transmission of health care data. In December 2000, the Department of Health and Human Services promulgated final regulations regarding the privacy of "protected health information." The rules would, among other things, require that health plans give patients a clear written explanation of how they intend to use, keep and disclose patient health information, prohibit health plans from conditioning payment or coverage on a patient's agreement to disclose health information for other purposes, and create federal criminal penalties for health plans, providers and claims clearinghouses that knowingly and improperly disclose information or obtain information under false pretenses. Final regulations regarding the standard formats for the transmission of health care information have also been released, with an effective date of October 2002. In December 2001, legislation was enacted which offered health entities the option of extending the date for compliance with these regulations until October 2003. The Company currently expects that it will file for such extension. The privacy and standardization regulations could have the effect of increasing the Company's expenses.

Maternity length of stay and mental health parity benefits measures became effective for plan years beginning January 1, 1998. The maternity stay provision requires health plans to cover the cost of a 48−hour hospital stay (96 hours following a Caesarian section). This measure does not mandate the length of hospital stays but requires that longer stays be covered if deemed necessary by the mother or her physician (in consultation with the mother). Although many states already guarantee minimum hospital stays for mothers and newborns, these measures have further increased WellPoint's claims expense.

Balanced Budget Act. In August 1997, President Clinton signed into law the Balanced Budget Act of 1997 (the "Balanced Budget Act"). The Balanced Budget Act included a number of measures affecting the provision of health care. The act placed restrictions on the variation in Medicare reimbursement amounts (so−called "risk adjusters") between counties. CMS has released proposed risk adjusters, which are currently expected to be implemented in phases through the year 2005. In addition, the Balanced Budget Act ostensibly expanded the managed health plan options available to Medicare enrollees to include PPO, POS and high deductible health plans intended for MSAs. Regulations

regarding these changes were adopted in June 1998. Finally, the Balanced Budget Act implemented certain changes with respect to Medicare supplement programs, including guaranteed coverage issues. Certain of the changes under the Balanced Budget Act could have the result of increasing the Company's costs.

Medicare Legislation. WellPoint's health benefits programs include products that are marketed to Medicare beneficiaries as a supplement to their Medicare coverage. These products are subject to Federal regulations intended to provide Medicare supplement customers with standard minimum benefits and levels of coverage and full disclosure of coverage terms and assure that fair sales practices are employed in the marketing of Medicare supplement coverage.

In California and Georgia, WellPoint provides a senior plan product under a Medicare + Choice contract that is subject to regulation by CMS. Under this contract and CMS regulations, if WellPoint's premiums received for Medicare−covered health care services provided to senior plan Medicare members are more than the Company's projected costs associated with the provision of health care services provided to senior plan members, then WellPoint must provide its senior plan members with additional benefits beyond those required by Medicare or reduce its premiums, or deductibles or co−payments, if any. CMS has the right to audit HMOs operating under Medicare contracts to determine the quality of care being rendered and the degree of compliance with CMS' contracts and regulations.

Future Health Care Reform. A number of legislative proposals have been made at the Federal and state levels over the past several years. These proposals would, among other things, mandate benefits with respect to certain diseases or medical procedures, require plans to offer an independent external review of certain coverage decisions or establish health plan liability in a manner similar to the California legislation discussed above or the Georgia and Texas legislation discussed in the following section. The United States Congress is currently considering a number of alternative health care reform measures that would, among other things, mandate external review of treatment denial decisions and provide for managed care liability. There have also been proposals made at the Federal level to implement greater restrictions on employer−funded health plans, which are generally exempted from state regulation by ERISA.

WellPoint is unable to evaluate what legislation may be proposed and when or whether any legislation will be enacted and implemented. However, many of the proposals, if adopted, could have a material adverse effect on WellPoint's financial condition, cash flows or results of operations, while others, if adopted, could potentially benefit WellPoint's business.

Other States

The Company's activities in other states are subject to state regulation applicable to the provision of managed health care services and the sale of traditional health indemnity insurance. As a result of the Company's various acquisitions, the Company and certain of its subsidiaries are also subject to regulation by the DOI in Delaware (which is the state of incorporation and domicile of UNICARE Life & Health Insurance Company, one of the Company's principal operating subsidiaries outside of California), Georgia, Illinois, Indiana, Missouri, Texas and in all other states. As the Company expands its offering of managed care products in new geographic locations, it will be subject to additional regulation by governmental agencies applicable to the provision of health care services. The Company believes it is in compliance in all material respects with all current state regulatory requirements applicable to its business as presently conducted. However, changes in government regulations could affect the level of services which the Company is required to provide or the rates which the Company can charge for its health care products and services.

As the Company continues to expand its operations outside of California, new legislative and regulatory developments in Delaware, Georgia, Illinois, Missouri, Texas and various other states will

have greater potential effect on the Company's financial condition, cash flows or results of operations. In 1999 the Georgia Legislature adopted several new bills, including one that requires managed care plans to offer coverage for services rendered by out−of−network providers and one that establishes a Consumers' Insurance Advocate with authority to review and comment upon matters pending before the Department of Insurance. Over the past few years, there has also been an increase in other states in proposed legislation regarding, among other things, mandated benefits, prompt payment of claims, health plan liability, third−party review of health plan coverage determinations and health plan relationships with providers. The Company expects that this trend of increased legislation will continue. These laws may have the effect of increasing the Company's claims expense.

In 1997, the Texas legislature adopted SB 386 which, among other things, purports to make managed care organizations ("MCOs") such as the Company liable for the failure by the MCO, its employees or agents to exercise ordinary care when making "health care treatment decisions" (as defined in the legislation). The legislation was effective as of September 1, 1997. In September 1998, the United States District Court for the Southern District of Texas ruled, in part, that the MCO liability provisions of SB 386 are not preempted by ERISA. To date, this legislation has not adversely affected the Company's results of operations. However, although the Company maintains insurance covering such liabilities, to the extent that this legislation (or similar legislation that may be subsequently adopted at the Federal or state level) effectively expands the scope of liability of MCOs, such as the Company, it may have a material adverse effect on the Company's results of operations, financial condition and cash flows. Even if the Company is not held liable under any litigation, the existence of potential MCO liability may cause the Company to incur greater costs in defending such litigation.

In connection with the GBO acquisition, the Company has entered into a reinsurance arrangement, on a 100% coinsurance basis, of the insured business of the GBO. This business includes a small number of insured persons in Canada covered by group policies issued to U.S.−based employers. As a result, the Company may be subject to certain rules and regulations of applicable Canadian regulatory agencies.

Service Marks

WellPoint and its subsidiaries have filed for registration of and maintain several service marks, trademarks and trade names at the Federal level and in various states in which it operates. WellPoint and various of its operating subsidiaries are currently parties to license agreements with the Blue Cross Blue Shield Association (the "BCBSA") which allow them to use the Blue Cross or Blue Shield names and marks in California, Georgia and parts of Missouri with respect to WellPoint's HMO and PPO network−based plans. The BCBSA is a national trade association of Blue Cross and Blue Shield licensees. Each licensee is an independent legal organization and is not responsible for the obligations of other BCBSA member organizations. A Blue Cross or Blue Shield license requires payment of a fee to the BCBSA and compliance with various requirements established by the BCBSA, including the maintenance of specified minimum capital. The failure to meet such capital requirements can subject the Company to certain corrective action, while the failure to meet a lower specified level of capital can result in termination of the Company's license agreement with the BCBSA. WellPoint considers the licensed Blue Cross and Blue Shield names and their registered service marks, trademarks and trade names important in the operation of its business.

Employees

At December 31, 2001, WellPoint and its subsidiaries employed approximately 13,900 persons. Approximately 145 of the Company's employees are presently covered by a collective bargaining agreement with the Office and Professional Employees International Union, Local 29. Approximately 163 of the Company's office clerical employees in the greater Detroit area are presently covered by a collective bargaining agreement with the International Brotherhood of Teamsters, Chauffeurs,

Warehousemen and Helpers of America, Local No. 614. As of December 31, 2001, RightCHOICE and its subsidiaries employed approximately 2,300 persons. WellPoint believes that its relations with its employees are good, and it has not experienced any work stoppages.

Executive Officers

Leonard D. Schaeffer, age 56, has been Chairman of the Board of Directors and Chief Executive Officer of the Company since August 1992. Mr. Schaeffer has also been Chief Executive Officer of BCC since 1986 and Chairman of the Board of Directors since 1989. From 1982 to 1986, Mr. Schaeffer served as President of Group Health, Inc., an HMO in the midwestern United States. Prior to joining Group Health, Inc., Mr. Schaeffer was the Executive Vice President and Chief Operating Officer of the Student Loan Marketing Association, a financial institution that provides a secondary market for student loans, from 1980 to 1981. From 1978 to 1980, Mr. Schaeffer was the Administrator of HCFA (now known as CMS), which administers the Federal Medicare and Medicaid programs. Mr. Schaeffer serves as a director of Allergan, Inc. and Providian Financial Corporation.

D. Mark Weinberg, age 49, has been Executive Vice President and Chief Development Officer since February 2002. From March 1999 until February 2002, he was Executive Vice President, Individual and Small Group Division of the Company since April 1999. From October 1995 until March 1999, he served as Executive Vice President, UNICARE Businesses of the Company. From August 1992 until May 1996, Mr. Weinberg served as a director of the Company. From February 1993 to October 1995, Mr. Weinberg was Executive Vice President, Consumer and Specialty Services of the Company. Prior to February 1993, Mr. Weinberg was Executive Vice President of BCC's Consumer Services Group from December 1989 to February 1993 and was Senior Vice President of Individual and Senior Services of BCC from April 1987 to December 1989. From 1981 to 1987, Mr. Weinberg held a variety of positions at Touche Ross & Co. From 1976 to 1981, Mr. Weinberg was general manager for the CTX Products Division of PET, Inc.

Joan E. Herman, age 48, joined the Company in June 1998 as Executive Vice President, Specialty Division. From April 1999 until March 2000, Ms. Herman was Executive Vice President, Senior and Specialty Businesses. Since March 2000, Ms. Herman has been Executive Vice President, Senior Specialty and State−Sponsored Programs Division. From 1982 until joining the Company, Ms. Herman was with Phoenix Home Life Mutual Insurance Company, a mutual insurance company, most recently serving as Senior Vice President. Ms. Herman is a member of the Society of Actuaries and American Academy of Actuaries.

David S. Helwig, age 45, has been Executive Vice President, Blue Cross of California Businesses since February 2002. From March 2001 until February 2002, he was Executive Vice President, Large Group Division of the Company. From May 2000 until March 2001, Mr. Helwig was Senior Vice President, Western Region, Large Group Businesses of the Company and from March 1999 until May 2000, Mr. Helwig served as Senior Vice President and Chief Actuary for the Company. From 1995 until March 1999, Mr. Helwig served as Senior Vice President of Individual and Small Group Services for the Company and from May 1994 until 1995, Mr. Helwig was Senior Vice President of Consumer Services for CaliforniaCare Health Plans, a subsidiary of the Company. From 1991 to May 1994, Mr. Helwig was Senior Vice President and Chief Actuary of Blue Cross of California and from February 1993 until May 1994, Mr. Helwig also served as Chief Financial Officer and Treasurer of Blue Cross of California.

Rebecca Kapustay, age 50, has been Executive Vice President, Blue Cross and Blue Shield of Georgia since March 2001. From 1979 until 1992, Ms. Kapustay held various positions with Blue Cross of California of increasing responsibility in both operations and data processing. From 1993 until April 1994, Ms. Kapustay was General Manager of the Company and from May 1994 until 2000, Ms. Kapustay held various positions with the Company including Senior Vice President, California Operations and more recently Senior Vice President, Large Group Services.

John A. O'Rourke, age 58, joined the Company in February 2002 as Executive Vice President, Central Business Region. From February 1997 until January 2002, Mr. O'Rourke was Chairman and Chief Executive Officer of RightCHOICE Managed Care, Inc. From January 1985 until joining RightCHOICE, Mr. O'Rourke was President and Chief Executive Officer of HealthLink. Prior to joining HealthLink Mr. O'Rourke was Deputy Director of the Office of HMOs in the U.S. Department of Health and Human Services.

David C. Colby, age 48, joined the Company in September 1997 as Executive Vice President and Chief Financial Officer. From April 1996 until joining the Company, Mr. Colby was Executive Vice President, Chief Financial Officer and Director of American Medical Response, Inc., a health care services company focusing on ambulance services and emergency physician practice management. From July 1988 until March 1996, Mr. Colby was with Columbia/HCA Healthcare Corporation, most recently serving as Senior Vice President and Treasurer. From September 1983 until July 1988, Mr. Colby was Senior Vice President and Chief Financial Officer of The Methodist Hospital in Houston, Texas.

Thomas C. Geiser, age 51, has been Executive Vice President, General Counsel and Secretary of the Company since May 1996. From July 1993 until May 1996, Mr. Geiser held the position of Senior Vice President, General Counsel and Secretary. Prior to joining the Company, he was a partner in the law firm of Brobeck, Phleger & Harrison from June 1990 to June 1993 and a partner in the law firm of Epstein Becker Stromberg & Green from May 1985 to May 1990. Mr. Geiser joined the law firm of Hanson, Bridgett, Marcus, Vlahos & Stromberg as an associate in March 1979 and became a partner in the firm, leaving in May 1985.

Woodrow A. Myers, Jr., M.D., age 48, has been Executive Vice President, Chief Medical Officer of the Company since September 2000. From 1995 until September 2000, he served as Director, Healthcare Management of Ford Motor Company. From 1991 until 1995, Dr. Myers served as Senior Vice President and Corporate Medical Director of The Associated Group (now known as Anthem Blue Cross Blue Shield). From 1990 to 1991, Dr. Myers was the Commissioner of Health for the City of New York. Dr. Myers serves as a director of Somnus Medical Technologies.

Alice F. Rosenblatt, age 53, has been Executive Vice President and Chief Actuary of the Company since March 2002. From October 1996 until March 2002, she served as Senior Vice President and Chief Actuary of the Company. From February 1994 until September 1996, Ms. Rosenblatt was a partner with Coopers & Lybrand LLP. From May 1989 until December 1993, Ms. Rosenblatt served as the Senior Vice President and Chief Actuary of Blue Cross Blue Shield of Massachusetts. From 1987 until 1989, Ms. Rosenblatt served as the Chief Actuary and Senior Vice President of Blue Cross of California's health maintenance organization and group services.

May 1996 Recapitalization and Restrictions on Ownership and Transfer of Securities

The Company's predecessor, WellPoint Health Networks Inc., a Delaware corporation ("Old WellPoint"), was organized in 1992 as a public for−profit subsidiary of Blue Cross of California ("BCC"), to own and operate substantially all of the managed health care businesses of BCC. In order to fulfill BCC's public benefit obligations to the State of California arising out of the creation of Old WellPoint, BCC and Old WellPoint undertook a recapitalization (the "Recapitalization") which was concluded on May 20, 1996. As a result of the Recapitalization, among other things, Old WellPoint merged into BCC, a special dividend of $995.0 million was made to the shareholders of Old WellPoint

and the California HealthCare Foundation (the "Foundation") became the holder of 53,360,000 shares, or approximately 80%, of the surviving WellPoint entity. As of January 2001, the Foundation ceased to own any shares of WellPoint Common Stock.

In connection with the Recapitalization, BCC relinquished its rights under the Blue Cross License Agreement dated January 1, 1991, between Blue Cross of California and the BCBSA. The BCBSA and the Company entered into a new License Agreement (the "License Agreement"), pursuant to which the Company became the exclusive licensee for the right to use the Blue Cross name and related service marks in California and became a member of the BCBSA. See "Service Marks."

At the time of the Recapitalization, pursuant to an agreement with the BCBSA, the Company's Certificate of Incorporation included an "Ownership Limit" with respect to the Company's voting securities. At such time, the "Ownership Limit" was established as one share less than 5% of the Company's outstanding voting securities. In December 1997, the Company and the BCBSA, in accordance with the provisions of Article VII, Section 14(f)(2) of the Company's Certificate of Incorporation, agreed to modify the Ownership Limit to the following: (i) for any "Institutional Investor," one share less than 10% of the Company's outstanding voting securities; and (ii) for any "Noninstitutional Investor," other than the Foundation, one share less than 5% of the Company's outstanding voting securities. For these purposes, "Institutional Investor" means any person if (but only if) such person is (1) a broker or dealer registered under Section 15 of the Securities Exchange Act of 1934 (the "Exchange Act"), (2) a bank as defined in Section 3(a)(6) of the Exchange Act, (3) an insurance company as defined in Section 3(a)(19) of the Exchange Act, (4) an investment company registered under Section 8 of the Investment Company Act of 1940, (5) an investment adviser registered under Section 203 of the Investment Advisers Act of 1940, (6) an employee benefit plan, or pension fund which is subject to the provisions of the Employee Retirement Income Security Act of 1974 or an endowment fund, (7) a parent holding company, provided the aggregate amount held directly by the parent, and directly and indirectly by its subsidiaries which are not persons specified in paragraphs (1) through (6), does not exceed one percent of the securities of the subject class, or (8) a group, provided that all the members are persons specified in paragraphs (1) through (7). In addition, every filing made by such person with the SEC under Regulation 13D−G (or any successor Regulation) under the Exchange Act with respect to such person's beneficial ownership must contain a certification (or a substantially similar one) that the WellPoint Common Stock acquired by such person was acquired in the ordinary course of business and was not acquired for the purpose of and does not have the effect of changing or influencing the control of WellPoint and was not acquired in connection with or as a participant in any transaction having such purpose or effect. For such purposes, "Noninstitutional Investor" means any person that is not an Institutional Investor.

In December 1997, the Company and the BCBSA also agreed that the License Agreement would be subject to termination in the event that any entity other than the Foundation became the beneficial owner of 20% or more of WellPoint's then−outstanding Common Stock or other equity securities which (either by themselves or in combination) represented an ownership interest of 20% or greater. WellPoint also agreed that it would not issue any class or series of securities other than shares of Common Stock, non−voting, non−convertible debt securities or such other securities as WellPoint may approve, provided that WellPoint will provide the BCBSA with at least 30 days advance notice of the issuance of such securities and the BCBSA will have the authority to determining how such securities will be treated for purposes of determine a particular holder's beneficial ownership of Common Stock.

In July 1999, WellPoint issued an aggregate of $299 million in principal amount at maturity of Zero Coupon Convertible Subordinated Debentures Due 2019 (the "Debentures"). The BCBSA has determined that it will treat a holder of Debentures at a particular time as beneficially owning shares of Common Stock equal to the greater of (i) the number of shares into which the Debentures could be converted upon exercise of the conversion right of the Debentures at such time, and (ii) the number of shares of Common Stock which the holder would receive if WellPoint paid the holder in shares of

Common Stock upon exercise of the holder's redemption right (assuming redemption of the Debentures at a price equal to the original issue price plus then−accrued original issue discount and based on the then−current market price of the Common Stock). This deemed beneficial ownership will be aggregated with a Debentureholder's other beneficial ownership of Common Stock for purposes of determining if the Ownership Limit provisions have been violated. Any Debentureholder's deemed beneficial ownership of Common Stock may fluctuate as a result of changes in the market price of the Common Stock.

In connection with the Recapitalization, BCC also received a ruling from the IRS that, among other things, the conversion of BCC from a nonprofit public benefit corporation to a for−profit entity (the "BCC Conversion") qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. The Foundation and the Company have entered into an Indemnification Agreement which provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes.

In August 1997, pursuant to approval by the stockholders at the Company's 1997 Annual Meeting, the Company reincorporated in the state of Delaware. Each of the material agreements (other than the Indemnification Agreement) entered into in connection with the Recapitalization was amended and restated on substantially similar terms at the time of the reincorporation.

In connection with the RightCHOICE transaction, the Missouri Foundation for Health (the "Missouri Foundation"), which was formerly the largest stockholder of RightCHOICE, acquired 4,805,200 shares of WellPoint Common Stock, or approximately 6.7% of the then−outstanding WellPoint Common Stock. Because the Missouri Foundation did not qualify as an Institutional Investor for purposes of the Ownership Limit, the Company requested and received a waiver of the Ownership Limit requirements from the BCBSA. In connection therewith, the Missouri Foundation committed to sell sufficient shares of WellPoint Common Stock such that its ownership would be reduced to below 5% of WellPoint's outstanding voting securities on or prior to January 31, 2003. As of March 2002, the Missouri Foundation had sold sufficient shares to reduce its ownership to below 5% of WellPoint's outstanding voting securities.

Factors That May Affect Future Results of Operations

Certain statements contained in "Item 1. Business," such as statements concerning the Company's geographic expansion and other business strategies, the effect of recent health care reform legislation, changes in the competitive environment and small group membership growth and other statements contained herein regarding matters that are not historical facts, are forward−looking statements (as such term is defined in the Securities Exchange Act of 1934). Such statements involve a number of risks and uncertainties that may cause actual results to differ from those projected. Factors that can cause actual results to differ materially include, but are not limited to, those discussed below. Readers are cautioned not to place undue reliance on these forward−looking statements, which speak only as of the date hereof.

Federal and State Health Care Regulation; Legislative Reform; Activities as Government Contractor

WellPoint's operations are subject to substantial regulation by Federal, state and local agencies. Such regulation may either relate to the Company's business operations or to the financial condition of regulated subsidiaries. With regard to the former, regulation typically covers prescribed benefits, prompt payment of claims, relationships with providers, marketing, advertising, quality assurance and member grievance resolution. With regard to the latter, regulation typically governs the amount of capital required to be retained in regulated subsidiaries and the ability of such subsidiaries to pay dividends. From time to time, the Company and its subsidiaries receive requests for information from

regulatory agencies or are notified that such agencies or other officials are conducting reviews, investigations or other proceedings with respect to certain of the Company's activities. There can be no assurance that any past or future regulatory action by any such agencies will not have a material adverse effect on the profitability or marketability of WellPoint's health plans, the Company's ability to access capital from the operations of its regulated subsidiaries or on its financial condition, cash flows or result of operations.

In addition to capital requirements imposed by the DMHC and certain Departments of Insurance, the Company and its BCBSA−licensed affiliates are required to maintain certain levels of capital to satisfy BCBSA requirements. During 1998, the National Association of Insurance Commissioners (the "NAIC"), the trade association representing state insurance regulators, adopted a risk−based capital formula for licensed managed care organizations called Managed Care Organization Risk−Based Capital ("MCORBC"). The NAIC also approved an accompanying Risk−Based Capital for Health Organizations Model Act (the "Model Act"), which will serve as a model for states considering enacting new legislation. The BCBSA adopted the MCORBC formula effective as of December 31, 1999. If adopted by states, the minimum capital requirements under the Model Act are not expected to have a material impact on the Company, although there can be no assurances that new minimum capital requirements will not increase the Company's capital requirements in the future.

The health care industry has become the subject of greater legislative and media scrutiny in recent years. In 1999, California adopted a considerable number of health care reform measures, including legislation providing for health plan liability and independent review of health plan decisions. See "Government Regulation." An increasing number of proposals are being considered by the United States Congress and state legislatures relating to health care reform and the Company expects that some of such proposals will be enacted. There can be no assurance that compliance with recently enacted or future legislation will not have a material adverse impact on WellPoint's claims expense, financial condition, cash flows or results of operations.

The Company provides insurance products to Medi−Cal beneficiaries in various California counties under contracts with the DHS (or a delegated local agency). The Company also provides administrative services for CMS in various capacities, including certain Medicare programs and under its Blue Cross Senior Secure plan. There can be no assurance that acting as a government contractor in these circumstances will not increase the risk of heightened scrutiny by such government agencies, or that the profitability from this business will not be adversely affected through inadequate premium rate increases due to governmental budgetary issues. Future actions by any regulatory agencies may have a material adverse effect on the Company's business.

As a result of the PrecisionRx transaction completed in December 2000, one of the Company's subsidiaries conducts business as a mail order pharmacy. The pharmacy business is subject to extensive federal, state and local regulations which are in many instances different from those under which the Company's traditional health care businesses operate. The failure to properly adhere to these and other applicable regulations could result in the imposition of civil and criminal penalties, which could adversely affect the Company's result of operations or financial condition. In addition, pharmacies are exposed to risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Although the Company intends to maintain professional liability insurance, there can be no assurances that the coverage limits under such insurance programs will be adequate to protect against future claims or that the Company will be able to maintain insurance on acceptable terms in the future.

Pending Transaction with CareFirst

WellPoint has entered into the CareFirst Merger Agreement pursuant to which CareFirst will become a wholly owned subsidiary of the Company (See "Recent Completed Transactions and Pending Transactions—Pending Acquisition of CareFirst.") Completion of this transaction is subject to the satisfaction of a number of conditions, including approval of the insurance regulators in each of

Maryland, Delaware and the District of Columbia. In addition, one of CareFirst's operating affiliates must have its federal charter amended or repealed by the United States Congress (subject to presidential approval) and must obtain approval from the Washington D.C. Corporation Counsel. There can be no assurances that the required approvals will be obtained. If all conditions to closing are not met on or before November 20, 2004, each of WellPoint and CareFirst will have the right to terminate the CareFirst Merger Agreement. As a result, there can be no assurances that the transaction will be consummated.

As a condition to approval of the transaction, regulatory agencies may seek to impose requirements or limitations on the way that the combined company conducts it business. Although neither WellPoint nor CareFirst is obligated to agree to any material requirements or limitations in order to obtain approval, if either or both companies were to agree to any such conditions, such requirements or limitations or additional costs associated therewith could adversely affect WellPoint's ability to integrate the operations of CareFirst with those of WellPoint. Accordingly, a material adverse effect on WellPoint's revenue, results of operations and cash flows following the CareFirst transaction could result.

Indebtedness from Completed and Pending Acquisitions

In connection with the RightCHOICE and Cerulean transactions, the Company incurred significant additional indebtedness to fund the cash payments made to the acquired companies' stockholders. In addition, the Company currently expects to incur additional indebtedness to fund some or all of the cash payments to be made in connection with the pending CareFirst transaction. This existing or new indebtedness may result in a significant percentage of the Company's cash flow being applied to the payment of interest, and there can be no assurance that the Company's operations will generate sufficient future cash flow to service this indebtedness. The Company's current indebtedness, as well as any indebtedness that the Company may incur in the future (such as indebtedness incurred to fund repurchases of its Common Stock or to fund the CareFirst or other transactions), may adversely affect the Company's ability to finance its operations and could limit the Company's ability to pursue business opportunities that may be in the best interests of the Company and its stockholders.

Class Action Lawsuits and Other Evolving Theories of Recovery

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in the ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California

Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11 th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Health Care Costs and Premium Pricing Pressures

WellPoint's future profitability will depend in part on accurately predicting health care costs and on its ability to control future health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. Changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups and numerous other factors affecting health care costs may adversely affect WellPoint's ability to predict and control health care costs as well as WellPoint's financial condition, results of operations or cash flows. Periodic renegotiations of hospital and other provider contracts, coupled with

continued consolidation of physician, hospital and other provider groups, may result in increased health care costs or limit the Company's ability to negotiate favorable rates. In the past few years, large physician practice management companies have experienced extreme financial difficulties (including bankruptcy), which may subject the Company to increased credit risk related to provider groups and cause the Company to incur duplicative claims expense.

In addition to the challenge of controlling health care costs, the Company faces competitive pressure to contain premium prices. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, the Company expects that price will continue to be a significant basis of competition. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates for government−sponsored programs. WellPoint's financial condition or results of operations would be adversely affected by significant premium decreases by any of its major competitors or by any limitation on the Company's ability to increase or maintain its premium levels.

Integration of Acquisitions; Geographic Expansion Strategy; Future Acquisitions

One component of the Company's business strategy has been to diversify into new geographic markets, particularly through strategic acquisitions. The Company has completed a number of significant acquisitions since 1996. Since the relevant dates of acquisition, the Company has worked extensively on the integration of the acquired MMHD, GBO and Rush Prudential businesses. The Company has also completed significant work on the integration of the Cerulean businesses. The Company expects to begin its integration of RightCHOICE during the remainder of 2002. The Company is continuing the consolidation of these acquired operations into its operations, which will require considerable expenditures and a significant amount of management time. Due to the complex nature of the merger integration process, particularly the information systems designed to serve these businesses, the Company may temporarily experience increases in claims inventory or other service−related issues that may negatively affect the Company's relationship with its customers and contribute to increased attrition of such customers. The success of these acquisitions will, among other things, also require the integration of a significant number of the employees into the Company's existing operations and the completion of the integration of separate information systems. No assurances can be given regarding the ultimate success of the integration of these acquisitions into the Company's business.

As the Company pursues its geographic expansion strategy, the Company's market share in new markets will not be as significant, and its provider networks not as extensive, as in California, Georgia and Missouri, and the Company will not have the benefit of the Blue Cross or Blue Shield names and marks which are important components of its success in California, Georgia and Missouri. The Company no longer has the benefit of the MassMutual, John Hancock or Rush Prudential trade names. There can be no assurance that the absence of one or more of these elements will not adversely affect the success of the Company's geographic expansion strategy.

The Company actively considers acquisition opportunities on a regular basis, both in connection with its geographic expansion strategy and its California operations. The Company currently has no existing agreements or commitments to effect any material acquisition, other than CareFirst. Accordingly, there can be no assurance that the Company will be able to identify additional acquisition, candidates available for sale at reasonable prices or consummate any acquisition or that any discussions will result in an acquisition. Any such acquisitions may require significant additional capital resources and there can be no assurance that the Company will have access to adequate capital resources to effect such future acquisitions. To the extent that the Company consummates acquisitions, there can be no assurance that such acquisitions will be successfully integrated into the Company or that such acquisitions will not adversely affect the Company's results of operations, cash flows and financial condition.

Prior to the Company's acquisition of the GBO, John Hancock Mutual Life Insurance Company ("John Hancock") entered into a number of reinsurance arrangements with respect to personal accident insurance and the occupational accident component of workers' compensation insurance, a portion of which was originated through a pool managed by Unicover Managers, Inc. Under these arrangements, John Hancock assumed risks as a reinsurer and transferred certain of such risks to other companies. These arrangements have become the subject of disputes, including a number of legal proceedings to which John Hancock is a party. The Company believes that it has a number of defenses to avoid any ultimate liability with respect to these matters and believes that such liabilities were not transferred to the Company as part of the GBO acquisition. However, if the Company were to become subject to such liabilities, the Company could suffer losses that might have a material adverse effect on its financial condition, results of operations or cash flows.

Competition

Managed health care organizations operate in a highly competitive environment that is subject to significant change from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other managed health care organizations, the development of companies offering Internet−based connections between providers, employers and members and other market pressures. A significant portion of the Company's operations are in California, where the managed health care industry is especially competitive. In addition, the managed health care industry in California has undergone significant changes in recent years, including substantial consolidation. Outside of California, the Company faces competition from other regional and national companies, many of which have (or due to future consolidation, may have) significantly greater financial and other resources and market share than the Company. If competition were to further increase in any of its markets, WellPoint's financial condition, cash flows or results of operations could be materially adversely affected.

A substantial portion of WellPoint's California business is in the individual and small employer group market, where the loss ratio is significantly lower than in the large employer group market. The individual and small employer group business constituted approximately 31.0% of WellPoint's total premium revenue for the year ended December 31, 2001. WellPoint has experienced increasing competition in the individual and small employer group market over the past several years, which could adversely affect WellPoint's loss ratio and future financial condition or results of operations. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations."

Dependence on Independent Agents and Brokers

The Company is dependent on the services of independent agents and brokers in the marketing of its health care plans, particularly with respect to individuals, seniors and small employer group members. Such independent agents and brokers are typically not exclusively dedicated to the Company and may frequently also market health care plans of the Company's competitors. The Company faces intense competition for the services and allegiance of independent agents and brokers.

Employee Matters

The Company is dependent on retaining existing employees and attracting and retaining additional qualified employees to meet its future needs. The Company faces intense competition for qualified employees and there can be no assurance that the Company will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. There can be no assurance that an inability to retain existing employees or attract additional employees will not have a material adverse effect on the results of operations of the Company. The Company is especially dependent on attracting and retaining qualified information technology personnel and other skilled professionals.

Tax Issues Relating to the WellPoint and RightCHOICE Recapitalizations

In connection with the Recapitalization, BCC received a ruling from the IRS that, among other things, the BCC Conversion qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. If the ruling were subsequently revoked, modified or not honored by the IRS (due to a change in law or for any other reason), WellPoint, as the successor to BCC, could be subject to Federal income tax on the difference between the value of BCC at the time of the BCC Conversion and BCC's tax basis in its assets at the time of the BCC Conversion. The potential tax liability to WellPoint if the BCC Conversion is treated as a taxable transaction is currently estimated to be approximately $696 million, plus interest (and possibly penalties). BCC and the Foundation entered into an Indemnification Agreement that provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes. In the event a tax liability should arise against which the Foundation has agreed to indemnify WellPoint, there can be no assurance that the Foundation will have sufficient assets to satisfy the liability in full, in which case WellPoint would bear all or a portion of the cost of the liability, which could have a material adverse effect on WellPoint's financial condition.

On November 30, 2000, RightCHOICE completed a reorganization (the "RightCHOICE Recapitalization") with its majority stockholder, RightCHOICE Managed Care, Inc., a Missouri corporation ("Old RightCHOICE"). As part of the RightCHOICE Recapitalization, the Missouri Foundation became the holder of approximately 80% of RightCHOICE Common Stock. In connection with the RightCHOICE Recapitalization, the predecessor of Old RightCHOICE, Blue Cross and Blue Shield of Missouri, received a ruling from the IRS that, among other things, the conversion of Blue Cross and Blue Shield of Missouri from a non−profit corporation to a for−profit corporation qualified as a reorganization under the Internal Revenue Code and that Blue Cross and Blue Shield of Missouri recognized no gain or loss for federal income tax purposes. If the IRS subsequently revoked, modified or decided not to honor the ruling due to a change in law or for any other reason, RightCHOICE, as the successor to Old RightCHOICE, could be subject to federal income tax on the difference between the value of each of Blue Cross and Blue Shield of Missouri's assets at the time of the RightCHOICE Recapitalization and its tax basis in its assets at the time of the RightCHOICE Recapitalization. RightCHOICE is now a wholly owned subsidiary of WellPoint. RightCHOICE and the Missouri Foundation entered into an indemnification agreement that provides, with certain exceptions, that the Missouri Foundation will indemnify RightCHOICE against the tax liability as a result of the IRS's revocation or modification, in whole or in part, of its ruling, or an IRS determination that RightCHOICE's conversion was a taxable transaction for federal income tax purposes. If a tax liability should arise against which the Missouri Foundation has agreed to indemnify RightCHOICE, the Missouri Foundation may not have sufficient assets to pay the liability. RightCHOICE would then bear all or a portion of the liability, which could have a material adverse effect on RightCHOICE's and the Company's financial condition.

Item 2. Properties.

Effective as of January 1, 1996, the Company entered into a lease for Blue Cross of California's Woodland Hills, California headquarters facility, which provides for a term expiring in December 2019 with two options to extend the term for up to two additional five−year terms. In 1997, the Company entered into a lease, which expires in December 2019, for a new facility located in Thousand Oaks, California housing certain corporate and specialty services. This facility was completed in January 1999. The Company and its subsidiaries have additional offices in the greater Los Angeles and Ventura County area. As a result of the Company's continuing national expansion efforts, the Company leases or owns offices in various other locations, including Atlanta and Columbus, Georgia; St. Louis, Missouri; Springfield, Massachusetts; Charlestown, Massachusetts; the greater Chicago, Illinois area;

Dearborn, Michigan; and Plano, Texas. As a result of the PrecisionRx acquisition, the Company now owns an approximately 79,000 square foot mail−order pharmacy distribution facility in the greater Fort Worth, Texas area.

Item 3. Legal Proceedings.

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in the ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et. al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of

"bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Item 4. Submission of Matters to a Vote of Security Holders.

None.

PART II

Item 5. Market for the Registrant's Common Equity and Related Stockholder Matters

The Company's Common Stock has been traded on the New York Stock Exchange under the symbol "WLP" since the Company's initial public offering on January 27, 1993. The following table sets forth for the periods indicated the high and low sale prices for the Common Stock. The information shown below has been adjusted to reflect the Company's two−for−one stock split in the form of a stock dividend, which was effective on March 15, 2002.

	High	Low
Year Ended December 31, 2000		
First Quarter	$ 39.25	$ 28.47
Second Quarter	39.94	33.38
Third Quarter	48.19	35.19
Fourth Quarter	60.75	45.78
Year Ended December 31, 2001		
First Quarter	57.88	42.38
Second Quarter	50.09	40.83
Third Quarter	54.97	46.40
Fourth Quarter	61.45	49.75

On March 18, 2002 the closing price on the New York Stock Exchange for the Company's Common Stock was $62.48 per share. As of March 18, 2002, there were approximately 621 holders of record of Common Stock.

The Company did not pay any dividends on its Common Stock in 2000 or 2001. Management currently expects that all of WellPoint's future income will be used to expand and develop its business. The Board of Directors currently intends to retain the Company's net earnings during 2002.

Item 6. Selected Financial Data.

	Year Ended December 31,				
	2001	2000	1999	1998	1997
	(In thousands, except per share data, membership data and operating statistics)				
Consolidated Income Statements(A)(B)					
Revenues:					
Premium revenue	$ 11,577,170	$ 8,583,663	$ 6,896,857	$ 5,934,812	$ 5,068,947
Management services and other revenue	609,693	451,847	429,336	433,960	377,138
Investment income	241,784	193,448	159,234	109,578	196,153
	12,428,647	9,228,958	7,485,427	6,478,350	5,642,238
Operating Expenses:					
Health care services and other benefits	9,436,264	6,935,398	5,533,068	4,776,345	4,087,420
Selling expense	502,571	394,217	328,619	280,078	249,389
General and administrative expense	1,666,587	1,265,155	1,075,449	975,099	836,581
Nonrecurring costs	—	—	—	—	14,535
	11,605,422	8,594,770	6,937,136	6,031,522	5,187,925
Operating Income	823,225	634,188	548,291	446,828	454,313
Interest expense	49,929	23,978	20,178	26,903	36,658
Other expense, net	74,714	45,897	40,792	27,939	31,301
Income from Continuing Operations before provision for income taxes, extraordinary gain and cumulative effect of accounting change	698,582	564,313	487,321	391,986	386,354
Provision for Income Taxes	283,836	222,026	190,110	72,438	156,917
Income from Continuing Operations before extraordinary gain and cumulative effect of accounting change	414,746	342,287	297,211	319,548	229,437
Loss from Discontinued Operations	—	—	—	(88,268)	(2,028)
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891	—	—
Cumulative effect of accounting change, net of tax	—	—	(20,558)	—	—
Net Income	$ 414,746	$ 342,287	$ 278,544	$ 231,280	$ 227,409
Per Share Data(A)(C)(D):					
Income from Continuing Operations before extraordinary gain and cumulative effect of accounting change:					
Earnings Per Share	$ 3.27	$ 2.74	$ 2.25	$ 2.31	$ 1.67
Earnings Per Share Assuming Full Dilution	$ 3.15	$ 2.64	$ 2.19	$ 2.28	$ 1.65
Extraordinary gain:					
Earnings Per Share	$ —	$ —	$ 0.02	$ —	$ —
Earnings Per Share Assuming Full Dilution	$ —	$ —	$ 0.01	$ —	$ —
Cumulative Effect Of Accounting Change:					
Earnings (Loss) Per Share	$ —	$ —	$ (0.16)	$ —	$ —
Earnings (Loss) Per Share Assuming Full Dilution	$ —	$ —	$ (0.15)	$ —	$ —
Loss from Discontinued Operations:					
Earnings (Loss) Per Share	$ —	$ —	$ —	$ (0.64)	$ (0.02)
Earnings (Loss) Per Share Assuming Full Dilution	$ —	$ —	$ —	$ (0.63)	$ (0.01)
Net Income:					
Earnings Per Share	$ 3.27	$ 2.74	$ 2.11	$ 1.67	$ 1.65
Earnings Per Share Assuming Full Dilution	$ 3.15	$ 2.64	$ 2.05	$ 1.65	$ 1.64
Operating Statistics(A)(E):					
Loss ratio	81.5%	80.8%	80.2%	80.5%	80.6%
Selling expense ratio	4.1%	4.4%	4.5%	4.4%	4.6%
General and administrative expense ratio	13.7%	14.0%	14.7%	15.3%	15.4%
Net income ratio	3.4%	3.8%	3.8%	3.6%	4.2%

	December 31,				
	2001	2000	1999	1998	1997
Balance Sheet Data(A):					

Cash and investments	$ 4,986,069	$ 3,780,050	$ 3,258,666	$ 2,764,302	$ 2,560,537
Total assets	$ 7,472,133	$ 5,504,706	$ 4,593,234	$ 4,225,834	$ 4,234,124
Long−term debt	$ 837,957	$ 400,855	$ 347,884	$ 300,000	$ 388,000
Total equity(G)	$ 2,132,579	$ 1,644,417	$ 1,312,700	$ 1,315,223	$ 1,223,169
Medical Membership(F)	10,146,945	7,869,119	7,300,003	6,892,000	6,638,000

(A) Financial information for 1997 has been restated to present workers' compensation business as a discontinued operation.

(B) The Company's consolidated results of operations for the years presented above include the results of several acquisitions which are components of the Company's national expansion strategy. (See "Item 7. Management's Discussion and Analysis Of Financial Condition And Results Of Operations.")

(C) Per share data for each period presented has been restated to reflect the two−for−one stock split in the form of a stock dividend which occurred on March 15, 2002.

(D) Per share data includes nonrecurring costs of $0.06 per share for 1997 based on a restated basis to reflect the two−for one stock split which occurred on March 15, 2002.

(E) The loss ratio represents health care services and other benefits as a percentage of premium revenue. All other ratios are shown as a percentage of premium revenue and management services and other revenue.

(F) Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by each contract.

(G) No cash dividends were declared in each of the years presented.

Item 7. Management's Discussion And Analysis Of Financial Condition And Results Of Operations

This discussion contains forward−looking statements, which involve risks and uncertainties. The Company's actual results may differ materially from those anticipated in these forward−looking statements as a result of certain factors including, but not limited to, those set forth under "Factors That May Affect Future Results of Operations."

General

The Company is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. As a result of the January 31, 2002 closing of the RightCHOICE transaction, the Company's medical membership has increased to approximately 12.5 million as of January 31, 2002. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include HMOs, PPOs, POS plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial services, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products, including pharmacy, dental, utilization management, life insurance, preventive care, disability insurance, behavioral health, COBRA and flexible benefits account administration. The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in other states primarily under the name UNICARE or HealthLink. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks.

Acquisition of Cerulean

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross Blue Shield of Georgia, Inc. (See Note 2 to the Consolidated Financial Statements). Cerulean, principally through its Blue Cross and Blue Shield of Georgia subsidiary, offers insured and administrative services products primarily in the State of Georgia. Cerulean has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. Cerulean has also historically experienced a higher medical loss ratio than the Company's core businesses due to its higher percentage of Large Employer Group business and fewer managed care offerings. Accordingly, Cerulean's higher loss and administrative expense ratios have contributed to an increase in those ratios for the Company. The acquisition increased the Company's Georgia medical membership by approximately 1.9 million members as of March 31, 2001. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company estimates that it will incur up to $140.6 million in expenses, primarily related to change in control payments to Cerulean management and transaction costs. This acquisition was accounted for under the purchase method of accounting.

Acquisition of RightCHOICE

On October 17, 2001, the Company entered into an Agreement and Plan of Merger with RightCHOICE, through its wholly owned subsidiary, RWP Acquisition Corp. (See Note 22 to the Consolidated Financial Statements). On January 31, 2002, the Company completed this transaction, pursuant to which RightCHOICE became a wholly owned subsidiary of the Company. The acquisition price for RightCHOICE was approximately $1.4 billion, which was paid with $379.0 million in cash and approximately 8.3 million shares (on a pre−stock split basis) of WellPoint Common Stock.

RightCHOICE, through its exclusive license to use the "Blue Cross" and "Blue Shield" names and service marks, is the largest provider of managed health care benefits in the state of Missouri based on number of members. As of January 31, 2002, RightCHOICE served approximately 2.2 million medical members in Missouri, Arkansas, Illinois, Indiana, Iowa, Kentucky and West Virginia. RightCHOICE has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. Accordingly it is expected that RightCHOICE's higher administrative expense ratios will ultimately contribute to an increase in the administrative expense ratio for the Company.

Pending Acquisition of CareFirst

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to approximately 3.1 million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that the gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

National Expansion and Other Recent Developments

In an effort to pursue the expansion of the Company's business outside the state of California, the Company acquired two businesses in 1996 and 1997, the Life and Health Benefits Management Division ("MMHD") of Massachusetts Mutual Life Insurance Company and the Group Benefits Operations (the "GBO") of John Hancock Mutual Life Insurance Company. The acquisitions of Rush Prudential and PrecisionRx in 2000 and the acquisition of Cerulean in 2001 were also components of this expansion strategy. In 2001 the Company entered into definitive agreements to expand into the Midwest with its acquisition of RightCHOICE which closed on January 31, 2002 and into the Mid−Atlantic region with the pending acquisition of CareFirst which is expected to close in 2003.

As a result of these acquisitions, the Company has significantly expanded its operations outside of California. In order to integrate its acquired businesses and implement the Company's regional expansion strategy, the Company will need to develop satisfactory networks of hospitals, physicians and other health care service providers, develop distribution channels for its products and successfully convert acquired books of business to the Company's existing information systems, which will require continued investments by the Company.

In response to rising medical and pharmacy costs, the Company has from time to time implemented premium increases with respect to certain of its products. The Company will continue to evaluate the need for further premium increases, plan design changes and other appropriate actions in the future in order to maintain or restore profit margins. There can be no assurances, however, that

the Company will be able to take subsequent pricing or other actions or that any actions previously taken or implemented in the future will be successful in addressing any concerns that may arise with respect to the performance of certain businesses.

Legislation

Federal legislation enacted during the last several years seeks, among other things, to insure the portability of health coverage and mandates minimum maternity hospital stays. California legislation enacted since 1999, among other things, establishes an explicit duty on managed care entities to exercise ordinary care in arranging for the provision of medically necessary health care services and establishes a system of independent medical review. In 1997, Texas adopted legislation purporting to make managed care organizations such as the Company liable for their failure to exercise ordinary care when making health care treatment decisions. Similar legislation has also been enacted in Georgia and in other states in which the Company operates. These and other proposed measures may have the effect of dramatically altering the regulation of health care and of increasing the Company's loss ratio and administrative costs or decreasing the affordability of the Company's products.

Results of Operations

The Company's revenues are primarily generated from premiums earned for risk−based health care and specialty services provided to its members, fees for administrative services, including claims processing and access to provider networks for self−insured employers and investment income. Operating expenses include health care services and other benefits expenses, consisting primarily of payments for physicians, hospitals and other providers for health care and specialty products claims; selling expenses for broker and agent commissions; general and administrative expenses; interest expense; depreciation and amortization expense; and income taxes.

The Company's consolidated results of operations for the year ended December 31, 2001 include the results of Cerulean from March 15, 2001, the acquisition date.

The Company's consolidated results of operations for the year ended December 31, 2000 include the results of Rush Prudential from March 1, 2000 and PrecisionRx from December 5, 2000, their respective dates of acquisition.

The following table sets forth selected operating ratios. The loss ratio for health care services and other benefits is shown as a percentage of premium revenue. All other ratios are shown as a percentage of premium revenue and management services and other revenue combined.

	Year Ended December 31,		
	2001	2000	1999
Operating Revenues:			
Premium revenue	95.0%	95.0%	94.1%
Management services and other revenue	5.0%	5.0%	5.9%
	100.0%	100.0%	100.0%
Operating Expenses:			
Health care services and other benefits (loss ratio)	81.5%	80.8%	80.2%
Selling expense	4.1%	4.4%	4.5%
General and administrative expense	13.7%	14.0%	14.7%

Membership

The following table sets forth membership data and the percent change in membership:

	As of December 31,		
	2001	2000	Percent Change
Medical Membership(a)(b)(c):			
Large Employer Group(d)			
California			
HMO	2,000,026	1,800,932	11.1 %
PPO and Other	2,131,865	1,982,474	7.5 %
Total California	4,131,891	3,783,406	9.2 %
Texas	205,458	197,037	4.3 %
Georgia	1,543,900	43,160	3,477.2 %
Illinois	430,689	459,282	(6.2)%
Other States	1,251,271	1,205,883	3.8 %
Total Large Employer Group	7,563,209	5,688,768	32.9 %
Individual and Small Employer Group			
California			
HMO	308,213	355,400	(13.3)%
PPO and Other	1,256,478	1,228,230	2.3 %
Total California	1,564,691	1,583,630	(1.2)%
Texas	176,473	167,845	5.1 %
Georgia	346,357	34,185	913.2 %
Illinois	90,555	67,550	34.1 %
Other States	87,486	96,546	(9.4)%
Total Individual and Small Employer Group	2,265,562	1,949,756	16.2 %
Senior(e)			
California			
HMO	38,715	34,930	10.8 %
PPO and Other	177,268	173,311	2.3 %
Total California	215,983	208,241	3.7 %
Texas	317	222	42.8 %
Georgia	71,616	1,050	6,720.6 %
Illinois	12,112	10,936	10.8 %
Other States	18,146	10,146	78.8 %
Total Senior	318,174	230,595	38.0 %
Total Medical Membership	10,146,945	7,869,119	28.9 %
Membership by Network(f)			
Proprietary Networks	8,017,883	6,246,519	28.4 %
Affiliate Networks	1,317,946	994,166	32.6 %
Non−Network	811,116	628,434	29.1 %
Total Medical Membership	10,146,945	7,869,119	28.9 %
Management Services Membership			
California	1,367,147	1,309,994	4.4 %
Georgia	895,780	23,166	3,766.8 %
Other States	1,155,659	1,210,239	(4.5)%

Total Management Services Membership	3,418,586	2,543,399	34.4 %

(a) Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by the contract.

(b) Classification between states for employer groups is determined by the zip code of the subscriber.

(c) Medical membership includes management services members, which are primarily included in the Large Employer Group segment.

(d) Large Employer Group membership includes 1,075,026 and 813,468 state−sponsored program members as of December 31, 2001 and 2000, respectively.

(e) Senior membership includes members covered under both Medicare risk and Medicare supplement products.

(f) Proprietary networks consist of California, Georgia, Texas and other WellPoint−developed or WellPoint−controlled networks. Affiliate networks consist of third−party networks that incorporate provider discounts and some basic managed care elements. Non−network consists of fee for service and percentage−of−billed charges contracts with providers.

Specialty Membership

	As of December 31,		
	2001	2000	Percent Change
Pharmacy	32,754,990	29,038,815	12.8 %
Dental	2,630,225	2,245,490	17.1 %
Utilization Management	1,734,675	2,103,396	(17.5)%
Life	2,310,030	2,020,069	14.4 %
Disability	540,826	569,266	(5.0)%
Behavioral Health	5,144,220	4,352,988	18.2 %

Comparison of Results for the Year Ended December 31, 2001 to the Year Ended December 31, 2000

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint Common Stock for each share held. Share and per share data for all periods presented below have been adjusted to give effect to the stock split.

The following table depicts premium revenue by business segment:

	Year Ended December 31,	
	2001	2000
	(In thousands)	
Large Employer Group	$ 7,188,430	$ 5,011,562
Individual and Small Employer Group	3,583,839	3,030,503
Corporate and Other	804,901	541,598
Consolidated	$ 11,577,170	$ 8,583,663

Premium revenue increased 34.9%, or $2,993.5 million, to $11,577.2 million for the year ended December 31, 2001 from $8,583.7 million for the year ended December 31, 2000. The increase was primarily due to $1,905.2 million of premium revenue related to the Cerulean and Rush Prudential acquisitions, representing 63.6% of the increase. Excluding acquisitions, premium revenue would have increased 12.7% for the year ended December 31, 2001. The increase excluding acquisitions was primarily due to an increase in insured member months of approximately 5.8% primarily in the Large Employer Group business segment, and the implementation of premium increases overall.

The following table depicts management services and other revenue by business segment:

	Year Ended December 31,	
	2001	2000
	(In thousands)	
Large Employer Group	$ 500,290	$ 379,142
Individual and Small Employer Group	268	2,865
Corporate and Other	109,135	69,840
Consolidated	$ 609,693	$ 451,847

Management services and other revenue increased approximately $157.9 million to $609.7 million for the year ended December 31, 2001 from $451.8 million for the year ended December 31, 2000. The increase was primarily due to $124.5 million of management services revenue related to the Cerulean and Rush Prudential acquisitions, representing 78.8% of the increase. Excluding acquisitions, management services revenue would have increased 7.4% for the year ended December 31, 2001. The

increase excluding acquisitions was primarily due to an increase in pharmacy benefit management services revenues.

Investment income was $241.8 million for the year ended December 31, 2001 compared to $193.4 million for the year ended December 31, 2000, an increase of 25.0%, or $48.4 million. The Cerulean and Rush Prudential acquisitions represented $24.9 million, or 51.4%, of the increase. Excluding acquisitions, investment income would have increased $23.5 million or 12.2%. The increase excluding acquisitions was primarily due to lower net realized losses in 2001 of $3.0 million as compared to net realized losses in 2000 of $21.6 million. Additionally, net investment income, excluding acquisitions, increased $6.4 million to $220.3 million for the year ended December 31, 2001 in comparison to $213.9 million for the year ended December 31, 2000. The increase resulted from higher average investment balances during the year ended December 31, 2001 versus 2000.

The loss ratio attributable to managed care and related products for the year ended December 31, 2001 increased to 81.5% compared to 80.8% for the year ended December 31, 2000, due in part to the incremental effect of the Cerulean acquisition on the Company's overall results. The acquired Cerulean business has traditionally experienced a higher loss ratio than the Company's core businesses due to its higher percentage of Large Employer Group business and fewer managed care offerings. Excluding Cerulean, the loss ratio increased slightly to 80.9% for the year ended December 31, 2001. The health care services and other benefits expense includes an estimate of claims incurred during the period but which have not been reported to the Company. This estimate is actuarially determined based on a variety of factors and is inherently subject to a number of highly variable circumstances. See "Critical Accounting Policies" for a more complete discussion of this item and its potential effect on the Company's reported results of operations.

Selling expense consists of commissions paid to outside brokers and agents representing the Company. The selling expense ratio for the year ended December 31, 2001 decreased to 4.1% compared to 4.4% for the year ended December 31, 2000. The acquired Cerulean business has traditionally experienced a lower selling expense ratio due primarily to its lower percentage of Individual and Small Employer Group business. Excluding Cerulean, the selling expense ratio would have remained unchanged at 4.4% for the year ended December 31, 2001.

The general and administrative expense ratio decreased to 13.7% for the year ended December 31, 2001 from 14.0% for the year ended December 31, 2000. The acquired Cerulean business has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher percentage of administrative services business. Excluding Cerulean, the administrative expense ratio would have been 13.6% for the year ended December 31, 2001. The lower administrative expense ratio for the year ended December 31, 2001, excluding Cerulean, is primarily attributable to savings from the integration of information systems centers related to acquired businesses onto the Company's information systems platform, economies of scale associated with premium revenue growth in relation to fixed corporate administrative expenses in addition to technology investments made by the Company (e.g., electronic claims submission, internet self−service and interactive voice response).

Interest expense increased $25.9 million to $49.9 million for the year ended December 31, 2001 compared to $24.0 million for the year ended December 31, 2000. The increase in interest expense was related to the higher average debt balance for the year ended December 31, 2001 in comparison to the year ended December 31, 2000, primarily due to the Cerulean acquisition. The weighted average interest rate for all debt for the year ended December 31, 2001, including the fees associated with the Company's borrowings and interest rate swap agreements, was 6.70%.

The Company's net income for the year ended December 31, 2001 was $414.7 million, compared to $342.3 million for the year ended December 31, 2000. Earnings per share totaled $3.27 and $2.74 for the years ended December 31, 2001 and 2000, respectively. Earnings per share assuming full dilution totaled $3.15 and $2.64 for years ended December 31, 2001 and 2000, respectively.

Earnings per share for the year ended December 31, 2001 is based upon weighted average shares outstanding of 126.9 million, excluding potential common stock, and 132.4 million shares, assuming full dilution. Earnings per share for the year ended December 31, 2000 is based on 125.1 million shares, excluding potential common stock, and 130.2 million shares, assuming full dilution. Earnings per share and weighted average shares above reflect the two−for−one stock split which occurred on March 15, 2002.

Comparison of Results for the Year Ended December 31, 2000 to the Year Ended December 31, 1999

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint Common Stock for each share held. Share and per share data for all periods presented below have been adjusted to give effect to the stock split.

The following table depicts premium revenue by business segment:

	Year Ended December 31,	
	2000	1999
	(In thousands)	
Large Employer Group	$ 5,011,562	$ 3,889,032
Individual and Small Employer Group	3,030,503	2,551,961
Corporate and Other	541,598	455,864
Consolidated	$ 8,583,663	$ 6,896,857

Premium revenue increased 24.5%, or $1,686.8 million, to $8,583.7 million for the year ended December 31, 2000 from $6,896.9 million for the year ended December 31, 1999. The Rush Prudential acquisition contributed $378.1 million or 22.4% of the overall premium revenue increase. Also contributing to increased premium revenue was an increase in insured member months of 12.5% in the Large Employer Group and Individual and Small Employer Group business segments, in addition to the implementation of premium increases in both segments.

The following table depicts management services and other revenue by business segment:

	Year Ended December 31,	
	2000	1999
	(In thousands)	
Large Employer Group	$ 379,142	$ 367,060
Individual and Small Employer Group	2,865	4,579
Corporate and Other	69,840	57,697
Consolidated	$ 451,847	$ 429,336

Management services and other revenue increased approximately $22.5 million to $451.8 million for the year ended December 31, 2000 from $429.3 million for the year ended December 31, 1999. The Rush Prudential acquisition contributed $4.2 million, or 18.6% of the overall increase. Also contributing to the increased management services revenue was the implementation of price increases, partially offset by a decrease in non−insured member months of approximately 0.9%, related to attrition of previously acquired businesses.

Investment income was $193.4 million for the year ended December 31, 2000 compared to $159.2 million for the year ended December 31, 1999, an increase of 21.5%, or $34.2 million. The Rush Prudential acquisition accounted for $5.3 million or 15.4% of the increase. An increase in net interest and dividend income of $16.2 million to $212.7 million for the year ended December 31, 2000 in comparison to $196.5 million for the year ended December 31, 1999 also contributed to the overall net

increase in investment income. This increase was primarily due to higher average investment balances in 2000 versus 1999, partially offset by a reduction in other interest income related to interest income received in 1999 related to the Company's refund from the Internal Revenue Service. Net realized losses on investment securities totaled $21.6 million for the year ended December 31, 2000 in comparison to losses of $33.8 million for the year ended December 31, 1999.

The loss ratio attributable to managed care and related products for the year ended December 31, 2000 increased to 80.8% compared to 80.2% for the year ended December 31, 1999, due in part to the incremental effect of the Rush Prudential acquisition on the Company's overall results. The acquired Rush Prudential business has traditionally experienced a higher loss ratio than the Company's core business. Excluding the acquired operations of Rush Prudential, the loss ratio would have been 80.5%. The increase in the loss ratio excluding Rush Prudential was primarily due to growth in the Company's Large Employer Group business segment which has historically experienced a higher loss ratio than the Company's Individual and Small Employer Group business.

The selling expense ratio decreased slightly to 4.4% for the year ended December 31, 2000 from 4.5% for the year ended December 31, 1999.

The general and administrative expense ratio decreased to 14.0% for the year ended December 31, 2000 from 14.7% for the year ended December 31, 1999. The overall decline is primarily attributable to savings from the integration of information systems centers related to acquired businesses on the Company's information systems platform, a reduction in Year 2000 remediation expense from 1999 levels, economies of scale associated with premium revenue growth in relation to fixed corporate administrative expenses in addition to technology investments made by the Company (e.g., electronic claims submission, internet self−service and interactive voice response).

Interest expense increased $3.8 million to $24.0 million for the year ended December 31, 2000 compared to $20.2 million for the year ended December 31, 1999. The increase in interest expense was related to the higher average debt balance due to the Rush Prudential acquisition, which was partially offset by a decrease in the effective interest rate due to the issuance of the Company's Zero Coupon Convertible Subordinated Debentures (the "Debentures") in July 1999. The weighted average interest rate for all debt for the year ended December 31, 2000, including the fees associated with the Company's borrowings and interest rate swap agreements, was 6.16%.

The Company's income before extraordinary gain and the cumulative effect of accounting change for the year ended December 31, 2000 was $342.3 million, compared to $297.2 million for the year ended December 31, 1999. Earnings per share before extraordinary gain and cumulative effect of accounting change totaled $2.74 and $2.25 for the years ended December 31, 2000 and 1999, respectively. Earnings per share before extraordinary gain and cumulative effect of accounting change assuming full dilution totaled $2.64 and $2.19 for years ended December 31, 2000 and 1999, respectively.

Earnings per share for the year ended December 31, 2000 is based upon weighted average shares outstanding of 125.1 million, excluding potential common stock, and 130.2 million shares, assuming full dilution. Earnings per share for the year ended December 31, 1999 is based on 132.1 million shares, excluding potential common stock, and 136.2 million shares, assuming full dilution. The decrease in weighted average shares outstanding primarily resulted from the repurchase of approximately 5.0 million shares during the year ended December 31, 2000. For weighted average shares outstanding assuming full dilution, the decline was partially offset by the impact of the assumed conversion of the Debentures.

Effective January 1, 1999, the Company changed its method of accounting for start−up costs related to the Company's provider network and distribution channel development and is now expensing these

costs. The cumulative effect of this change of $20.6 million, net of tax, was reflected in the results of operations for the year ended December 31, 1999.

Financial Condition

The Company's consolidated assets increased by $1,967.4 million, or 35.7%, to $7,472.1 million as of December 31, 2001 from $5,504.7 million as of December 31, 2000. The Cerulean acquisition accounted for $1,058.1 million, or 53.8% of the increase. The remaining increase in total assets was primarily due to growth in cash and investments as a result of operating cash flow. Cash and investments totaled $5.0 billion, or 66.7% of total assets, as of December 31, 2001. Receivables and goodwill and intangible assets represented 11.3% and 14.6% of total assets at December 31, 2001, respectively.

Overall claims liabilities increased $327.6 million, or 17.3%, to $2,219.8 million as of December 31, 2001 from $1,892.2 million as of December 31, 2000. The Cerulean acquisition accounted for $266.2 million, or 81.3% of the total increase. The remaining increase in claims liabilities of $61.4 million was a result of an increase in insured membership (excluding the Cerulean acquisition) of 3.4%.

As of December 31, 2001, the Company's long−term indebtedness was $838.0 million, of which $153.9 million was related to the Debentures, $235.0 million was related to the Company's revolving credit facility and $449.1 million was related to the Company's 6 $^{3}/_{8}$% Notes due 2006 (the "2001 Notes"). (See Note 8 to the Consolidated Financial Statements). As a result of the Cerulean acquisition, the Company incurred $500.0 million of indebtedness under its revolving credit facility. During the quarter ended June 30, 2001, the Company used the proceeds from the aforementioned 2001 Notes to reduce the outstanding balance of the Company's revolving credit facility. As of December 31, 2000, the Company's long−term indebtedness was $400.9 million, of which $250.0 million was related to the Company's revolving credit facility and $150.9 million was related to the Debentures.

Stockholders' equity totaled $2,132.6 million as of December 31, 2001, an increase of $488.2 million from $1,644.4 million as of December 31, 2000. The increase was primarily due to net income of $414.7 million for the year ended December 31, 2001 in addition to $86.1 million of net proceeds from the reissuance of treasury stock related to the Company's employee stock option and purchase plans. Partially offsetting these increases were a decrease in other comprehensive income of $5.2 million, primarily related to an increase in the minimum pension liability of $22.5 million and an increase in unrealized losses on foreign currency adjustments of $0.3 million, offset by an increase in net unrealized gains on investment securites of $17.6 million. During the third quarter of 2001, the Company purchased 75,000 shares (on a pre−stock split basis) of its Common Stock, which reduced the stockholders' equity by approximately $7.4 million.

Liquidity and Capital Resources

The Company's primary sources of cash are premium and management services revenues received and investment income. The primary uses of cash include health care claims and other benefits, capitation payments, income taxes, repayment and repurchases of long−term debt, interest expense, broker and agent commissions, administrative expenses, common stock repurchases and capital expenditures. In addition to the foregoing, other uses of cash include costs of provider networks and systems development, and costs associated with the integration of acquired businesses.

The Company generally receives premium revenue in advance of anticipated claims for related health care services and other benefits. The Company's investment policies are designed to provide safety and preservation of capital, sufficient liquidity to meet cash flow needs, the integration of investment strategy with the business operations and objectives of the Company, and attainment of a competitive after−tax total return.

The Company's strategy for achieving its investment goals is broad diversification of its investments, both across and within asset classes. As of December 31, 2001, the Company's portfolio consisted primarily of investment grade fixed−maturity securities. The Company's portfolio also included large capitalization and small capitalization domestic equities, foreign equities, tax−exempt municipal bonds where the after−tax return is higher than the comparable taxable securities, and a small amount of non−investment grade debt securities. The fixed−income assets include both short and long−duration securities with an attempt to match the Company's funding needs. The investment policy contains limitations regarding concentrations in individual securities and industries and generally prohibits speculative and leveraged investments. Cash and investment balances maintained by the Company are sufficient to meet applicable regulatory financial stability and net worth requirements, including license requirements of the Blue Cross Blue Shield Association.

Cash flow provided by operating activities was $806.2 million for the year ended December 31, 2001, compared with $647.9 million for the year ended December 31, 2000. Cash flow from operations for the year ended December 31, 2001 was due primarily to net income of $414.7 million, increases in accounts payable and accrued expenses of $94.7 million, due to the timing of other operating liability payments, and an increase in medical claims payable of $110.0 million, which related to the growth of insured members, and the timing of other operating liability payments.

Net cash used in investing activities in 2001 totaled $857.2 million, compared with $557.4 million in 2000. The cash used in 2001 was attributable primarily to the purchase of investments of $4.9 billion, property and equipment, net of sales proceeds of $84.5 million, and the purchase of Cerulean, net of acquired cash, of $561.7 million. Proceeds from investments sold and matured totaled $4.7 billion, partially offsetting the aforementioned purchases.

Net cash provided by financing activities totaled $512.6 million in 2001 compared to net cash used in financing activities of $28.6 million in 2000. The increase was primarily related to additional debt incurred to finance the Cerulean acquisition of $500.0 million, in addition to the receipt of proceeds from the issuance of stock related to the Company's employee stock option and purchase programs of $86.1 million less $7.4 million in Company stock repurchases. During 2001, the Company decreased indebtedness under its revolving credit facility by $15.0 million.

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities (which are generally referred to collectively in this Annual Report on Form 10−K as the Company's "revolving credit facility") bear interest at rates determined by reference to the bank's base rate or to the London Inter Bank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million, expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, originally expired as of March 29, 2002. Any amount outstanding under this facility as of March 29, 2002 may be converted into a one−year term loan at the option of the Company. In March 2002, the Company amended this facility to provide for a one−year extension with an expiration date of March 28, 2003. Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control (See Note 8 to the Consolidated Financial Statements). The total amount outstanding under these facilities was $235.0 million as of December 31, 2001. The total amount outstanding under the Company's prior revolving credit facility was $250.0 million as of December 31, 2000.

As a part of a hedging strategy to limit its exposure to variable interest rate increases, the Company entered into interest rate swap agreements in order to reduce the volatility of interest expense resulting from changes in interest rates. The swap agreements are contracts to exchange variable−rate interest payments (weighted average rate for the year ended December 31, 2001 of 4.81%) for fixed−rate interest payments (weighted average rate for the year ended December 31, 2001 of 7.45%) without the exchange of the underlying notional amounts. As of December 31, 2001, the Company had entered into $200.0 million of fixed rate swap agreements, which consisted of a $150.0 million notional amount swap agreement at 6.99% maturing on October 17, 2003 and a $50.0 million notional amount swap agreement at 7.06% maturing on October 17, 2006.

During 2001, the Company entered into foreign currency forward exchange contracts for each of the fixed maturity securities on hand denominated in foreign currencies in order to hedge asset positions with respect to currency fluctuations related to these securities. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and as a result entered into a hedge to offset the remaining currency hedge. Subsequent to the implementation of SFAS No. 133, all gains and losses from both effective and ineffective forward exchange contracts have been reported in investment income offset by the related gains and losses on the Company's available−for−sale foreign securities (See Note 15 to the Consolidated Financial Statements).

Certain of the Company's subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory agencies, including the California Department of Managed Health Care and the Departments of Insurance in various states. As of December 31, 2001 (or the most recent date with respect to which compliance is required), those subsidiaries of the Company were in compliance with all minimum capital requirements.

On June 15, 2001, the Company issued $450.0 million aggregate principal amount at maturity of 6 3/8% Notes due June 15, 2006 (the "2001 Notes"). The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities which indirectly financed a portion of the Cerulean acquisition. The 2001 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest is computed on the basis of a 360−day year of twelve 30−day months.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

With the anticipated acquisition of RightCHOICE on January 31, 2002, the Company on January 16, 2002 issued $350.0 million aggregate principal amount at maturity of 6 3/8% Notes due January 15, 2012 (the "2002 Notes") The net proceeds of this offering totaled approximately $348.9 million. The 2002 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on January 15 and July 15 of each year commencing July 15, 2002. Interest is computed on the basis of a 360−day year of twelve 30−day months.

The 2002 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2002 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2002 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the

2002 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (J.P. Morgan Securities Inc. or Deutsche Banc Alex. Brown or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2002 Notes to the redemption date.

The 2001 and 2002 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2001 and 2002 Notes. The indenture governing the 2001 and 2002 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2001 and 2002 Notes.

The Company enters into operating leases primarily for office space, electronic data processing and office equipment. As of December 31, 2001, minimum annual rental commitments on operating leases having initial or remaining noncancellable lease terms in excess of one year during the years 2002 through 2006 were $89.6 million, $71.5 million, $49.0 million, $37.8 million and $29.6 million, respectively, with $245.6 million in minimum commitments thereafter.

The Company's obligations relating to debt and leases at December 31, 2001 were as follows:

	Total	2002	2003	2004	2005	2006	Thereafter
				(In millions)			
6 3/8% Notes due 2006	$ 450.0	$ —	$ —	$ —	$ —	$ 450.0	$ —
Revolving credit facility	235.0	—	35.0	—	—	200.0	—
Zero coupon convertible subordinated debentures	218.0	—	—	—	—	—	218.0
Operating leases	523.1	89.6	71.5	49.0	37.8	29.6	245.6
Total contractual obligations	$ 1,426.1	$ 89.6	$ 106.5	$ 49.0	$ 37.8	$ 679.6	$ 463.6

The Company's committed credit availability as of December 31, 2001 was as follows:

	Total committed	Total available	Amount of Available Commitment Expiration per Period				
			2002	2003	2004	2005	2006
				(In millions)			
Revolving Credit—committed and available	$ 1,000.0	$ 765.0	—	$ 215.0	—	—	$ 550.0

The Company believes that cash flow generated by operations and its cash and investment balances, supplemented by the Company's ability to borrow under its existing revolving credit facilities or through public or private financing sources, will be sufficient to fund continuing operations and expected capital requirements for the foreseeable future.

Pending Acquisition

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst. The Company will pay at least $450.0 million of the purchase price in cash and the balance in shares of the Company's Common Stock and under certain circumstances a five−year subordinated note. The transaction, which is subject to regulatory approvals, is currently expected to be completed within 18−24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003. (See Note 23 to the Consolidated Financial Statements for further discussion.)

Tax Issues Relating to the WellPoint and RightCHOICE Recapitalizations

In connection with the Recapitalization, BCC received a ruling from the IRS that, among other things, the BCC Conversion qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. If the ruling were subsequently revoked, modified or not honored by the IRS (due to a change in law or for any other reason), WellPoint, as the successor to BCC, could be subject to Federal income tax on the difference between the value of BCC at the time of the BCC Conversion and BCC's tax basis in its assets at the time of the BCC Conversion. The potential tax liability to WellPoint if the BCC Conversion is treated as a taxable transaction is currently estimated to be approximately $696 million, plus interest (and possibly penalties). BCC and the Foundation entered into an Indemnification Agreement that provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes. In the event a tax liability should arise against which the Foundation has agreed to indemnify WellPoint, there can be no assurance that the Foundation will have sufficient assets to satisfy the liability in full, in which case WellPoint would bear all or a portion of the cost of the liability, which could have a material adverse effect on WellPoint's financial condition.

During the quarter ended September 30, 1998 the Company received a private letter ruling from the IRS with respect to the treatment of certain payments made at the time of the Recapitalization and the acquisition of the commercial operations of BCC. The ruling allowed the Company to deduct as an ordinary and necessary business expense the $800 million cash payment made by BCC in May 1996 to one of two newly formed charitable foundations. As a result of and in reliance on the ruling, the Company experienced a reduction in its income tax expense of $85.5 million and the Company reduced its goodwill resulting from the Recapitalization by $194.5 million during the year ended December 31, 1998. The Company filed for refund claims of approximately $198.6 million of previous year income tax payments and reduced income tax payments during 1998 and 1999 by approximately $81.4 million. In August 1999, the Company received a cash refund (including applicable accrued interest) of approximately $183.0 million, which was reflected in the statement of cash flows for such year. The Company has refund claims pending of approximately $39.3 million.

In March 2002, the Company received a letter from the IRS notifying the Company that the IRS was considering revoking the September 1998 private letter ruling. The letter stated that the IRS was considering, in essence, reversing its earlier position and concluding that the $800 million payment was not an ordinary and necessary business expense. The letter further stated that the IRS was withdrawing the private letter ruling and that the Company could no longer rely on the private letter ruling. Under Section 7805(b) of the Code, the IRS has discretionary authority to limit the retroactive effect of any revocation of a letter ruling. The Company has submitted a written request for such relief under Section 7805(b). According to regulations promulgated by the United States Treasury, such relief will be granted whenever a taxpayer meets all of five specified criteria, including that the taxpayer has relied in good faith on an earlier ruling and that the revocation of the ruling would be to the detriment of the taxpayer. The Company believes that it meets substantially all of these criteria. Therefore, although no assurances can be given, the Company currently expects that such relief will be granted. The Company's request for relief under Section 7805(b) is being made without prejudice to the Company's right to subsequently argue that the $800 million cash payment should continue to be treated as an ordinary and necessary business expense under the Code.

On November 30, 2000 RightCHOICE completed a reorganization (the "RightCHOICE Recapitalization") with its majority stockholder, RightCHOICE Managed Care, Inc., a Missouri corporation ("Old RightCHOICE"). As part of the RightCHOICE Recapitalization, The Missouri Foundation For Health (the "Missouri Foundation") became the holder of approximately 80% of RightCHOICE Common Stock. In connection with the RightCHOICE Recapitalization, the

predecessor of Old RightCHOICE, Blue Cross and Blue Shield of Missouri, received a ruling from the IRS that, among other things, the conversion of Blue Cross and Blue Shield of Missouri from a non−profit corporation to a for−profit corporation qualified as a reorganization under the Internal Revenue Code and that Blue Cross and Blue Shield of Missouri recognized no gain or loss for federal income tax purposes. If the IRS subsequently revoked, modified or decided not to honor the ruling due to a change in law or for any other reason, RightCHOICE, as the successor to Old RightCHOICE, could be subject to federal income tax on the difference between the value of each of Blue Cross and Blue Shield of Missouri's assets at the time of the RightCHOICE Recapitalization and its tax basis in its assets at the time of the RightCHOICE Recapitalization. RightCHOICE is now a wholly owned subsidiary of WellPoint. RightCHOICE and the Missouri Foundation entered into an indemnification agreement that provides, with certain exceptions, that the Missouri Foundation will indemnify RightCHOICE against the tax liability as a result of the IRS's revocation or modification, in whole or in part, of its ruling, or an IRS determination that RightCHOICE's conversion was a taxable transaction for federal income tax purposes. If a tax liability should arise against which the Missouri Foundation has agreed to indemnify RightCHOICE, the Missouri Foundation may not have sufficient assets to pay the liability. RightCHOICE would then bear all or a portion of the liability, which could have a material adverse effect on RightCHOICE's and the Company's financial condition.

Critical Accounting Policies

The preparation of financial statements in conformity with generally accepted accounting principles requires the Company's management to make a variety of estimates and assumptions. These estimates and assumptions affect, among other things, the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Actual results can differ from the amounts previously estimated, which were based on the information available at the time the estimates were made.

The critical accounting policies described below are those that the Company believes are important to the portrayal of the Company's financial condition and results, and which require management to make difficult, subjective and/or complex judgments. Critical accounting policies cover accounting matters that are inherently uncertain because the future resolution of such matters is unknown. The Company believes that critical accounting policies include medical claims payable, reserves for future policy benefits and intangible assets and goodwill.

Medical Claims Payable

Medical claims payable includes claims in process and a provision for the Company's estimate of incurred but not reported claims. Such estimates are developed using actuarial principles and assumptions which consider, among other things, contractual requirements, historical utilization trends and payment patterns, medical inflation, product mix, seasonality, membership and other relevant factors. Claim processing expenses are also accrued based on an estimate of expenses necessary to process such claims. Such reserves are continually monitored and reviewed with any adjustments reflected in current operations. Capitation costs represent monthly fees paid one month in advance to physicians, certain other medical service providers and hospitals in the Company's HMO networks as retainers for providing continuing medical care. The Company maintains various programs that provide incentives to physicians, certain other medical service providers and hospitals participating in its HMO networks through the use of risk−sharing agreements and other programs. Payments under such agreements are made based on the providers' performance in controlling health care costs while providing quality health care. Expenses related to these programs, which are based in part on estimates, are recorded in the period in which the related services are rendered. Management believes that its reserves for medical claims payable are adequate to satisfy its ultimate claim liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The Company's future results of operations will depend in part on its ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. WellPoint's ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above−listed or other factors may adversely affect the Company's future profitability.

Reserves for Future Policy Benefits

The estimated reserves for future policy benefits relate to life and disability insurance policies written in connection with health care contracts. Reserves for future life benefit coverage are based on projections of past experience. Reserves for future policy and contract benefits for certain long−term disability products and group paid−up life products are based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon the Company's experience. Reserves are continually monitored and reviewed, and as settlements are made or reserves adjusted, differences are reflected in current operations. The current portion of reserves for future policy benefits relates to the portion of such reserves which management expects to pay within one year. Management believes that its reserves for future policy benefits are adequate to satisfy its ultimate benefit liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Intangible Assets and Goodwill

The Company has made several acquisitions in the past several years that included a significant amount of intangible assets and goodwill. Under generally accepted accounting principles in effect through December 31, 2001, these assets were amortized over their useful lives, and were tested periodically to determine if they were recoverable from operating earnings on an undiscounted basis over their useful lives.

The Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, such potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity.

Effective January 1, 2002, intangible assets and goodwill will be accounted for under SFAS No. 142, "Goodwill and Other Intangible Assets." The new rules eliminate amortization of goodwill and other intangibles with indefinite lives, but these assets will be subject to the impairment tests. (See "New Accounting Pronouncements" and Note 7 to the Consolidated Financial Statements for a more complete discussion of the Company's intangible assets and goodwill). Management is required to make assumptions and estimates, such as the discount factor, in determining estimated fair value. Such estimated fair values might produce significantly different results if other reasonable assumptions and estimates were to be used.

New Accounting Pronouncements

In June 2001, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 141, "Business Combinations" ("SFAS No. 141"). SFAS No. 141 addresses financial accounting and reporting for business combinations and supersedes APB Opinion No. 16, "Business Combinations," and FASB Statement No. 38, "Accounting for Preacquisition Contingencies of Purchased Enterprises." Upon adoption of SFAS No. 141, all business combinations must be accounted for using the purchase method. The use of the pooling of interests method is now prohibited. The provisions of the new standard apply to all business combinations initiated after June 30, 2001. For business combinations accounted for using the purchase method before July 1, 2001, the provisions of this statement will be effective in the first quarter of 2002. The adoption of SFAS No. 141 did not have a material effect on the financial statements of the Company.

In July 2001, the FASB issued SFAS No. 142, "Goodwill and Other Intangible Assets," which supersedes APB Opinion No. 17, "Intangible Assets." This statement addresses the accounting and reporting of goodwill and other intangible assets subsequent to their acquisition. SFAS No. 142 provides that (i) goodwill and indefinite−lived intangible assets will no longer be amortized, (ii) impairment will be measured using various valuation techniques based on discounted cash flows, (iii) goodwill will be tested for impairment at least annually at the reporting unit level, (iv) intangible assets deemed to have an indefinite life will be tested for impairment at least annually and (v) intangible assets with finite lives will be amortized over their useful lives. The statement provides specific guidance on testing goodwill and intangible assets for impairment, and requires that reporting units be identified for the purpose of assessing potential future impairments. Goodwill and intangible assets acquired after June 30, 2001 were subjected to the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. Utilizing internal and external resources, the Company is in the process of adopting SFAS No. 142 and is identifying its reporting units and the amounts of goodwill, intangible assets, other assets and liabilities to be allocated to those reporting units.

SFAS No. 142 requires that goodwill be tested annually for impairment using a two−step process. The first step is to identify a potential impairment and, in transition, this step must be measured as of the beginning of the fiscal year. However, companies have six months from the date of adoption to complete the first step. The Company expects to complete the first step of the goodwill impairment test during the first quarter of 2002. The second step of the goodwill impairment test measures the amount of impairment loss (measured as of the beginning of the year of adoption), if any, and must be completed by December 31, 2002. Intangible assets deemed to have an indefinite life will be tested for impairment using a one−step process which compares the fair value to the carrying amount of the asset as of the beginning of the year. This process will be completed during the first quarter of 2002. The Company is in the process of completing these impairment tests for goodwill and other intangible assets and, based on current information, does not anticipate transitional impairment losses. The Company expects the adoption of SFAS No. 142 to benefit earnings, net of taxes, of approximately $31.7 million compared to 2001.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 143, "Accounting for Asset Retirement Obligations" ("SFAS No. 143"). SFAS No. 143 is effective for financial statements issued for fiscal years beginning after June 15, 2002. The Company will adopt SFAS No. 143 on January 1, 2003. The provisions of SFAS No. 143 require companies to record an asset and related liability for the costs associated with the retirement of a long−lived tangible asset if a legal liability to retire the asset exists. The Company is in the process of analyzing the provisions of SFAS No. 143; however, the effect of adoption is not expected to have a significant impact on the Company's financial condition and results of operations.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long−Lived Assets" ("SFAS No. 144"). SFAS No. 144 is

effective for financial statements issued for fiscal years beginning after December 15, 2001. This statement addresses financial accounting and reporting for the impairment or disposal of long−lived assets and supersedes SFAS No. 121, "Accounting for the Impairment of Long−Lived Assets and for Long−Lived Assets to be Disposed of" and the accounting and reporting provisions of APB 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," for the disposal of a segment of business (as previously defined in that opinion). SFAS No. 144 retains the basic principles of SFAS No. 121 for long−lived assets to be disposed of by sale or held and used and broadens discontinued operations presentation to include a component of an entity that is held for sale or that has been disposed. Components must have operations and cash flows that can be clearly distinguished from the rest of the entity. The Company is in the process of analyzing the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. The adoption of this standard is not expected to have a significant impact on the Company's financial results.

Factors That May Affect Future Results Of Operations

Certain statements contained herein, such as statements concerning potential or future loss ratios, the effects as the Company continues to integrate its recently acquired operations and other statements regarding matters that are not historical facts, are forward−looking statements (as such term is defined in the Securities Exchange Act of 1934). Such statements involve a number of risks and uncertainties that may cause actual results to differ from those projected. Factors that can cause actual results to differ materially include, but are not limited to, those discussed below and those discussed from time to time in the Company's various filings with the Securities and Exchange Commission.

The Company's operations are subject to substantial regulation by federal, state and local agencies in all jurisdictions in which the Company operates. Many of these agencies have increased their scrutiny of managed health care companies in recent periods or are expected to increase their scrutiny, as newly passed legislation becomes effective. From time to time, the Company and its subsidiaries receive requests for information from regulatory agencies or are notified that such agencies are conducting reviews, investigations or other proceedings with respect to certain of the Company's activities. The Company also provides insurance products to Medi−Cal beneficiaries in various California counties under contracts with the California Department of Health Services (or delegated local agencies) and provides administrative services to the Centers for Medicare and Medicaid Services ("CMS") in various capacities. There can be no assurance that acting as a government contractor in these circumstances will not increase the risk of heightened scrutiny by such government agencies or that such scrutiny will not have a material adverse effect on the Company, either through negative publicity about the Company or through an adverse impact on the Company's results of operations. In addition, profitability from this business may be adversely affected through inadequate premium rate increases due to governmental budgetary issues. Future actions by any regulatory agencies may have a material adverse effect on the Company's business.

In connection with the RightCHOICE and Cerulean transactions, the Company incurred significant additional indebtedness to fund the cash payments made to the acquired companies' stockholders. In addition, the Company currently expects to incur additional indebtedness to fund some or all of the cash payments to be made in connection with the pending CareFirst transaction. This existing or new indebtedness may result in a significant percentage of the Company's cash flow being applied to the payment of interest, and there can be no assurance that the Company's operations will generate sufficient future cash flow to service this indebtedness. The Company's current indebtedness, as well as any indebtedness that the Company may incur in the future (such as indebtedness incurred to fund repurchases of its Common Stock or to fund the CareFirst or other transactions), may adversely affect

the Company's ability to finance its operations and could limit the Company's ability to pursue business opportunities that may be in the best interests of the Company and its stockholders.

As part of the Company's business strategy, the Company has acquired substantial operations in new geographic markets over the last five years. These businesses, some of which include substantial indemnity−based insurance operations, have experienced varying profitability or losses in recent periods. Since the relevant dates of acquisition of Rush Prudential and Cerulean, the Company has continued to work extensively on the integration of these businesses. The Company has also begun its integration of the RightCHOICE business. However, there can be no assurances regarding the ultimate success of the Company's integration efforts or regarding the ability of the Company to maintain or improve the results of operations of the businesses of completed or pending transactions. The Company has incurred and will, among other things, need to continue to incur considerable expenditures for provider networks, distribution channels and information systems in addition to the costs associated with the integration of these acquisitions. The integration of these complex businesses may result in, among other things, temporary increases in claims inventory or other service−related issues that may negatively affect the Company's relationship with its customers and contribute to increased attrition of such customers. The Company's results of operations could be adversely affected in the event that the Company experiences such problems or is otherwise unable to implement fully its expansion strategy.

The Company and certain of its subsidiaries are subject to capital surplus requirements by the California Department of Managed Health Care, the Georgia Department of Insurance, the Missouri Department of Insurance, various other state Departments of Insurance and the Blue Cross Blue Shield Association. Although the Company believes that it is currently in compliance with all applicable requirements, there can be no assurances that such requirements will not be increased in the future.

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in

early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status. The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The Company's future results will depend in large part on accurately predicting health care costs incurred on existing business and upon the Company's ability to control future health care costs through product and benefit design, underwriting criteria, utilization management and negotiation of favorable provider contracts. Changes in mandated benefits, utilization rates, demographic characteristics, health care practices, provider consolidation, inflation, new pharmaceuticals/technologies, clusters of high−cost cases, the regulatory environment and numerous other factors are beyond the control of any health plan provider and may adversely affect the Company's ability to predict and control health care costs and claims, as well as the Company's financial condition, results of operations or cash flows. Periodic renegotiations of hospital and other provider contracts coupled with continued consolidation of physician, hospital and other provider groups may result in increased health care costs and limit the Company's ability to negotiate favorable rates. Recently, large physician practice management companies have experienced extreme financial difficulties, including bankruptcy, which may subject the Company to increased credit risk related to provider groups and cause the Company to incur duplicative claims expense. Additionally, the Company faces competitive pressure to contain premium prices. Fiscal concerns regarding the continued viability of government−sponsored programs such as Medicare and Medicaid may cause decreasing reimbursement rates for these programs. Any limitation on the Company's ability to increase or maintain its premium levels, design

products, implement underwriting criteria or negotiate competitive provider contracts may adversely affect the Company's financial condition or results of operations.

Managed care organizations, both inside and outside California, operate in a highly competitive environment that has undergone significant change in recent years as a result of business consolidations, new strategic alliances, aggressive marketing practices by competitors and other market pressures. Additional increases in competition could adversely affect the Company's financial condition, cash flows or results of operations. Additional increases in competition (including competition from market entrants offering Internet−based products and services), could adversely affect the Company's financial condition.

As a result of the Company's acquisitions, the Company operates on a select geographic basis nationally and offers a spectrum of health care and specialty products through various risk−sharing arrangements. The Company's health care products include a variety of managed care offerings as well as traditional fee−for−service coverage. With respect to product type, fee−for−service products are generally less profitable than managed care products. A component of the Company's expansion strategy is to transition over time the traditional insurance members of the Company's acquired businesses to more managed care products.

With respect to the risk−sharing nature of products, managed care products that involve greater potential risk to the Company generally tend to be more profitable than management services products and those managed care products where the Company is able to shift risks to employer groups. Individuals and small employer groups are more likely to purchase the Company's higher−risk managed care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government−sponsored programs involve the Company's higher−risk managed care products. Over the past few years, the Company has experienced a slight decline in margins in its higher−risk managed care products and to a lesser extent on its lower−risk managed care and management services products. This decline is primarily attributable to product mix change, product design, competitive pressure and greater regulatory restrictions applicable to the small employer group market. From time to time, the Company has implemented price increases in certain of its managed care businesses. While these price increases are intended to improve profitability, there can be no assurance that this will occur. Subsequent unfavorable changes in the relative profitability between the Company's various products could have a material adverse effect on the Company's results of operations and on the continued merits of the Company's geographic expansion strategy.

Substantially all of the Company's investment assets are in interest−yielding debt securities of varying maturities or equity securities. The value of fixed income securities is highly sensitive to fluctuations in short− and long−term interest rates, with the value decreasing as such rates increase and increasing as such rates decrease. In addition, the value of equity securities can fluctuate significantly with changes in market conditions. Changes in the value of the Company's investment assets, as a result of interest rate fluctuations, can affect the Company's results of operations and stockholders' equity. There can be no assurances that interest rate fluctuations will not have a material adverse effect on the results of operations or financial condition of the Company.

The Company's operations are dependent on retaining existing employees, attracting additional qualified employees and achieving productivity gains from the Company's investment in technology. The Company faces intense competition for qualified information technology personnel and other skilled professionals. There can be no assurances that an inability to retain existing employees or attract additional employees will not have a material adverse effect on the Company's results of operations.

In December 2000, a wholly owned subsidiary of the Company completed its acquisition of certain mail order pharmaceutical service assets and conducts business as a mail order pharmacy. The pharmacy business is subject to extensive federal, state and local regulations which are in many instances different from those under which the Company's core health plan business currently operates.

The failure to properly adhere to these and other applicable regulations could result in the imposition of civil and criminal penalties, which could adversely affect the Company's results of operations or financial condition. In addition, pharmacies are exposed to risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Although the Company intends to maintain professional liability and errors and omissions liability insurance, there can be no assurances that the coverage limits under such insurance programs will be adequate to protect against future claims or that the Company will be able to maintain insurance on acceptable terms in the future.

Following the terrorist attacks of September 11, 2001, there have been various incidents of suspected bioterrorist activity in the United States. To date, these incidents have resulted in related isolated incidents of illness and death. However, federal and state law enforcement officials have issued public warnings about additional potential terrorist activity involving biological weapons. If the United States were to experience more widespread bioterrorist attacks, the Company's covered medical expenses could rise and the Company could experience a material adverse effect on its results of operations, financial condition and cash flow.

Item 7a. Quantitative and Qualitative Disclosures about Market Risk

The Company regularly evaluates its asset and liability interest rate risks as well as the appropriateness of investments relative to its internal investment guidelines. The Company operates within these guidelines by maintaining a well−diversified portfolio, both across and within asset classes. The Company has from time to time retained an independent consultant to advise the Company on the appropriateness of its investment policy and the compliance therewith.

Asset interest rate risk is managed within a duration band tied to the Company's liability interest rate risk. Credit risk is managed by maintaining high average quality ratings and a well−diversified portfolio.

The Company's use of derivative instruments is generally limited to hedging purposes and has principally consisted of forward exchange contracts and interest rate swaps. The foreign exchange contracts are intended to minimize the portfolio's exposure to currency volatility associated with certain foreign currency denominated bond holdings. The Company's investment policy prohibits the use of derivatives for leveraging purposes as well as the creation of risk exposures not otherwise allowed within the policy.

Since 1996, the Company has from time to time entered into interest rate swap agreements primarily by exchanging the floating debt payments due under its outstanding indebtedness for fixed rate payments. The Company believes that this allows it to better anticipate its interest payments while helping to manage the asset−liability relationship.

Interest Rate Risk

As of December 31, 2001, approximately 71% of the Company's investment portfolio consisted of fixed income securities (maturing in more than one year). Of the remainder, 10% was comprised of equities and 19% was comprised of cash, which is not subject to interest rate risk, the value of which generally varies inversely with changes in interest rates.

The Company has evaluated the net impact to the fair value of its fixed income investments from a hypothetical change in all interest rates of 100, 200 and 300 basis points ("bp"). In doing so, optionality was addressed through Monte Carlo simulation of the price behavior of securities with embedded options. In addressing prepayments on mortgage−backed securities, the model follows the normal market practice of estimating a non−interest rate sensitive component (primarily related to relocations) and an interest sensitive component (primarily related to refinancings) separately. The model is based on statistical techniques applied to historical prepayment and market data, and then incorporates

forward−looking mortgage market research and judgments about future prepayment behavior. Changes in the fair value of the investment portfolio are reflected in the balance sheet through stockholders' equity. Under the requirements of SFAS No. 133, effective January 1, 2001, all derivative financial instruments are reflected on the balance sheet at fair value. The results of this analysis as of December 31, 2001 are reflected in the table below. The table reflects the change in valuation of interest rate swap agreements for the year ended December 31, 2001 to the extent that the notional amount of interest rate swap agreements exceeded the principal balance of the Company's floating rate indebtedness.

	Increase (decrease) in fair value given an interest rate increase of:		
	100 bp	200 bp	300 bp
	(In millions)		
Fixed Income Portfolio	$ (120.0)	$ (236.3)	$ (346.8)
Valuation of Interest Rate Swap Agreements	4.8	9.4	13.8
	$ (115.2)	$ (226.9)	$ (333.0)

Results as of December 31, 2000 are reflected in the table below. The table reflects the change in valuation of interest rate swap agreements for the year ended December 31, 2000 to the extent that the notional amount of interest rate swap agreements exceeded the principal balance of the Company's floating rate indebtedness.

	Increase (decrease) in fair value given an interest rate increase of:		
	100 bp	200 bp	300 bp
	(In millions)		
Fixed Income Portfolio	$ (85.5)	$ (170.0)	$ (250.1)
Valuation of Interest Rate Swap Agreements	6.1	12.0	17.6
	$ (79.4)	$ (158.0)	$ (232.5)

The Company believes that an interest rate shift in a 12−month period of 100 bp represents a moderately adverse outcome, while a 200 bp shift is significantly adverse and a 300 bp shift is unlikely given historical precedents. Although the Company holds its bonds as "available for sale" for purposes of SFAS No. 115, the Company's cash flows and the short duration of its investment portfolio should allow it to hold securities to maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Interest Rate Swap Agreements

The Company has entered into interest rate swap agreements in order to reduce the volatility of interest expense resulting from changes in interest rates. As of December 31, 2001, the Company had entered into $200 million of floating to fixed rate swap agreements, which consisted of a $150 million notional amount swap agreement at 6.99% and a $50 million notional amount swap agreement at 7.06%. As of December 31, 2001, the Company also had $235 million of LIBOR−based floating rate debt outstanding. The Company also receives a LIBOR−based payment as a result of its swap arrangements, thereby eliminating the payment exposure to changes in interest rates on that $235 million of outstanding debt.

Equity Price Risk

The Company's equity securities are comprised primarily of domestic stocks as well as certain foreign holdings. Assuming an immediate decrease of 10% in market value, as of December 31, 2001

and 2000, the hypothetical loss in fair value of stockholders' equity was estimated to be approximately $47.8 million and $39.3 million, respectively.

Foreign Exchange Risk

The Company has generally hedged the foreign exchange risk associated with its fixed income portfolio. The Company uses short−term foreign exchange contracts to hedge the risk associated with certain fixed−income securities denominated in foreign currencies. Therefore, the Company believes that there is minimal risk to the fixed−income portfolio due to currency exchange rate fluctuations. The Company's hedging program related to its foreign currency denominated investments is described in Note 15 to the Consolidated Financial Statements. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and entered into a hedge to offset the remaining currency hedge.

The Company does not hedge its foreign exchange risk arising from equity investments denominated in foreign currencies. Assuming a foreign exchange loss of 10% across all foreign equity investments, the net hypothetical pretax loss in fair value as of December 31, 2001 and 2000, was estimated to be $6.6 million and $8.1 million, respectively.

Item 8. Financial Statements and Supplementary Data

The location in this Annual Report on Form 10−K of the Company's Consolidated Financial Statements is set forth in the "Index" on Page F−1.

WellPoint Health Networks Inc.
Quarterly Selected Financial Information
(Unaudited)

	As of and for the Quarter Ended			
	March 31, 2001	June 30, 2001	September 30, 2001	December 31, 2001
	(In thousands, except per share data and membership data)			
Total revenues	$ 2,615,453	$ 3,145,406	$ 3,245,472	$ 3,422,316
Operating income	180,656	201,550	217,809	223,210
Income before provision for income taxes	159,151	169,381	183,820	186,230
Net income	$ 96,503	$ 99,929	$ 108,446	$ 109,868
Per Share Data(A):				
Earnings Per Share	$ 0.77	$ 0.79	$ 0.85	$ 0.86
Earnings Per Share Assuming Full Dilution	$ 0.74	$ 0.76	$ 0.82	$ 0.83
Medical membership	9,763,829	9,835,091	9,992,764	10,146,945

	As of and for the Quarter Ended			
	March 31, 2000	June 30, 2000	September 30, 2000	December 31, 2000
	(In thousands, except per share data and membership data)			
Total revenues	$ 2,145,246	$ 2,288,835	$ 2,353,324	$ 2,441,553
Operating income	143,946	157,692	165,133	167,417
Income before provision for income taxes	130,615	137,194	146,727	149,777
Net income	$ 79,644	$ 83,667	$ 89,504	$ 89,472
Per Share Data(A):				
Earnings Per Share	$ 0.63	$ 0.67	$ 0.72	$ 0.71
Earnings Per Share Assuming Full Dilution	$ 0.62	$ 0.65	$ 0.69	$ 0.69
Medical membership	7,541,027	7,617,773	7,742,973	7,869,119

(A) Per share data for each period presented has been restated to reflect the two−for−one stock split which occurred March 15, 2002.

Item 9. Changes And Disagreements With Accountants On Accounting And Financial Disclosure

None.

PART III

Item 10. Directors And Executive Officers Of The Registrant

A. Directors of the Company.

Information regarding the directors of the Company will be contained in the Company's proxy statement for its 2002 Annual Meeting of Stockholders and is incorporated herein by reference.

B. Executive Officers of the Company

Information regarding the Company's executive officers is contained in Part I above under the caption "Item 1. Business."

Item 11. Executive Compensation

The information required by Item 11 will be contained in the Company's proxy statement for its 2002 Annual Meeting of Stockholders and is incorporated herein by reference.

Item 12. Security Ownership Of Certain Beneficial Owners And Management

The information required by Item 12 will be contained in the Company's proxy statement for its 2002 Annual Meeting of Stockholders and is incorporated herein by reference.

Item 13. Certain Relationships And Related Transactions

The information required by Item 13 will be contained in the Company's proxy statement for its 2002 Annual Meeting of Stockholders and is incorporated herein by reference.

PART IV

Item 14. Exhibits, Financial Statements Schedules And Reports On Form 8−K.

a. 1) Financial Statements

The consolidated financial statements are contained herein as listed on the "Index" on page F−1 hereof.

2) Financial Statement Schedules

All of the financial statement schedules for which provision is made in the applicable accounting regulations of the Commission are not required under the applicable instructions or are not applicable and therefore have been omitted.

b. Reports on Form 8−K

On December 7, 2001, the Company filed a Current Report on Form 8−K which reported that the Company had signed the Agreement and Plan of Merger dated as of November 20, 2001 among the Company, CareFirst, Inc. ("CareFirst") and Congress Acquisition Corp., a wholly owned subsidiary of the Company, pursuant to which CareFirst would merge with Congress Acquisition Corp.

c. Exhibits

Exhibit Number	Exhibit
2.01	Amended and Restated Recapitalization Agreement dated as of March 31, 1995, by and among the Registrant, Blue Cross of California, Western Health Partnerships and Western Foundation for Health Improvement incorporated by reference to Exhibit 2.1 of Registrant's Registration Statement on Form S−4 dated April 8, 1996
2.02	Amended and Restated Agreement and Plan of Merger dated as of November 29, 2000, by and among Cerulean Companies, Inc., the Registrant and Water Polo Acquisition Corp, incorporated by reference to Exhibit 2.01 of the Registrant's Current Report on Form 8−K dated March 15, 2001.
2.03	Agreement and Plan of Merger dated as of October 17, 2001 by and among the Registrant, RightCHOICE Managed Care, Inc. ("RightCHOICE") and RWP Acquisition Corp., Incorporated by reference to Exhibit 2.01 to the Registrant's Registration Statement on Form S−4 (registration no. 333−73382)
2.04	Agreement and Plan of Merger dated as of November 20, 2001 by and among WellPoint Health Networks Inc., CareFirst, Inc. and Congress Acquisition Corp., incorporated by reference to Exhibit 99.1 to the Registrant's Current Report on Form 8−K dated November 20, 2001
3.01	Restated Certificate of Incorporation of the Registrant, incorporated by reference to Exhibit 3.1 of the Registrant's Current Report on Form 8−K filed on August 5, 1997.
3.02	Bylaws of the Registrant, incorporated by reference to Exhibit 4.2 of the Registrant's Registration Statement on Form S−8 (Registration No. 333−90791)
4.01	Specimen of Common Stock certificate of WellPoint Health Networks Inc., incorporated by reference to Exhibit 4.4 of the Registrant's Registration Statement on Form 8−B, Registration No. 001−13083
4.02	Restated Certificate of Incorporation of the Registrant (included in Exhibit 3.01)
4.03	Bylaws of the Registrant (included in Exhibit 3.02)
4.04	Indenture dated as of July 2, 1999 by and between Registrant and the Bank of New York, as trustee (including the Form of Debenture attached as Exhibit A thereto), incorporated by reference to Exhibit 4.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 1999.
4.05	Amended and Restated Senior Indenture dated as of June 8, 2001 by and between the Registrant and the Bank of New York, as trustee, incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8−K dated June 7, 2001.
4.06	Form of Note evidencing the Registrant's $6^{3}/_{8}$% Notes due 2006, incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8−K dated June 12, 2001.
4.07	Form of Note evidencing the Registrant's $6^{3}/_{8}$% Notes due 2012, incorporated by reference to Exhibit 4.1 of the Registrant's Current Report on Form 8−K dated January 12, 2002.
9.01	Voting Trust Agreement dated as of January 31, 2002 by and among the Registrant, the Missouri Foundation for Health and Wilmington Trust Company, incorporated by reference to Exhibit 9.01 to the Registrant's Current Report on Form 8−K dated January 31, 2002
10.01	Undertakings dated January 7, 1993, by the Registrant, Blue Cross of California and certain subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 10.24 of the Registrant's Form S−1 Registration Statement No. 33−54898

10.02* Supplemental Pension Plan of Blue Cross of California, incorporated by reference to Exhibit 10.15 of the Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1992

10.03* Form of Indemnification Agreement between the Registrant and its Directors and Officers, incorporated by reference to Exhibit 10.17 of the Registrant's Form S−1 Registration Statement No. 33−54898

10.04* Officer Severance Agreement, dated as of July 1, 1993, between the Registrant and Thomas C. Geiser, incorporated by reference to Exhibit 10.24 of the Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1993

10.05 Orders Approving Notice of Material Modification and Undertakings dated September 7, 1995, by BCC, the Registrant and the Registrant's subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 10.47 of Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 1995

10.06 Lease Agreement, dated as of January 1, 1996, by and between TA/Warner Center Associates II, L.P., and the Registrant, incorporated by reference to Exhibit 10.46 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995

10.07* Letter, dated November 13, 1995, from the Registrant to D. Mark Weinberg regarding severance benefits, together with underlying Officer Severance Agreement, incorporated by reference to Exhibit 10.48 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995

10.08* Letter, dated November 13, 1995, from the Registrant to Thomas C. Geiser regarding severance benefits, incorporated by reference to Exhibit 10.49 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995

10.09 Amended and Restated Undertakings dated March 5, 1996, by BCC, the Registrant and the Registrant's subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 99.1 of the Registrant's Current Report on Form 8−K dated March 5, 1996

10.10 Indemnification Agreement dated as of May 17, 1996, by and among the Registrant, WellPoint Health Networks Inc., a Delaware corporation, and Western Health Partnerships, incorporated by reference to Exhibit 99.9 of the Registrant's Current Report on Form 8−K dated May 20, 1996

10.11 Amended and Restated Share Escrow Agent Agreement dated as of August 4, 1997 by and between the Registrant and U.S. Trust Company of California, N.A., incorporated by reference to Exhibit 99.4 of the Registrant's Current Report on Form 8−K filed on August 5, 1997

10.12 Blue Cross License Agreement effective as of January 31, 2002 by and among the Registrant and the Blue Cross Blue Shield Association (the "BCBSA")

10.13 Blue Cross Controlled Affiliate License Agreement effective as of August 4, 1997 by and between the BCBSA and Blue Cross of California, incorporated by reference to Exhibit 99.8 of Registrant's Current Report on Form 8−K filed on August 5, 1997

10.14 Blue Cross Affiliate License Agreement effective as of August 4, 1997 by and between the BCBSA and BC Life & Health Insurance Company, incorporated by reference to Exhibit 99.9 of Registrant's Current Report on Form 8−K filed on August 5, 1997

10.15 Blue Cross Controlled Affiliate License Agreement Applicable to Life Insurance Companies effective as of August 4, 1997 by and between the BCBSA and BC Life & Health Insurance Company, incorporated by reference to Exhibit 99.10 of Registrant's Current Report on Form 8−K filed on August 5, 1997

10.16	Undertakings dated July 31, 1997 by the Registrant, WellPoint California and WellPoint California Services, Inc. to the California Department of Corporations, incorporated by reference to Exhibit 99.12 to the Registrant's Current Report on Form 8−K filed on August 5, 1997
10.17*	401(k) Retirement Savings Program of WellPoint Health Networks Inc., as amended through January 1, 2001, incorporated by reference to Exhibit 10.23 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.18*	WellPoint Officer Benefit Enrollment Guide Brochure
10.19*	Office Lease dated as of December 2, 1997 by and among the Registrant and Westlake Business Park, Ltd., incorporated by reference to Exhibit 10.48 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 1997
10.20	Amendment No. 1 dated as of June 12, 1998 to the Amended and Restated Share Escrow Agent Agreement by and between the Registrant and U.S. Trust Company of California, N.A., incorporated by reference to Exhibit 99.3 to the Registrant's Current Report on Form 8−K filed on June 15, 1998
10.21*	Promissory Note dated as of June 23, 1998 made by Joan E. Herman in favor of the Registrant, incorporated by reference to Exhibit 10.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 1998
10.22*	WellPoint Health Networks Inc. Officer Change−in−Control Plan (as amended and restated through December 4, 2001)
10.23*	WellPoint Health Networks Inc. Officer Severance Plan (as amended and restated through December 4, 2001)
10.24*	WellPoint Health Networks Inc. Management Bonus Plan, incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.25*	Board of Directors Deferred Compensation Plan of WellPoint Health Networks Inc., incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 1998.
10.26*	Employment Agreement dated as of February 10, 1999 by and between the Registrant and Leonard D. Schaeffer, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999.
10.27*	Promissory Note dated as of February 10, 1999 made by Leonard D. Schaeffer in favor of the Registrant, incorporated by reference to Exhibit 10.02 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999
10.28*	Special Executive Retirement Plan dated as of February 10, 1999 by and between the Registrant and Leonard D. Schaeffer, incorporated by reference to Exhibit 10.03 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999
10.29*	1999 Stock Incentive Plan, as amended through December 6, 2000, incorporated by reference to Exhibit 10.37 of the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.30*	1999 Executive Officer Annual Incentive Plan, incorporated by reference to Annex II to the Registrant's Proxy Statement on Schedule 14A dated March 28, 2001
10.31*	WellPoint Health Networks Inc. Comprehensive Executive Non−Qualified Retirement Plan (as amended through February 1, 2001), incorporated by reference to Exhibit 10.39 of the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000

10.32*	WellPoint Health Networks Inc. Employee Stock Purchase Plan (as amended and restated effective April 1, 2000), incorporated by reference to Annex I to the Registrant's definitive Proxy Statement on Schedule 14A dated March 23, 2000
10.33*	WellPoint Health Networks Inc. 2000 Employee Stock Option Plan (as amended through October 19, 2001)
10.34*	Amendment No. 1 to the Special Executive Retirement Plan for Leonard D. Schaeffer, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 2000
10.35*	WellPoint Health Networks Inc. Supplemental Executive Retirement Plan (as restated effective December 4, 2001)
10.36*	Promissory Note made by Woodrow A. Myers, Jr., M.D. in favor of the Registrant, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 2000
10.37	Credit Agreement ($750,000,000 Five−Year Revolving Credit and Competitive Advance Facility) dated as of March 30, 2001 by and among the Registrant, the lenders from time to time party thereto, Bank of America, N.A., as administrative agent, and Banc of America Securities LLC and JPMorgan, as joint arrangers and joint book managers, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.38	Credit Agreement ($250,000,000 364−Day Revolving Credit and Competitive Advance Facility) dated as of March 30, 2001 by and among the Registrant, the lenders from time to time party thereto, Bank of America, N.A., as administrative agent, and Banc of America Securities LLC and JPMorgan, as joint arrangers and joint book managers, incorporated by reference to Exhibit 10.02 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.39	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Blue Cross and Blue Shield of Georgia, Inc. ("Georgia Blue") and the Registrant, incorporated by reference to Exhibit 10.03 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.40	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Georgia Blue and the Registrant, incorporated by reference to Exhibit 10.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.41	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Blue Cross Blue Shield Health Care Plan of Georgia, Inc. ("Georgia Blue HMO") and Registrant, incorporated by reference to Exhibit 10.05 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.42	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Georgia Blue HMO and the Registrant, incorporated by reference to Exhibit 10.06 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.43	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Greater Georgia Life Insurance Company ("GGL") and the Registrant, incorporated by reference to Exhibit 10.07 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.44	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, and GGL and the Registrant, incorporated by reference to Exhibit 10.08 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001

10.45*	Amendment No. 1 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001), incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 2001
10.46	California Blue Cross License Addendum dated as of January 31, 2002 by and among the Registrant and the BCBSA
10.47	California Blue Shield License Addendum dated as of January 31, 2002 by and among the Registrant and the BCBSA
10.48	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, RightCHOICE Managed Care, Inc. ("RightCHOICE") and the Registrant
10.49	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, RightCHOICE and the Registrant
10.50	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, Healthy Alliance Life Insurance Company ("HALIC") and the Registrant
10.51	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HALIC and the Registrant
10.52	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HMO Missouri, Inc. ("HMO Missouri") and the Registrant
10.53	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HMO Missouri and the Registrant
10.54	Registration Rights Agreement dated as of October 17, 2001 by and between the Registrant and the Missouri Foundation for Health, incorporated by reference to Exhibit 10.01 to the Registrant's Current Report on Form 8−K dated January 31, 2002
10.55*	Amendment No. 2 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.56*	Amendment No. 3 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.57*	Amendment No. 4 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.58	Blue Shield License Agreement effective as of January 31, 2002 by and between the Registrant and the BCBSA
21	List of Subsidiaries of the Registrant
23.1	Consent of Independent Accountants
24	Power of Attorney (included on Signature Page).

*

Management contract or compensatory plan or arrangement

SIGNATURES

Pursuant to the requirement of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: March 28, 2002

WELLPOINT HEALTH NETWORKS INC.

By: /s/ LEONARD D. SCHAEFFER

Leonard D. Schaeffer
Chairman of the Board of Directors and Chief Executive Officer

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS:

That the undersigned officers and directors of WellPoint Health Networks Inc. do hereby constitute and appoint Leonard D. Schaeffer and Thomas C. Geiser, and each of them, the lawful attorney and agent or attorneys and agents with power and authority to do any and all acts and things and to execute any and all instruments which said attorneys and agents, or either of them, determine may be necessary or advisable or required to enable WellPoint Health Networks Inc. to comply with the Securities Exchange Act of 1934, as amended, and any rules or regulations or requirements of the Securities and Exchange Commission in connection with this Annual Report on Form 10−K. Without limiting the generality of the foregoing power and authority, the powers granted include the power and authority to sign the names of the undersigned officers and directors in the capacities indicated below to this Annual Report on Form 10−K or amendment or supplements thereto, and each of the undersigned hereby ratifies and confirms all that said attorneys and agent, or either of them, shall do or cause to be done by virtue hereof. This Power of Attorney may be signed in several counterparts.

IN WITNESS WHEREOF, each of the undersigned has executed this Power of Attorney as of the date indicated opposite his or her name.

Pursuant to the requirements of the Securities Exchange Act of 1934, the Report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ LEONARD D. SCHAEFFER Leonard D. Schaeffer	Chairman of the Board of Directors and Chief Executive Officer (Principal Executive Officer)	March 28, 2002
/s/ DAVID C. COLBY David C. Colby	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	March 28, 2002

/s/ KENNETH C. ZUREK Kenneth C. Zurek	Senior Vice President, Controller and Taxation (Principal Accounting Officer)	March 28, 2002
/s/ W. TOLIVER BESSON W. Toliver Besson	Director	March 28, 2002
/s/ ROGER E. BIRK Roger E. Birk	Director	March 28, 2002
/s/ SHEILA P. BURKE Sheila P. Burke	Director	March 28, 2002
/s/ WILLIAM H.T. BUSH William H.T. Bush	Director	March 28, 2002
/s/ STEPHEN L. DAVENPORT Stephen L. Davenport	Director	March 28, 2002
/s/ JULIE A. HILL Julie A. Hill	Director	March 28, 2002
/s/ WARREN Y. JOBE Warren Y. Jobe	Director	March 28, 2002
/s/ ELIZABETH A. SANDERS Elizabeth A. Sanders	Director	March 28, 2002

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WELLPOINT HEALTH NETWORKS INC.

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Report of Independent Accountants

To the Stockholders and Board of Directors
WellPoint Health Networks Inc.

In our opinion, the accompanying consolidated balance sheets and the related consolidated income statements and consolidated statements of changes in stockholders' equity and cash flows present fairly, in all material respects, the financial position of WellPoint Health Networks Inc. and its subsidiaries (the "Company") at December 31, 2001 and 2000, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2001, in conformity with accounting principles generally accepted in the United States of America. 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 of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 3 to the Consolidated Financial Statements, effective January 1, 1999, the Company changed its method of accounting for start−up costs.

PricewaterhouseCoopers LLP
Los Angeles, California
January 31, 2002,
except Note 3 as to which the date is March 15, 2002, and
Note 22 as to which the date is March 18, 2002

WellPoint Health Networks Inc.

Consolidated Balance Sheets

	2001	2000
	(In thousands, except share data)	
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 1,028,476	$ 566,889
Investment securities, at market value	3,832,982	3,096,350
Receivables, net	841,722	699,868
Deferred tax assets, net	79,063	77,757
Other current assets	90,398	59,545
Total Current Assets	5,872,641	4,500,409
Property and equipment, net	222,080	151,031
Intangible assets, net	430,488	165,164
Goodwill, net	661,346	418,120
Long−term investments, at market value	124,611	116,811
Deferred tax assets, net	54,486	92,982
Other non−current assets	106,481	60,189
Total Assets	$ 7,472,133	$ 5,504,706
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Medical claims payable	$ 1,934,620	$ 1,566,569
Reserves for future policy benefits	62,739	58,085
Unearned premiums	332,813	232,132
Accounts payable and accrued expenses	783,026	513,637
Experience rated and other refunds	255,570	249,725
Income taxes payable	64,654	53,898
Other current liabilities	632,383	398,867
Total Current Liabilities	4,065,805	3,072,913
Accrued postretirement benefits	94,124	71,510
Reserves for future policy benefits, non−current	222,406	267,552
Long−term debt	837,957	400,855
Other non−current liabilities	119,262	47,459
Total Liabilities	5,339,554	3,860,289
Stockholders' Equity:		
Preferred Stock—$0.01 par value, 50,000,000 shares authorized, none issued and outstanding	—	—
Common Stock—$0.01 par value, 300,000,000 shares authorized, 71,390,971 issued at December 31, 2001 and 2000	714	714
Treasury stock, at cost, 7,474,305 and 8,566,399 shares at December 31, 2001 and 2000, respectively	(465,805)	(536,524)
Additional paid−in capital	1,002,193	983,028
Retained earnings	1,548,941	1,145,464
Accumulated other comprehensive income	46,536	51,735
Total Stockholders' Equity	2,132,579	1,644,417
Total Liabilities and Stockholders' Equity	$ 7,472,133	$ 5,504,706

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.

Consolidated Income Statements

	Year Ended December 31,		
	2001	**2000**	**1999**
	(In thousands, except earnings per share)		
Revenues:			
Premium revenue	$ 11,577,170	$ 8,583,663	$ 6,896,857
Management services and other revenue	609,693	451,847	429,336
Investment income	241,784	193,448	159,234
	12,428,647	9,228,958	7,485,427
Operating Expenses:			
Health care services and other benefits	9,436,264	6,935,398	5,533,068
Selling expense	502,571	394,217	328,619
General and administrative expense	1,666,587	1,265,155	1,075,449
	11,605,422	8,594,770	6,937,136
Operating Income	823,225	634,188	548,291
Interest expense	49,929	23,978	20,178
Other expense, net	74,714	45,897	40,792
Income before Provision for Income Taxes, Extraordinary Gain and Cumulative Effect of Accounting Change	698,582	564,313	487,321
Provision for income taxes	283,836	222,026	190,110
Income before Extraordinary Gain and Cumulative Effect of Accounting Change	414,746	342,287	297,211
Extraordinary Gain from Early Extinguishment of Debt, net of tax	—	—	1,891
Cumulative Effect of Accounting Change, net of tax	—	—	(20,558)
Net Income	$ 414,746	$ 342,287	$ 278,544
Earnings Per Share(A):			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.27	$ 2.74	$ 2.25
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.02
Cumulative effect of accounting change, net of tax	—	—	(0.16)
Net income	$ 3.27	$ 2.74	$ 2.11
Earnings Per Share Assuming Full Dilution(A):			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.15	$ 2.64	$ 2.19
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.01
Cumulative effect of accounting change, net of tax	—	—	(0.15)
Net income	$ 3.15	$ 2.64	$ 2.05

(A) Per share data for each period presented has been calculated to reflect the two−for−one stock split which occurred March 15, 2002.

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.
Consolidated Statements of Changes in Stockholders' Equity

	Preferred Stock	Common Stock Issued Shares	Common Stock Issued Amount	Common Stock In Treasury Shares	Common Stock In Treasury Amount	Additional Paid−in Capital	Retained Earnings	Accumulated Other Comprehensive Income	Total
				(in thousands)					
Balance as of January 1, 1999	$ —	70,621	$ 706	3,502	$ (193,435)	$ 921,747	$ 576,598	$ 9,607	$ 1,315,223
Stock grants to employees and directors		75	1	(4)	172	3,051			3,224
Stock issued for employee stock option and stock purchase plans		695	7	(66)	3,616	30,218			33,841
Stock repurchased, at cost				4,333	(291,684)				(291,684)
Net losses from treasury stock reissued							(500)		(500)
Comprehensive income (loss)									
Net income							278,544		278,544
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								(26,179)	(26,179)
Foreign currency adjustments, net of tax								231	231
Total comprehensive income (loss)							278,544	(25,948)	252,596
Balance as of December 31, 1999	—	71,391	714	7,765	(481,331)	955,016	854,642	(16,341)	1,312,700
Stock grants to employees and directors				(15)	1,013				1,013
Stock issued for employee stock option and stock purchase plans				(1,668)	118,396	28,012			146,408
Stock repurchased, at cost				2,484	(174,602)				(174,602)
Net losses from treasury stock reissued							(51,465)		(51,465)
Comprehensive income									
Net income							342,287		342,287
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								68,045	68,045
Foreign currency adjustments, net of tax								31	31
Total comprehensive income							342,287	68,076	410,363
Balance as of December 31, 2000	—	71,391	714	8,566	(536,524)	983,028	1,145,464	51,735	1,644,417
Stock grants to employees and directors				(14)	886				886
Stock issued for employee stock option and stock purchase plans				(1,153)	77,266	19,165			96,431
Stock repurchased, at cost				75	(7,433)				(7,433)
Net losses from treasury stock reissued							(11,269)		(11,269)
Comprehensive income (loss)									
Net income							414,746		414,746
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								17,569	17,569
Foreign currency adjustments, net of tax								(262)	(262)
Minimum pension liability adjustment, net of tax								(22,506)	(22,506)
Total comprehensive income (loss)							414,746	(5,199)	409,547
Balance as of December 31, 2001	$ —	71,391	$ 714	7,474	$ (465,805)	$ 1,002,193	$ 1,548,941	$ 46,536	$ 2,132,579

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.

Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Cash flows from operating activities:			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Adjustments to reconcile income before extraordinary gain and cumulative effect of accounting change to net cash provided by operating activities:			
Depreciation and amortization, net of accretion	110,157	75,402	68,767
Loss on sales of assets, net	13,283	24,170	31,898
Provision (benefit) for deferred income taxes	15,915	(61,188)	41,087
Amortization of deferred gain on sale of building	(4,426)	(4,426)	(4,426)
Accretion of interest on zero coupon convertible subordinated debentures and 6 3/8% Notes	3,128	2,971	1,465
(Increase) decrease in certain assets:			
Receivables, net	18,365	(162,375)	(29,263)
Income taxes recoverable	—	—	191,079
Other current assets	(20,892)	1,829	(26,169)
Other non−current assets	(9,126)	(5,324)	(8,451)
Increase (decrease) in certain liabilities:			
Medical claims payable	109,676	367,189	195,681
Reserves for future policy benefits	(48,307)	(23,424)	(25,019)
Unearned premiums	66,812	1,460	15,349
Accounts payable and accrued expenses	94,663	61,856	107,086
Experience rated and other refunds	2,315	26,659	(26,619)
Income taxes payable	(32,256)	(30,070)	—
Other current liabilities	81,199	20,692	(5,227)
Accrued postretirement benefits	3,047	2,607	1,845
Other non−current liabilities	(12,135)	7,634	3,064
Net cash provided by operating activities	806,164	647,949	829,358
Cash flows from investing activities:			
Investments purchased	(4,914,118)	(3,427,465)	(3,456,317)
Proceeds from investments sold	4,628,088	2,979,906	2,892,802
Proceeds from investments matured	74,972	86,412	83,404
Property and equipment purchased	(92,937)	(46,891)	(38,516)
Proceeds from property and equipment sold	8,481	2,358	1,925
Settlement of sales price for sale of Workers' Compensation business	—	—	(6,733)
Acquisition of new businesses, net of cash acquired	(561,652)	(151,748)	(7,700)
Net cash used in investing activities	(857,166)	(557,428)	(531,135)
Cash flows from financing activities:			
Proceeds from issuance of zero coupon convertible subordinated debentures	—	—	200,823
Net borrowing (repayment) of long−term debt under the revolving credit facility	(15,000)	50,000	(149,788)
Net borrowing of long−term debt under 6 3/8% Notes due 2006	448,974	—	—
Proceeds from issuance of common stock	86,048	95,956	36,565
Common stock repurchased	(7,433)	(174,602)	(291,684)
Net cash provided by (used in) financing activities	512,589	(28,646)	(204,084)
Net increase in cash and cash equivalents	461,587	61,875	94,139
Cash and cash equivalents at beginning of period	566,889	505,014	410,875
Cash and cash equivalents at end of period	1,028,476	$ 566,889	$ 505,014

See the accompanying notes to the consolidated financial statements.

1. ORGANIZATION

WellPoint Health Networks Inc. (the "Company" or "WellPoint") is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), point−of−service ("POS") plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial service, network access, medical cost management and claims processing. The Company offers a continuum of managed health care plans while providing incentives to members and employers to select more intensively managed plans. The Company also provides a broad array of specialty and other products and services including pharmacy, dental, utilization management, vision, life insurance, preventive care, disability, behavioral health, medicare supplements, COBRA and flexible benefits account administration.

2. ACQUISITIONS

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross Blue Shield of Georgia, Inc., which served approximately 1.9 million medical members in the state of Georgia as of March 31, 2001. This acquisition was accounted for under the purchase method of accounting and, accordingly, the consolidated results of operations of the Company include the results of Cerulean from the date of acquisition. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company estimates that it will incur up to $140.6 million in expenses primarily related to change in control payments to Cerulean management and transaction costs. Generally accepted accounting principles require that these expenses, which are not associated with the generation of future revenues and have no future economic benefit, be reflected as assumed liabilities in the allocation of the purchase price to the net assets acquired. Cash of $200.0 million and debt of $500.0 million were used to purchase net assets with a fair value of approximately $334.8 million. Goodwill and other intangibles totaling $572.7 million includes $66.9 million of deferred and current tax liabilities relating to identified intangibles. The estimated purchase price allocation between goodwill and identifiable intangible assets is $282.7 million and $290.0 million, respectively.

On March 1, 2000, the Company completed its acquisition of Rush Prudential Health Plans ("Rush Prudential"). Rush Prudential offers a broad array of products and services ranging from HMO products to traditional PPO products. The acquisition significantly increased the Company's Illinois medical membership to nearly 600,000 members as of March 31, 2000. Subsequent to the acquisition, the acquired business has been operated as UNICARE Health Plans. The transaction, which was financed with both cash from operations and debt from the Company's existing revolving credit facility, is valued at approximately $202.6 million. This acquisition was accounted for under the purchase method of accounting. Cash of $102.6 million and debt totaling $100.0 million were used to purchase net assets with a fair value of approximately $19.4 million, resulting in goodwill and other intangibles totaling $215.5 million. The resulting goodwill includes $32.3 million of deferred tax liabilities relating to identified intangibles. The purchase price allocation between goodwill and identifiable intangible assets is $135.8 million and $79.7 million, respectively.

On December 5, 2000, the Company completed its acquisition of a mail order pharmacy fulfillment facility from RxAmerica LLC ("RxAmerica"). RxAmerica is a pharmacy benefits management joint

venture between Albertson's, Inc. and Longs Drugs Stores California, Inc. Subsequent to the acquisition, the business was re−named PrecisionRx. This acquisition was accounted for under the purchase method of accounting.

In accordance with the requirements of APB Opinion No. 16, "Business Combinations," the following unaudited pro forma summary presents revenues, net income and per share data of WellPoint as if the acquisitions of Cerulean, Rush Prudential and PrecisionRx had occurred on January 1, 2000. The pro forma information includes the results of operations for the period prior to the acquisition, adjusted for interest expense on long−term debt incurred to fund the acquisition of Cerulean and Rush Prudential, amortization of goodwill and intangible assets and the related income tax effects. The pro forma financial information is presented for informational purposes only and may not be indicative of the results of operations had the Company been a single entity during the years ended December 31, 2001 and 2000, nor is it necessarily indicative of future results of operations. Pro forma earnings per share is based on 126.9 million and 125.1 million weighted average shares for the years ended December 31, 2001 and 2000, respectively. Pro forma earnings per share assuming full dilution is based on 132.4 million and 130.2 million weighted average shares for the years ended December 31, 2001 and 2000, respectively.

	Year Ended December 31,	
	2001	2000
	(In millions, except earnings per share)	
Revenues	$ 12,915.3	$ 11,473.9
Net Income	$ 424.1	$ 342.3
Earnings Per Share	$ 3.34	$ 2.74
Earnings Per Share Assuming Full Dilution	$ 3.22	$ 2.64

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

As a managed health care organization, the Company derives the majority of its revenues from premiums received for providing prepaid health services and prepares its financial statements in accordance with the AICPA Audit and Accounting Guide for "Health Care Organizations." The following is a summary of significant accounting policies used in the preparation of the accompanying consolidated financial statements. Such policies are in accordance with accounting principles generally accepted in the United States of America and have been consistently applied. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses for each reporting period. The significant estimates made in the preparation of the Company's consolidated financial statements relate to the assessment of the carrying value of the goodwill and intangible assets, medical claims payable, reserves for future policy benefits, experience rated refunds and contingent liabilities. While management believes that the carrying value of such assets and liabilities is adequate as of December 31, 2001 and 2000, actual results could differ from the estimates upon which the carrying values were based.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its subsidiaries. All significant intercompany transactions and accounts have been eliminated in consolidation.

Cash Equivalents

The Company considers cash equivalents to include highly liquid debt instruments purchased with an original remaining maturity of three months or less.

Concentration of Credit Risk

Financial instruments that potentially subject the Company to significant concentrations of credit risk consist principally of cash investments, bonds, foreign currency denominated forward exchange contracts and interest rate swap agreements. The Company invests its excess cash primarily in commercial paper and money market funds. Although a majority of the cash accounts exceed the federally insured deposit amount, management does not anticipate nonperformance by financial institutions and reviews the financial viability of these institutions. The Company attempts to limit its risk in investment securities by maintaining a diversified portfolio. The components of investment securities are shown in Note 4.

Investments

Investment securities consist primarily of U.S. Treasury and agency securities, foreign currency denominated bonds, mortgage−backed securities, investment grade and non−investment grade corporate bonds, equity securities and venture capital. The Company has determined that its investment securities are available for use in current operations and, accordingly, has classified such investment securities as current without regard to contractual maturity dates.

Long−term investments consist primarily of restricted assets, equity and other investments. Restricted assets, at market value, included in long−term investments at December 31, 2001 and 2000 were $106.6 million and $104.1 million, respectively, and consisted of investments on deposit with the California Department of Managed Health Care ("DMHC"). These deposits consisted primarily of U.S. Treasury and agency securities. Due to their restricted nature, such investments are classified as long−term without regard to contractual maturity.

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. Unrealized gains and losses are computed on the basis of specific identification and are included in other comprehensive income, net of applicable deferred income taxes. Realized gains and losses on the disposition of investments are included in investment income. The specific identification method is used in determining the cost of debt and equity securities sold.

The Company evaluates all of its investments based on current economic conditions, declining market valuation and financial condition of the issuer. Investments that have declines in fair value below cost, which are judged to be other than temporary, are written down to estimated fair value.

The Company participates in a securities lending program whereby marketable securities in the Company's portfolio are transferred to an independent broker or dealer in exchange for collateral equal to at least 101% of the market value of securities on loan.

In June 1998, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). SFAS No. 133, as amended by SFAS Nos. 137 and 138, establishes the accounting and reporting standards for derivative instruments and for hedging activities. Upon adoption of SFAS No. 133, all derivatives must be recognized on the balance sheet at their then fair value. Any deferred gains and losses remaining on the balance sheet under previous hedge−accounting rules must be removed from the balance sheet and all hedging relationships must be designated anew and documented pursuant to the new accounting. The new standard was adopted in the first quarter of 2001.

The adoption of SFAS No. 133 on January 1, 2001, resulted in a pre−tax increase to other income of $0.1 million and an after−tax decrease to other comprehensive income of $4.2 million.

The Company utilizes derivative instruments, specifically forward exchange contracts, to mitigate foreign currency risk associated with its foreign currency denominated investment portfolio. Forward exchange contracts are used to hedge the foreign currency risk between trade date and settlement date of foreign currency investment transactions. Gains and losses from such instruments are recognized in the Company's income statement at the settlement date.

Forward exchange contracts are also used to hedge asset positions in foreign denominated securities. The unrealized gains and losses, net of deferred taxes, from such forward contracts and related hedging investments are reflected in other comprehensive income at the balance sheet dates. As of December 31, 2001, the Company no longer invested in foreign government securities.

Premiums Receivable

Premiums receivable are shown net of an allowance based on historical collection trends and management's judgment on the collectibility of these accounts. These collection trends, as well as prevailing and anticipated economic conditions, are routinely monitored by management, and any adjustments required are reflected in current operations.

Property and Equipment, net

Property and equipment are stated at cost, net of depreciation, and are depreciated on the straight−line method over the estimated useful lives of the assets. Leasehold improvements are stated net of amortization and are amortized over a period not exceeding the term of the lease. Upon disposal of property and equipment, the cost of the asset and the related accumulated depreciation are removed from the accounts while the resulting gain or loss is reflected in current operations.

Computer software costs that are incurred in the preliminary project stage are expensed as incurred. Direct consulting costs, payroll and payroll related cost for employees, incurred during the development stage, who are directly associated with each project are capitalized and amortized over a five−year period when placed into production.

Intangible Assets and Goodwill, net

Intangible assets and goodwill represent the cost in excess of fair value of the net assets, net of the related tax impact, acquired in purchase transactions. Intangible assets and goodwill are being amortized on a straight−line basis over periods ranging from 1.5 to 40 years. For acquisitions

consummated prior to 1998, intangible assets and goodwill are being amortized utilizing a composite useful life. For acquisitions consummated after 1997, the specific identified useful life method is utilized. (See Note 7 for a more complete discussion of the Company's intangible assets and goodwill.)

The Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, such potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity.

Effective January 1, 2002, intangible assets and goodwill will be accounted for under SFAS No. 142, "Goodwill and Other Intangible Assets." The new rules eliminate amortization of goodwill and other intangibles with indefinite lives, but these assets will be subject to the impairment tests. (See "New Accounting Pronouncements" and Note 7 for a more complete discussion of the Company's intangible assets and goodwill).

Medical Claims Payable

The liability for medical claims payable includes claims in process and a provision for incurred but not reported claims, which is actuarially determined based on historical claims payment experience and other statistics. Claim processing expenses are also accrued based on an estimate of expenses necessary to process such claims. Such reserves are continually monitored and reviewed with any adjustments reflected in current operations. Capitation costs represent monthly fees paid one month in advance to physicians, certain other medical service providers and hospitals in the Company's HMO networks as retainers for providing continuing medical care. The Company maintains various programs that provide incentives to physicians, certain other medical service providers and hospitals participating in its HMO networks through the use of risk−sharing agreements and other programs. Payments under such agreements are made based on the providers' performance in controlling health care costs while providing quality health care. Expenses related to these programs, which are based in part on estimates, are recorded in the period in which the related services are rendered. Management believes that its reserves for medical claims payable are adequate to satisfy its ultimate claim liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The Company's future results of operations will depend in part on its ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. WellPoint's ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above−listed or other factors may adversely affect the Company's future profitability.

Reserves for Future Policy Benefits

The estimated reserves for future policy benefits relate to life and disability policies written in connection with health care contracts. Reserves for future extended benefit coverage are based on projections of past experience. Reserves for future policy and contract benefits for certain long−term disability products and group paid−up life products are based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon the Company's experience. Reserves are continually monitored and reviewed, and as settlements are made or reserves adjusted, differences are reflected in current operations. The current portion of reserves for future policy benefits relates to the portion of such reserves which management expects to pay within one year. Management believes that its reserves for future policy benefits are adequate to satisfy its ultimate benefit liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Postretirement Benefits

The Company currently provides certain health care and life insurance benefits to eligible retirees and their dependents under plans administered by the Company. The Company accrues the estimated costs of retiree health and other postretirement benefits during the periods in which eligible employees render service to earn the benefits.

Interest Rate Swap Agreements

The Company uses interest rate swap agreements to manage interest rate exposures. The principal objective of such contracts is to minimize the risks and costs associated with financial activities. The counterparties to these contractual arrangements are major financial institutions with which the Company also has other financial relationships. These counterparties expose the Company to credit loss in the event of nonperformance. However, the Company does not anticipate nonperformance by the counterparties.

The Company entered into interest rate swap agreements to reduce the impact of changes in interest rates on its floating rate debt under its revolving credit facility. The swap agreements are contracts to exchange floating interest rate payments for fixed interest rate payments periodically over the life of the agreements without the exchange of the underlying notional amounts. The notional amounts of the interest rate swap agreements are used to measure interest to be paid. For interest rate instruments that effectively hedge interest rate exposures, the net cash amounts paid on the agreements are accrued and recognized as an adjustment to interest expense. If an agreement no longer qualifies as a hedge instrument, then it is marked to market and carried on the balance sheet at fair value. The change in fair value of these instruments is included in investment income.

Income Taxes

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

Recognition of Premium Revenue and Management Services and Other Revenue

For most health care and life insurance contracts, premiums are billed in advance of coverage periods and are recognized as revenue over the period in which services or benefits are obligated to be provided. Premiums include revenue from other contracts, which principally relate to minimum premium contracts, where revenue is recognized based upon the ultimate loss experience of the contract. These contracts obligate the Company to arrange for the provision of health care for the members covered by the related contract and exposes the Company to financial risk based upon its ability to manage health care costs below a contractual fixed attachment point. Premium revenue includes an adjustment for experience rated refunds based on an estimate of incurred claims. Experience rated refunds are paid based on contractual requirements.

The Company's group life and disability insurance contracts are traditional insurance contracts, which are typically issued only in conjunction with a health care contract. Additionally, WellPoint has a limited number of indemnity health insurance contracts. All of these contracts provide insurance protection for a fixed period ranging from one month to a year.

The Company has the ability at a minimum to cancel the contract or adjust the provisions of the contract at the end of the contract period. As a result, the Company's insurance contracts are considered short−duration contracts.

Premiums applicable to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheet as unearned premiums.

Management services revenue is earned as services are performed and consists of administrative fees for services provided to third parties, including management of medical services, claims processing and access to provider networks. Under administrative service contracts, self−funded employers retain the full risk of financing benefits. Funds received from employers are equal to amounts required to fund benefit expenses and pay earned administrative fees. Because benefit expenses are not the obligation of the Company, premium revenue and benefit expenses for these contracts are not included in the Company's financial statements. Administrative service fees received from employer groups are included in the Company's revenues. Revenues from PrecisionRx, a mail order pharmacy acquired in December 2000, are shown net of pharmaceutical costs. Gross pharmaceutical sales for the years ended December 31, 2001 and 2000 were $200.3 million and $11.0 million, respectively. The pharmaceutical costs for the years ended December 31, 2001 and 2000 were $186.8 million and $10.3 million, respectively.

Loss Contracts

The Company monitors its contracts for the provision of medical care and recognizes losses on those contracts when it is probable that expected future health care and maintenance costs, under a group of existing contracts, will exceed anticipated future premiums on those contracts. The estimation of future health care medical costs includes all costs related to the provision of health care to members covered by the related group of contracts. In determining whether a loss has been incurred, the Company reviews contracts either individually or collectively, depending upon the Company's method of establishing premium rates for such contracts.

The Company further monitors its life insurance contracts and recognizes losses on those contracts for which estimated future claims costs and maintenance costs exceed the related unearned premium.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Health Care Services and Other Benefits

Health care services and other benefits expense includes the costs of health care services, capitation expenses and expenses related to risk sharing agreements with participating physicians, medical groups and hospitals and incurred losses on the disability and life products. The costs of health care services are accrued as services are rendered, including an estimate for claims incurred but not yet reported.

Advertising Costs

The Company uses print and broadcast advertising to promote its products. The cost of advertising is expensed as incurred and totaled approximately $59.6 million, $61.8 million and $40.8 million for the years ended December 31, 2001, 2000 and 1999, respectively.

Earnings per Share

Basic earnings per share is computed excluding the impact of potential common stock and earnings per share assuming full dilution is computed including the impact of potential common stock.

Stock Split

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint stock for each share held. Share and per share data for all periods presented herein have been adjusted to give effect to the stock split. Except for the Consolidated Balance Sheets, Consolidated Statements of Changes in Stockholders' Equity and as noted otherwise, all per share, weighted average share amounts and other share related numbers have been restated retroactively to reflect this stock split.

Stock−Based Compensation

The Company accounts for stock−based compensation using the intrinsic method. Accordingly, compensation cost for stock options under existing plans is measured as the excess, if any, of the quoted market price of the Company's stock at the date of the grant over the amount an employee must pay to acquire the stock.

Comprehensive Income

Comprehensive income encompasses all changes in stockholders' equity (except those arising from transactions with stockholders) and includes net income and net unrealized gains or losses on available−for−sale securities, foreign currency adjustments and adjustments to minimum pension liabilities. Comprehensive income is net of reclassification adjustments to adjust for items currently included in net income, such as realized gains on investment securities.

Start−Up Costs

Effective January 1, 1999, the Company changed its method of accounting for start−up costs related to the Company's provider and sales network development to comply with the AICPA Statement of Position No. 98−5, "Reporting on the Costs of Start−Up Activities." The change involves expensing

these costs as incurred, rather than capitalizing and subsequently amortizing such costs. The total amount of deferred start−up costs reported as a cumulative effect of a change in accounting principle was $20.6 million, net of a tax benefit of $14.3 million, for the year ended December 31, 1999.

Reclassifications

Certain amounts in the prior years consolidated financial statements have been reclassified to conform to the 2001 presentation.

New Accounting Pronouncements

In June 2001, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 141, "Business Combinations" ("SFAS No. 141"). SFAS No. 141 addresses financial accounting and reporting for business combinations and supersedes APB Opinion No. 16, "Business Combinations," and FASB Statement No. 38, "Accounting for Preacquisition Contingencies of Purchased Enterprises." Upon adoption of SFAS No. 141, all business combinations must be accounted for using the purchase method. The use of the pooling of interests method is now prohibited. The provisions of the new standard apply to all business combinations initiated after June 30, 2001. The adoption of SFAS No. 141 did not have a material effect on the financial statements of the Company.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 142 addresses financial accounting and reporting for acquired goodwill and other intangible assets and supersedes APB Opinion No. 17, "Intangible Assets." The new rules change the accounting methodology for goodwill from a model that amortizes goodwill to one which evaluates it for impairment. Amortization of goodwill, including previously recorded goodwill, will end upon adoption of the new rules. The new rules also eliminate amortization of other intangibles with indefinite useful lives, but these assets also will be subject to the impairment tests. SFAS No. 142 is effective for fiscal years beginning after December 15, 2001. Based upon the Company's review of its operations conducted thus far, the accounting impact of SFAS No. 142 related to goodwill amortization would increase the Company's net income by approximately $31.7 million on an annualized basis. The Company is in the process of completing the impairment tests for goodwill and other intangible assets and based on current information, does not anticipate transitional impairment losses.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 143, "Accounting for Asset Retirement Obligations" ("SFAS No. 143"). SFAS No. 143 is effective for financial statements issued for fiscal years beginning after June 15, 2002. The Company will adopt SFAS No. 143 on January 1, 2003. The provisions of SFAS No. 143 require companies to record an asset and related liability for the costs associated with the retirement of a long−lived tangible asset if a legal liability to retire the asset exists. The Company is in the process of analyzing the provisions of SFAS No. 143; however, the effect of adoption is not expected to have a significant impact on the Company's financial condition and results of operations.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long−Lived Assets" ("SFAS No. 144"). SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001. This statement addresses financial accounting and reporting for the impairment or disposal of long−lived

assets and supersedes SFAS No. 121, "Accounting for the Impairment of Long−Lived Assets and for Long−Lived Assets to be Disposed of" and the accounting and reporting provisions of APB 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," for the disposal of a segment of business (as previously defined in that opinion). SFAS No. 144 retains the basic principles of SFAS No. 121 for long−lived assets to be disposed of by sale or held and used and broadens discontinued operations presentation to include a component of an entity that is held for sale or that has been disposed. Components must have operations and cash flows that can be clearly distinguished from the rest of the entity. The Company is in the process of analyzing the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. The adoption of this standard is not expected to have a significant impact on the Company's financial results.

4. INVESTMENTS

Investment Securities

The Company's investment securities consist of the following:

	December 31, 2001			
		Gross Unrealized		
	Cost or Amortized Cost	Gains	Losses	Estimated Fair Value
	(in thousands)			
U.S. Treasury and agency securities	$ 427,013	$ 12,901	$ 421	$ 439,493
Municipal securities	730	21	—	751
Mortgage−backed securities	906,022	15,413	1,459	919,976
Corporate and other securities	1,964,773	42,106	12,572	1,994,307
Total debt securities	3,298,538	70,441	14,452	3,354,527
Equity and other investments	408,450	88,863	18,858	478,455
Total investment securities	$ 3,706,988	$ 159,304	$ 33,310	$ 3,832,982

	December 31, 2000			
		Gross Unrealized		
	Cost or Amortized Cost	Gains	Losses	Estimated Fair Value
	(in thousands)			
U.S. Treasury and agency securities	$ 136,051	$ 3,852	$ 42	$ 139,861
Foreign government securities	128,367	2,065	122	130,310
Mortgage−backed securities	886,972	14,136	3,552	897,556
Corporate and other securities	1,546,369	18,999	29,445	1,535,923
Total debt securities	2,697,759	39,052	33,161	2,703,650
Equity and other investments	312,225	102,192	21,717	392,700
Total investment securities	$ 3,009,984	$ 141,244	$ 54,878	$ 3,096,350

The amortized cost and estimated fair value of debt securities as of December 31, 2001, based on contractual maturity dates are summarized below (in thousands). Expected maturities for mortgage−backed securities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Estimated Fair Value
	(in thousands)	
Due in one year or less	$ 80,050	$ 82,000
Due after one year through five years	1,374,080	1,405,415
Due after five years through ten years	867,976	877,677
Due after ten years	976,432	989,435
Total debt securities	$ 3,298,538	$ 3,354,527

For the years ended December 31, 2001, 2000 and 1999, proceeds from the sales and maturities of debt securities were $4,534.7 million, $2,760.8 million and $2,713.8 million, respectively. For 2001, gross realized gains and gross realized losses from sales of debt securities were $54.2 million and $41.6 million, respectively. Gross gains of $12.0 million and gross losses of $28.8 million were realized on the sales of debt securities for the year ended December 31, 2000. In 1999, gross realized gains and gross realized losses from sales of debt securities were $16.2 million and $52.6 million, respectively.

For the years ended December 31, 2001, 2000 and 1999, proceeds from the sales of equity securities were $168.4 million, $310.3 million and $262.4 million, respectively. In 2001, gross realized gains and gross realized losses on the sales of equity securities were $6.4 million and $23.3 million, respectively. Gross gains of $11.0 million and gross losses of $15.3 million were realized on the sales of equity securities in 2000. For 1999, gross realized gains and gross realized losses on the sales of equity securities were $30.9 million and $26.5 million, respectively.

Securities on loan under the Company's securities lending program are included in its cash and investment portfolio shown on the accompanying consolidated balance sheets. Under this program, broker/dealers are required to deliver substantially the same security to the Company upon completion of the transaction. The balance of securities on loan as of December 31, 2001 and 2000 was $110.8 million and $101.9 million, respectively, and income earned on security lending transactions for the years ended December 31, 2001, 2000 and 1999 was $0.3 million, $0.3 million and $0.6 million, respectively.

Long−term Investments

The Company's long−term investments consist of the following:

	December 31, 2001			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(in thousands)			
Mortgage−backed securities	$ 97,365	$ 2,779	$ —	$ 100,144
Equity and other investments	24,467	—	—	24,467
Total long−term investments	$ 121,832	$ 2,779	$ —	$ 124,611

	December 31, 2000			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(in thousands)			
Mortgage−backed securities	$ 95,950	$ 632	$ —	$ 96,582
Equity and other investments	20,229	—	—	20,229
Total long−term investments	$ 116,179	$ 632	$ —	$ 116,811

At December 31, 2001 the Company's debt securities had contractual maturity dates: due in one through five years, amortized cost of $97.4 million and market value of $100.1 million. Expected maturities for mortgage−backed securities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

5. RECEIVABLES, NET

Receivables consist of the following:

	December 31,	
	2001	2000
	(In thousands)	
Premiums receivable	$ 442,503	$ 373,616
Investment income and other receivables	487,745	385,175
	930,248	758,791
Less: allowance for doubtful accounts	88,526	58,923
Receivables, net	$ 841,722	$ 699,868

6. PROPERTY AND EQUIPMENT, NET

Property and equipment, at cost, consist of the following:

		December 31,	
	Useful Life	2001	2000
		(in thousands)	
Equipment	5 years	$ 135,863	$ 123,994
Software	5 years	186,158	94,371
Leasehold improvements	Term of Lease	75,630	67,931
Furniture and fixtures	8 years	81,658	58,338
Building	30 years	14,427	3,373
Land		1,429	382
		495,165	348,389
Less: accumulated depreciation and amortization		273,085	197,358
Property and equipment, net		$ 222,080	$ 151,031

Depreciation and amortization expense for the years ended December 31, 2001, 2000 and 1999 was $45.4 million, $38.5 million and $39.3 million, respectively.

7. INTANGIBLE ASSETS AND GOODWILL

The intangible asset balance consists of the following components:

	December 31,	
	2001	2000
	(in thousands)	
Employer group relationships	$ 282,148	$ 160,609
Tradenames and trademarks	135,000	—
Self−developed software	27,280	7,280
Provider contracts	23,378	13,247
Miscellaneous intangible assets	10,495	11,197
	478,301	192,333
Less: accumulated amortization	47,813	27,169
Intangible assets, net	$ 430,488	$ 165,164

The goodwill balance consists of the following components:

	December 31,	
	2001	2000
	(in thousands)	
Goodwill	$ 778,407	$ 492,804
Less: accumulated amortization	117,061	74,684
Goodwill, net	$ 661,346	$ 418,120

In May 1999, the Company entered into an agreement with Omni Healthcare ("Omni"), a Sacramento, California−based health plan to transition Omni members to the Company's Blue Cross of California subsidiary. The Company paid $7.7 million, subject to adjustment, in exchange for Omni's cooperation in transferring its approximately 124,000 members. The entire amount has been allocated to intangible assets and was originally being amortized over 3 years. During the second quarter of 2000, the Company re−evaluated the useful life of intangible assets related to its acquisition of Omni and reduced its related useful life to 1.5 years.

On March 1, 2000, the Company completed its acquisition of Rush Prudential Health Plans ("Rush Prudential"), which was valued at approximately $202.6 million, subject to certain post−closing adjustments. This acquisition generated goodwill and other intangibles of $135.8 million and $79.7 million, respectively. (See Note 2 for a more complete discussion of this acquisition).

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean") for $700.0 million. This estimated purchase price allocation between goodwill and other intangibles was $282.7 million and $290.0 million, respectively. (See Note 2 for a more complete discussion of this acquisition). Goodwill and other intangibles are being amortized on a straight−line basis ranging from 15 to 25 years for goodwill and ranging from three to 40 years for other intangible assets.

Amortization charged to operations was $63.1 million, $38.1 million and $25.5 million for the years ended December 31, 2001, 2000 and 1999, respectively.

8. LONG−TERM DEBT

$6\frac{3}{8}$% Notes due 2006

On June 15, 2001, the Company issued $450.0 million aggregate principal amount at maturity of $6\frac{3}{8}$% Notes due June 15, 2006 (the "2001 Notes"). The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities. The 2001 Notes bear interest at a rate of $6\frac{3}{8}$% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest is computed on the basis of a 360−day year of twelve 30−day months. At December 31, 2001, the Company had $449.1 million (based upon the principal amount of $450.0 million less discount) of 2001 Notes outstanding and the related interest expense for 2001 totaled $16.4 million.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the designated Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

The 2001 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2001 Notes. The indenture governing the 2001 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2001 Notes.

Revolving Credit Facility

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities, which are generally referred to collectively in this Annual Report on Form 10−K as the Company's "revolving credit facility," bear interest at rates determined by reference to the bank's base rate or to the London Inter Bank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million, expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, expires as of March 30, 2002. Any amount outstanding under this facility as of March 29, 2002 may be converted into a one−year term loan at the option of the Company. In March 2002, the Company amended this facility to provide for a one year extension with an expiration date of March 28, 2003. Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive

convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control. The total amount outstanding under these facilities was $235.0 million as of December 31, 2001. The total amount outstanding under the Company's prior revolving credit facility was $250.0 million as of December 31, 2000.

The agreement provides for interest on committed advances at rates determined by reference to the bank's base rate or to the London Interbank Offered Rate ("LIBOR") plus a margin determined by reference to the Company's leverage ratio (as defined in the credit agreement) or the then−current rating of the Company's unsecured long−term debt by specified rating agencies. Interest is determined using whichever of these methods is the most favorable to the Company. The effective interest rates were 2.76% and 6.87% at December 31, 2001 and 2000, respectively. Borrowings under the credit facility are made on a committed basis or pursuant to an auction−bid process. A facility fee based on the facility amount, regardless of utilization, is payable quarterly. The facility fee rate is also determined by the unsecured debt ratings or the leverage ratio of the Company.

Zero Coupon Convertible Subordinated Debentures

On July 2, 1999, the Company issued $299.0 million aggregate principal amount at maturity of zero coupon convertible subordinated debentures due 2019 (the "Debentures"). The proceeds totaled approximately $200.8 million. The Debentures accrue interest at a yield to maturity of 2.0% per year compounded semi−annually. Holders have the option to convert the Debentures into the Company's Common Stock at any time prior to maturity at a rate of 13.594 shares per $1,000 principal amount at maturity. In lieu of delivering shares of common stock upon conversion of any Debentures, the Company may elect to pay cash for the Debentures in an amount equal to the last reported sales price of its Common Stock on the trading day preceding the conversion date. The Debentures are subordinate in right of payment to all existing and future senior indebtedness.

On October 6, 1999, the Board of Directors authorized the repurchase of some or all of the Company's Debentures for cash. The Company did not repurchase any Debentures during the years ended December 31, 2001 and 2000. During the year ended December 31, 1999, the Company repurchased $81.0 million in aggregate principal amount at maturity of the Debentures at a total purchase price of $49.8 million. The gain on such repurchase is shown on the Company's income statement as an extraordinary gain, net of applicable tax.

As of December 31, 2001 and 2000, the Company had $153.9 million and $150.9 million (based upon the original issue price plus accreted interest), respectively, of Debentures outstanding. For the years ended December 31, 2001 and 2000, the Company accrued $3.0 million and $3.1 million, respectively, of interest related to the Debentures.

Maturities

At December 31, 2001, the Company's long−term debt maturities were as follows: 2002—zero; 2003—$35 million; 2004—zero; 2005—zero; 2006—$650 million; 2019—$218 million.

Debt Covenants

The Company's revolving credit facility requires the maintenance of certain financial ratios and contains other restrictive covenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control. As of December 31, 2001, the Company was in compliance with the requirements in these agreements.

Interest Rate Swaps

As described in Note 15, as of December 31, 2001, the Company was a party to two separate interest rate swap agreements, which convert underlying variable−rate debt into fixed−rate debt.

Interest Paid

Interest paid on long−term debt for the years ended December 31, 2001, 2000 and 1999 was $43.0 million, $21.5 million and $22.1 million, respectively.

9. INCOME TAXES

The components of the provision (benefit) for income taxes are as follows:

	Year Ended December 31,		
	2001	2000	1999
	(in thousands)		
Current:			
Federal	$ 224,380	$ 226,606	$ 106,036
State	43,541	56,608	42,987
	267,921	283,214	149,023
Deferred:			
Federal	13,180	(54,552)	43,968
State	2,735	(8,383)	(2,881)
	15,915	(62,935)	41,087
Valuation allowance	—	1,747	—
Provision for income taxes	$ 283,836	$ 222,026	$ 190,110

The overall effective tax rate differs from the statutory federal tax rate as follows (percent of pretax income from continuing operations):

	Year Ended December 31,		
	2001	2000	1999
Tax provision based on the federal statutory rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	4.3	5.6	5.3
Non−deductible expenses/non−taxable items	1.2	(0.1)	(0.4)
Change in valuation allowance	—	0.3	—
Other, net	0.1	(1.5)	(0.9)
Effective tax rate	40.6%	39.3%	39.0%

Net deferred tax assets are comprised of the following:

	December 31,	
	2001	2000
	(in thousands)	
Gross deferred tax assets:		
Net operating loss	$ 6,028	$ 4,420
Investment basis difference	39,696	—
Vacation and holiday accruals	9,322	6,224
Incurred claim reserve discounting	19,587	23,038
Provision for doubtful accounts	33,530	22,472
Unearned premium reserve	24,424	18,644
State income taxes	15,942	21,068
Postretirement benefits	37,161	29,138
Deferred gain on building	1,653	3,456
Deferred compensation	30,909	25,114
Expenses not currently deductible	95,699	73,774
Intangible asset impairment	5,689	6,439
Capital loss carryover	5,676	26,708
Start−up costs	2,540	4,327
Deferred acquisition costs	9,321	8,904
Other, net	10,282	4,733
Total gross deferred tax assets	347,459	278,459
Gross deferred tax liabilities:		
Market valuation on investment securities	(35,736)	(35,687)
Depreciation and amortization	(2,827)	(5,582)
Investment basis difference	—	(6,947)
Internally developed software	(25,216)	(13,119)
Purchased intangibles	(138,272)	(32,330)
Lease expense	(6,221)	(6,239)
Other, net	(1,935)	(1,728)
Total gross deferred tax liabilities	(210,207)	(101,632)
Valuation allowance:		
Net operating loss carryover	(1,337)	(4,341)
Capital loss carryover	(2,366)	(1,747)
	(3,703)	(6,088)
Net deferred tax assets	$ 133,549	$ 170,739

In connection with the acquisition of Cerulean, the Company acquired $112.8 million deferred tax liabilities and $72.0 million net deferred tax assets. The net result was an increase to goodwill of $40.8 million. In connection with the acquisition of Rush Prudential, the Company acquired $32.3 million deferred tax liabilities and $7.4 million net deferred tax assets. The net result was an

increase to goodwill of approximately $24.9 million, which included a valuation allowance for certain operating loss carryforwards acquired in such transaction.

As of December 31, 2001, the Company had $5.5 million of federal net operating loss carryforwards acquired from Cerulean and $9.6 million of federal net operating loss carryforwards acquired from Rush Prudential. In addition, the Company's $16.6 million of Illinois net operating loss carryforward acquired from Rush Prudential was completely utilized during the year ended December 31, 2001. As a result, management reduced the valuation allowance from $4.3 million to $1.3 million and recorded the change as a reduction to goodwill. The federal carryforward begins to expire in 2014.

As of December 31, 2001, the Company has a state capital loss carryforward of $98.0 million. The Company established a valuation allowance of $2.4 million related to this carryforward. Management believes it is more likely than not that the recorded deferred tax assets, net of the valuation allowance, will be realized. The state carryforward begins to expire in 2003. As of December 31, 2001, the Company utilized its entire federal capital loss carryforward.

During 2001, the Internal Revenue Service ("IRS") completed its examination of the Company's consolidated federal income tax returns for 1992 through 1994. The settlement of the audit had no material impact on the financial position or results of operations. The IRS has begun its audit of tax years 1995 through 1998. The results of this audit are not expected to have a material impact on the Company's financial position or results of operations.

Income taxes paid (refunded) for the years ended December 31, 2001, 2000 and 1999 were $222.5 million, $283.8 million and ($57.0) million, respectively.

10. PENSION AND POSTRETIREMENT BENEFITS

Pension Benefits

The Company covers substantially all employees through two non−contributory defined benefit pension plans. The Restated Employees' Retirement Plan of Blue Cross of California covers employees of a bargaining unit. The WellPoint Pension Accumulation Plan, which was established on January 1, 1987, covers all eligible employees (employees covered under a collective bargaining agreement participate if the terms of the collective bargaining agreement permits) meeting certain age and service requirements. Plan assets are invested primarily in pooled income funds. The Company's policy is to fund its plans according to the applicable Employee Retirement Income Security Act of 1974 and income tax regulations. The Company uses the projected unit credit method of cost determination.

In conjunction with the acquisition of Cerulean on March 15, 2001, the Company's Board of Directors approved the merger of Cerulean's Non−Contributory Retirement Program for Certain Employees of Blue Cross and Blue Shield of Georgia, Inc. into the WellPoint Pension Accumulation Plan.

The funded status of the plans is as follows:

	December 31,	
	2001	2000
	(In thousands)	
Change in Benefit Obligation		
Benefit obligation at beginning of year	$ 86,680	$ 77,656
Service cost	10,987	8,008
Interest cost	10,353	6,456
Actuarial (gain) loss	13,699	(59)
Acquisitions	65,814	—
Benefits paid	(12,178)	(5,381)
Benefit obligation at end of year	$ 175,355	$ 86,680
Change in Plan Assets		
Fair value at beginning of year	$ 72,180	$ 72,128
Actual return on fair value	(5,028)	(3,206)
Employer contributions	24,455	8,639
Acquisitions	65,770	—
Benefits paid	(12,178)	(5,381)
Fair value at end of year	$ 145,199	$ 72,180
Funded status	$ (30,156)	$ (14,500)
Unrecognized prior service cost	377	424
Unrecognized actuarial loss	48,037	20,252
Net amount recognized	$ 18,258	$ 6,176

Amounts recognized in the Consolidated Balance Sheets consists of:

	December 31,	
	2001	2000
	(In thousands)	
Prepaid benefit cost	$ 18,258	$ 6,176
Additional minimum liability	(38,523)	—
Intangible asset	377	—
Accumulated other comprehensive income	38,146	—
Net amount recognized	$ 18,258	$ 6,176

As of December 31, 2001 and December 31, 2000 the Company's Pension Accumulation Plan had accumulated benefits in excess of plan assets as follows:

	December 31,	
	2001	2000
	(In thousands)	
Projected benefit obligation	$ 163,386	$ 78,771
Accumulated benefit obligation	156,510	73,350
Fair value of assets	133,758	61,870
Weighted Average Assumptions		
Discount rate	7.25%	7.75%
Expected return on plan assets	9.50%	9.50%
Rate of compensation increases	4.50%	5.00%

Net periodic pension expense for the Company's defined benefit pension plans includes the following components:

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Service cost—benefits earned during the year	$ 10,987	$ 8,008	$ 8,117
Interest cost on projected benefits obligations	10,353	6,456	5,583
Expected return on plan assets	(10,736)	(6,946)	(6,603)
Amortization of prior service cost	47	15	14
Recognized net actuarial loss	1,677	286	81
Net periodic pension expense	$ 12,328	$ 7,819	$ 7,192

The Company sponsors the WellPoint 401(k) Retirement Savings Plan (the "401(k) Plan"). Generally, employees (excluding temporary employees working less than 1,000 hours and leased employees) over 18 years of age are eligible to participate in the 401(k) Plan if they meet certain length of service requirements. Under this plan, employees may contribute a percentage of their pre−tax earnings to the 401(k) Plan. After one year of service, employee contributions up to 6% of eligible compensation are matched by an employer contribution equal to 75% on the employee's contribution. Matching contributions are immediately vested. One third of the employer contribution is in the Company's Common Stock. As of December 31, 2001, employees were prohibited from transferring the Company's match received in the form of Common Stock until the calendar year following receipt of such Company match. Effective March 1, 2002, the 401(k) Plan was amended to remove this restriction. The 401(k) Plan includes a grandfather match provision whereby the employer contribution is 85% for those employees with 10 to 19 years of service as of January 1, 1997 and 100% for those employees with 20 years or more of service as of such date. Company expense related to the 401(k) Plan totaled $20.2 million, $16.5 million and $15.9 million for the years ended December 31, 2001, 2000 and 1999, respectively. In conjunction with the acquisition of Cerulean on March 15, 2001, the Company's Board of Directors approved the merger of Cerulean's Blue Cross and Blue Shield of Georgia, Inc. Savings Program into the Company's 401(k) Plan.

Postretirement Benefits

The Company currently provides certain health care and life insurance benefits to eligible retirees and their dependents. Employees outside of California and certain employees in California acquired as a result of the acquisitions and all employees hired, rehired or reinstated after January 1, 1997 are not covered under the Company's postretirement benefit plan. All eligible employees in Georgia acquired as a result of the Cerulean acquisition will continue to be covered under the Cerulean Defined Dollar Benefit Plan ("DDB Plan"). Blue Cross Blue Shield of Georgia employees hired, rehired or reinstated after March 15, 2001 are not eligible to be covered under the Cerulean DDB Plan or any WellPoint retiree plan. All other Company employees are fully eligible for retiree benefits upon attaining 10 years of service and a minimum age of 55. The plan, in effect for those retiring prior to September 1, 1994, provides for Company−paid life insurance for all retirees based on age and a percent of salary. In addition, the majority of retirees from age 62 or greater currently receive fully paid health benefit coverage for themselves and their dependents. For employees retiring on or after September 1, 1994, the Company currently subsidizes health benefit coverage based on the retiree's years of service at retirement and date of hire. Life insurance benefits for retirees hired on or after May 1, 1992 are set at $10,000 upon retirement and are reduced to $5,000 at age 70.

The accumulated postretirement benefit obligation ("APBO") and the accrued postretirement benefits as of December 31, 2001 and 2000 are as follows:

	December 31,	
	2001	2000
	(in thousands)	
Benefit obligation at the beginning of the year	$ 59,291	$ 54,932
Service cost	2,312	1,520
Interest cost	5,950	4,234
Actuarial (gain) loss	9,711	1,063
Acquisitions	19,568	—
Benefits paid	(3,564)	(2,458)
Accumulated postretirement benefits obligation	93,268	59,291
Unrecognized net gain from accrued postretirement benefit cost	856	12,219
Accrued postretirement benefits	$ 94,124	$ 71,510

The Company currently pays for its postretirement benefit obligations as they are incurred. As such, there are no plan assets.

The above actuarially determined APBO was calculated using a discount rate of 7.25% and 7.75% for 2001 and 2000, respectively. The original medical trend rate assumed a decline from 7.0% (under age 65) and 6.5% (age 65 and over) for 2001 to 6.0% by the year 2002. This medical trend rate was re−evaluated and modified to 10.0% for the year 2002 with a gradual decline to 5.0% by the year 2007. These estimated trend rates are subject to change in the future. The medical trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care trend rate of one percent in each year would increase the APBO as of December 31, 2001 by $8.5 million and would increase service and interest costs by $1.0 million. Conversely, a decrease in the assumed health care trend rate of one percent in each year would decrease the APBO as of December 31, 2001 by $7.6 million and would decrease service and interest costs by $0.9 million. For life insurance benefit calculations, a compensation increase of 4.5% was assumed.

10. PENSION AND POSTRETIREMENT BENEFITS (Continued)

Net periodic postretirement benefit cost includes the following components (in thousands):

	Year Ended December 31,		
	2001	2000	1999
Service cost	$ 2,312	$ 1,520	$ 1,650
Interest cost	5,950	4,234	3,933
Net amortization and deferral	(213)	(689)	(418)
Net periodic postretirement benefit cost	$ 8,049	$ 5,065	$ 5,165

11. COMMON STOCK

Stock Option Plans

In 1996, the Company adopted an Employee Stock Option Plan (the "Employee Option Plan"). In May 1996, all eligible employees were granted options to purchase common stock under the Employee Option Plan. The exercise price of options granted under the Employee Option Plan is the fair market value of the Common Stock on the date of the grant. Each option granted has a maximum term of 10 years. Options granted under the Employee Option Plan vest in accordance with the terms of the applicable grant.

In 1996, the Company also implemented a Stock Option/Award Plan (the "Stock Option/Award Plan") for key employees, officers and directors. The exercise price per share is fixed by a committee appointed by the Board of Directors to administer the Stock Option/Award Plan, but for any incentive stock option, the exercise price will not be less than the fair market value on the date of grant. The maximum term for an option is ten years. Options granted will vest in accordance with the terms of each grant. The Stock Option/Award Plan also allows the grant or award of restricted stock, performance units and phantom stock.

On May 11, 1999, the stockholders of the Company approved a new Stock Incentive Plan (the "Plan") for key employees, officers and directors. This new plan serves as the successor to the Company's Stock Option/Award Plan and Employer Stock Option Plan (the "Predecessor Plans"). All options granted under the Predecessor Plans and outstanding on the Plan's effective date were incorporated into the Plan and treated as outstanding awards under the Plan. The exercise price is determined by the plan administrator; however, it will generally not be less than the fair market value on the date of grant. The maximum term for an option is ten years. Options granted will vest in accordance with the terms of each grant. The Plan also allows the grant or award of restricted stock, performance units and phantom stock. As of December 31, 2001 the maximum number of shares issuable under the Plan, subject to subsequent adjustments for certain changes in the Company's capital structure, was 14.6 million.

Effective as of February 17, 2000, the Company adopted the 2000 Employee Stock Option Plan (the "2000 Employee Plan") for employees and non−executive officers of the Company. The exercise price and maximum term of any stock option granted under the 2000 Employee Plan are determined by the plan administrator. Options granted will vest in accordance with the terms of each grant. As of December 31, 2001, the maximum number of shares issuable under the 2000 Employee Plan, subject to subsequent adjustments for certain changes in the Company's capital structure, was 9.0 million shares.

The following summarizes activity in the Company's stock option plans for the years ended December 31, 2001, 2000 and 1999:

	Shares	Weighted Average Exercise Price Per Share
Outstanding at January 1, 1999	8,998,476	22.12
Granted	3,915,210	36.93
Canceled	(283,208)	26.29
Exercised	(2,028,958)	19.54
Outstanding at December 31, 1999	10,601,520	27.97
Granted	4,370,190	36.11
Canceled	(497,882)	33.73
Exercised	(3,821,630)	23.21
Outstanding at December 31, 2000	10,652,198	32.73
Granted	7,293,674	47.25
Canceled	(835,604)	42.41
Exercised	(2,402,460)	31.97
Outstanding at December 31, 2001	14,707,808	39.45
Exercisable at:		
December 31, 1999	4,928,650	23.96
December 31, 2000	4,924,224	30.99
December 31, 2001	5,993,936	34.02

The options outstanding at December 31, 2001 had exercise prices ranging from $13.43 to $61.82 per share.

	Options Outstanding			Options Exercisable	
Actual Range of Exercise Prices	Number Outstanding at 12/31/01	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number Outstanding at 12/31/01	Weighted Average Exercise Price
$13.43 − 19.84	1,175,998	4.3	$ 19.12	1,175,998	$ 19.12
$22.78 − 33.82	1,366,140	6.1	$ 28.43	1,356,952	$ 28.40
$34.19 − 51.25	11,375,568	8.3	$ 41.78	2,810,052	$ 37.96
$51.51 − 61.82	790,102	7.0	$ 55.29	650,934	$ 55.62
	14,707,808	7.7	$ 39.45	5,993,936	$ 34.02

Stock Purchase Plan

On May 18, 1996, the Company's stockholders approved the Company's Employee Stock Purchase Plan (the "ESPP"). The stockholders approved an amendment and restatement of the ESPP on May 9, 2000. The ESPP allows eligible employees to purchase Common Stock at the lower of 85% of the market price of the stock at the beginning or end of each offering period. The aggregate amount of Common Stock that may be issued pursuant to the ESPP shall not exceed 2,800,000 shares, subject to adjustment pursuant to the terms of the ESPP. During the years ended December 31, 2001, 2000 and 1999, approximately 218,000, 222,800, and 186,800 shares of Common Stock were purchased under the ESPP. There are offering periods for the first half and second half of the year and accordingly, two

purchase prices. For the year ended December 31, 2001, the purchase prices were $40.05 and $39.74 per share. For the year ended December 31, 2000, the purchase prices were $28.05 and $30.84 per share. For the year ended December 31, 1999, the purchase prices were $36.07 and $28.03 per share.

SFAS No. 123 Disclosure

In accordance with the provisions of SFAS No. 123, the Company applies APB Opinion No. 25 and related interpretations in accounting for its stock option plans and, accordingly, does not recognize compensation cost. If the Company had elected to recognize the compensation cost based on the fair value of the options granted at grant date as prescribed by SFAS No. 123, net income and earnings per share for the years ended December 31, 2001, 2000 and 1999 would have been reduced to the pro forma amounts indicated in the table which follows:

	2001	2000	1999
		(In millions, except per share amounts)	
Net income—as reported	$ 414.7	$ 342.3	$ 278.5
Net income—pro forma	$ 381.7	$ 315.7	$ 256.3
Earnings per share—as reported	$ 3.27	$ 2.74	$ 2.11
Earnings per share—pro forma	$ 3.01	$ 2.52	$ 1.94
Earnings per share assuming full dilution—as reported	$ 3.15	$ 2.64	$ 2.05
Earnings per share assuming full dilution—pro forma	$ 2.90	$ 2.44	$ 1.88

2001	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	4.66%	4.53%
Expected stock price volatility	35.00%	35.00%
Expected life of options	four years	three years

2000	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	6.38%	6.37%
Expected stock price volatility	40.00%	40.00%
Expected life of options	four years	three years

1999	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	5.02%	4.86%
Expected stock price volatility	38.00%	38.00%
Expected life of options	four years	three years

The above pro forma disclosures may not be representative of the effects on reported pro forma net income for future years. The weighted average fair value of options granted during 2001, 2000 and 1999 is $14.46, $13.09, and $11.88 per share, respectively.

Treasury Stock

As of December 31, 2001, the Company was authorized to repurchase approximately 25.4 million shares of its Common Stock. As of December 31, 2001, 20.8 million shares of Common Stock had been repurchased pursuant to this authorization.

12. EARNINGS PER SHARE

The following is an illustration of the dilutive effect of the Company's potential Common Stock on earnings per share ("EPS"). There were no antidilutive securities in any of the three periods presented.

	Year Ended December 31,		
	2001	2000	1999
		(In thousands, except earnings per share)	
Basic Earnings Per Share Calculation:			
Numerator			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891
Cumulative effect of accounting change, net of tax	—	—	(20,558)
Net Income	$ 414,746	$ 342,287	$ 278,544
Denominator			
Weighted average shares outstanding	126,851	125,061	132,141
Earnings Per Share			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.27	$ 2.74	$ 2.25
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.02
Cumulative effect of accounting change, net of tax	—	—	(0.16)
Net Income	$ 3.27	$ 2.74	$ 2.11
Earnings Per Share Assuming Full Dilution Calculation:			
Numerator			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Interest expense on zero coupon convertible subordinated debentures, net of tax	1,880	1,890	930
Adjusted income before extraordinary gain and cumulative effect of accounting change	416,626	344,177	298,141
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891
Cumulative effect of accounting change, net of tax	—	—	(20,558)
Adjusted Net Income	$ 416,626	$ 344,177	$ 279,474
Denominator			
Weighted average shares outstanding	126,851	125,061	132,141
Net effect of dilutive stock options	2,608	2,195	2,154
Assumed conversion of zero coupon convertible subordinated debentures	2,963	2,963	1,898
Diluted weighted average shares outstanding	132,422	130,219	136,193
Earnings Per Share Assuming Full Dilution			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.15	$ 2.64	$ 2.19
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.01
Cumulative effect of accounting change, net of tax	—	—	(0.15)
Net Income	$ 3.15	$ 2.64	$ 2.05

13. LEASES

Effective January 1, 1996, the Company entered into a new lease agreement for a 24−year period for its former corporate headquarters, expiring in December 2019, with two options to extend the term for up to two additional five−year terms. In addition to base rent, beginning in January 1997, the Company must pay a contingent amount based upon annual changes in the consumer price index. The Company paid $30 million to the owner of the building in connection with this lease agreement which is being amortized on a straight−line basis over the life of the new lease.

The Company's other lease terms range from one to 19 years with certain options to renew. Certain lease agreements provide for escalation of payments which are based on fluctuations in certain published cost−of−living indices.

Future minimum rental payments under operating leases utilized by the Company having initial or remaining noncancellable lease terms in excess of one year at December 31, 2001 are as follows:

Year Ending December 31, (In thousands)	Operating Leases
2002	$ 89,635
2003	71,475
2004	49,001
2005	37,737
2006	29,640
Thereafter	245,610
Total minimum payments required	$ 523,098

Rental expense for the years ended December 31, 2001, 2000 and 1999 for all operating leases was $66.3 million, $47.5 million and $41.8 million, respectively. Contingent rentals included in the above rental expense for the years ended December 31, 2001, 2000 and 1999 were $1.5 million, $1.2 million and $0.9 million, respectively.

14. FAIR VALUE OF FINANCIAL INSTRUMENTS

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Cash and Cash Equivalents. The carrying amount approximates fair value, based on the short−term maturities of these instruments.

Investment Securities. The carrying amount approximates fair value, based on quoted market prices for the same or similar instruments.

Long−term Investments. The carrying amount approximates fair value, based on quoted market prices for the same or similar instruments.

Revolving Credit Facility. The carrying amount for the revolving credit facility approximates fair value as the underlying instruments have variable interest rates at market value.

Zero Coupon Convertible Subordinated Debentures. The fair value for the convertible debt is based upon quoted market prices. The carrying value is based on the face value adjusted for accretion of original issue discount.

6 3/8% Notes Due 2006. The fair value of the notes payable is based on quoted market prices. The carrying value is based on face value adjusted for the discount.

Interest Rate Swaps. The fair value of the interest rate swaps is based on its quoted market prices by the financial institutions which are the counterparties to the swaps.

Forward Exchange Contracts. The carrying value for forward exchange contracts represents the fair value of such contracts that exceed the fair value of the related foreign denominated bond position. The fair value of such contracts is determined by the counterparties to the contracts.

The carrying amounts and estimated fair values of the Company's financial instruments as of December 31, 2001 are summarized below:

	Carrying Amount	Estimated Fair Value
	(In thousands)	
Cash and cash equivalents	$ 1,028,476	$ 1,028,476
Investment securities	3,832,982	3,832,982
Long−term investments	124,611	124,611
Revolving credit facility	235,000	235,000
Zero Coupon Convertible Subordinated Debentures	153,887	185,280
6 3/8% Notes Due 2006	449,070	458,955
Interest rate swaps	(14,085)	(14,558)
Forward exchange contracts	775	775

15. HEDGING ACTIVITIES

In June 1998, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). SFAS No. 133, as amended by SFAS Nos. 137 and 138, establishes the accounting and reporting standards for derivative instruments and for hedging activities. Upon adoption of SFAS No. 133, all derivatives must be recognized on the balance sheet at their then fair value. Any deferred gains and losses remaining on the balance sheet under previous hedge−accounting rules must be removed from the balance sheet and all hedging relationships must be designated anew and documented pursuant to the new accounting. The Company adopted SFAS No. 133 on January 1, 2001.

The Company maintains an interest rate risk management strategy that uses derivative instruments to minimize significant, unanticipated earnings fluctuations caused by interest rate volatility. The Company's goal is to maintain a balance between fixed and floating interest rates on its long−term debt.

By using derivative financial instruments to hedge exposures to changes in exchange rates and interest rates, the Company exposes itself to credit risk and market risk. Market risk is the adverse effect on the value of a financial instrument that results from a change in currency exchange rates or interest rates. The Company manages exposure to market risk associated with interest rate and foreign exchange contracts by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

15. HEDGING ACTIVITIES (Continued)

The Company uses interest rate swap agreements and foreign currency contracts to manage interest rate and foreign currency exposures. The principal objective of such contracts is to minimize the risks and/or costs associated with financial and investing activities. The Company does not use derivative financial instruments for speculative purposes. The counterparties to these contractual arrangements are major financial institutions with which the Company also has other financial relationships. These counterparties expose the Company to credit loss in the event of non performance. However, the Company does not anticipate non performance by the other parties.

Fair Value Hedges

As part of the Company's investment strategy to diversify its investment portfolio, the Company has invested in certain fixed maturity securities denominated in foreign currencies. In order to mitigate the foreign currency risk, the Company has entered into foreign currency derivative instruments. Gains and losses related to such instruments are recognized in the Company's income statement. The Company recognized a gain of $0.5 million and losses of $0.5 million and $1.9 million from such hedging activities for the years ended December 31, 2001, 2000 and 1999, respectively. As of December 31, 2001, the Company had liquidated its non−dollar foreign bond holdings and, as a result, entered into a hedge to offset the remaining currency hedge.

The transition provisions of SFAS No. 133 state that any gain or loss previously reported in accumulated other comprehensive income on a derivative that hedged an available−for−sale security, together with the gain or loss on the related security shall be reclassified to earnings as a cumulative effect type adjustment of both net income and accumulated other comprehensive income. On January 1, 2001, the Company recorded a transition adjustment as a charge to other income of approximately $0.3 million, net of tax, which represented a gain of $2.0 million on the available−for−sale bonds related to the Company's foreign exchange contracts partially offset by a loss of $1.7 million on the related hedges.

For the year ended December 31, 2001, the Company recognized a net loss of $1.2 million, included in other income on the consolidated income statement, which represented the ineffective portion of all the Company's fair value hedges. All components of each derivative's gain or loss were included in the assessment of hedge effectiveness.

Cash Flow Hedges

The Company uses interest rate swap agreements to reduce the impact of changes in interest rates on its floating rate debt under its revolving credit facility. The swap agreements are contracts to exchange variable−rate for fixed−rate interest payments without the exchange of the underlying notional amounts. During the year ended December 31, 2001, the Company recognized a net gain of $0.1 million reported in other income in the consolidated income statement, which represented the total ineffectiveness of all cash flow hedges.

The adoption of SFAS No. 133 resulted in an after−tax reduction in accumulated other comprehensive income of $4.2 million to recognize at fair value all derivatives that were designated as cash flow hedges as of January 1, 2001.

Events that are expected to occur over the next 12 months and will necessitate reclassifying the derivative losses into earnings relate primarily to the repricing of variable rate debt. The Company does

not expect that the amounts that will be reclassified will be material to the Company's financial condition or results of operations.

As of December 31, 2001 the Company had the following interest rate swap agreements in effect (notional amount in thousands):

Notional Amount	Strike Rate	Expiration Date
$150,000	6.99 %	October 17, 2003
$50,000	7.06 %	October 17, 2006

As of December 31, 2001, the Company had recognized net derivative liabilities related to such interest rate swap agreements and foreign currency contracts of $13.3 million.

16. CONTINGENCIES

From time to time in the ordinary course of business, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to Shane v. Humana, et al., a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the Shane lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part

and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such a hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Certain of such legal proceedings are or may be covered under insurance policies or indemnification agreements. Based upon information presently available, management of the Company believes that the final outcome of all such proceedings should not have a material adverse effect on the Company's results of operations, cash flows or financial condition.

17. REGULATORY REQUIREMENTS

Certain of the Company's regulated subsidiaries must comply with certain minimum capital or tangible net equity requirements in each of the states in which they operate. As of December 31, 2001, the Company and its regulated subsidiaries were in compliance with these requirements.

The ability of the Company's licensed insurance company subsidiaries to pay dividends is limited by the Departments of Insurance in their respective states of domicile. Generally, dividends in any 12−month period are limited to the greater of the prior year's statutory net income or 10% of statutory surplus. Larger dividends, classified as extraordinary, require a special request of the applicable Departments of Insurance. The maximum dividend payable in 2002 without prior approval by WellPoint's licensed insurance company subsidiaries (which do not include the Company's Blue Cross of California subsidiary) is estimated to be $220.6 million.

18. FISCAL INTERMEDIARY FUNCTION

Under an agreement with the BCBSA, the Company's wholly−owned subsidiary Blue Cross of California ("BCC") was previously contracted to administer Part A of Title XVIII of the Social Security Act (Medicare) in certain regions or for certain health care providers. The agreement was renewable annually unless terminated by the parties involved. As fiscal intermediary under the agreement, BCC made disbursements to providers for medical care from funds provided by the Federal Government and was reimbursed for these expenses incurred under the agreement. Effective December 1, 2000, BCC ceased to participate as a Medicare fiscal intermediary. BCC disbursed approximately $7.6 billion and $8.8 billion and received administrative fees of approximately $39.1 million and $40.7 million for the years ended December 31, 2000 and 1999, respectively. The reimbursement was treated as a direct recovery of general and administrative expenses.

With the acquisition of Cerulean, the Company is currently a participant in the aforementioned Medicare plan through its wholly−owned subsidiary Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA"). BCBSGA disbursed approximately $2.9 billion and received administrative fees of approximately $8.5 million from March 15, 2001, the acquisition date, to December 31, 2001.

19. BUSINESS SEGMENT INFORMATION

The Company has two reportable segments: the Large Employer Group business segment and the Individual and Small Employer Group business segment. The Large Employer Group and Individual and Small Employer Group segments provide a broad spectrum of network−based health plans, including HMOs, PPOs, POS plans, other hybrid plans and traditional indemnity products to large and small employers and individuals. The Company's senior and specialty businesses are included in the Corporate and Other segment.

The Company's management identified its reportable segments based upon the following factors: (1) the Company's organizational structure contains a Division President that oversees each of these segments, (2) the Company's Chief Operating Decision Maker (Chief Executive Officer) reviews the results of operations for each of the following segments and holds each Division President accountable for results, and (3) a Division President's overall compensation is based upon the related segment's results.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies and are consistent with generally accepted accounting principles with the exception of the exclusion of allocated corporate overhead to the reportable segments.

The following tables present segment information for the Large Employer Group and Individual and Small Employer Group for the years ended December 31, 2001, 2000 and 1999:

2001

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
		(In thousands)		
Premium revenue	$ 7,188,430	$ 3,583,839	$ 804,901	$ 11,577,170
Management services and other revenue	500,290	268	109,135	609,693
Total revenue from external customers	7,688,720	3,584,107	914,036	12,186,863
Intersegment revenues	19,724	—	(19,724)	—
Investment income	139,701	82,119	19,964	241,784
Interest expense	36,358	10,140	3,431	49,929
Depreciation and amortization expense	62,500	23,503	24,154	110,157
Income tax expense (benefit)	244,257	93,500	(53,921)	283,836
Segment net income (loss)	$ 347,495	$ 135,817	$ (68,566)	$ 414,746
Segment Assets	$ 3,714,081	$ 1,416,361	$ 2,341,691	$ 7,472,133

2000

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
		(In thousands)		
Premium revenue	$ 5,011,562	$ 3,030,503	$ 541,598	$ 8,583,663
Management services and other revenue	379,142	2,865	69,840	451,847
Total revenue from external customers	5,390,704	3,033,368	611,438	9,035,510
Intersegment revenues	12,375	(583)	(11,792)	—
Investment income	102,037	77,886	13,525	193,448
Interest expense	23,244	310	424	23,978
Depreciation and amortization expense	38,167	17,014	20,221	75,402
Income tax expense (benefit)	176,342	131,027	(85,343)	222,026
Segment net income (loss)	$ 210,221	$ 172,051	$ (39,985)	$ 342,287
Segment Assets	$ 2,323,129	$ 1,067,692	$ 2,113,885	$ 5,504,706

19. BUSINESS SEGMENT INFORMATION (Continued)

1999

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
	(In thousands)			
Premium revenue	$ 3,889,032	$ 2,551,961	$ 455,864	$ 6,896,857
Management services and other revenue	367,060	4,579	57,697	429,336
Total revenue from external customers	4,256,092	2,556,540	513,561	7,326,193
Intersegment revenues	19,941	2,500	(22,441)	—
Investment income	98,410	53,627	7,197	159,234
Interest expense	20,949	278	(1,049)	20,178
Depreciation and amortization expense	36,829	14,641	13,328	64,798
Income tax expense (benefit)	145,973	105,347	(61,210)	190,110
Extraordinary gain / cumulative effect	(12,328)	(7,685)	1,346	(18,667)
Segment net income (loss)	$ 167,435	$ 134,828	$ (23,719)	$ 278,544
Segment Assets	$ 2,300,056	$ 998,060	$ 1,295,118	$ 4,593,234

As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002. As a result of these changes, the Company currently anticipates that its Quarterly Report on Form 10−Q for the quarterly period ending March 31, 2002 (and subsequent filings under the Securities Exchange Act of 1934) will reflect the following two reportable segments: Health Care business and Specialty business.

20. COMPREHENSIVE INCOME

The following summarizes comprehensive income reclassification adjustments included in the statements of changes in stockholders' equity:

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Holding gain (loss) on investment securities arising during the period (net of tax expense of $12,485, $53,624 and tax benefit of $6,295, respectively)	$ 21,051	$ 83,691	$ (9,847)
Holding gain (loss) related to foreign exchange transactions (net of tax expense of $222 and tax benefit of $1,013, respectively)	—	350	(1,584)
Net change in pension liability (net of tax benefit of $15,640)	(22,506)	—	—
Add: Reclassification adjustment for realized losses on investment securities (net of tax benefit of $2,420, $10,004 and $10,442, respectively)	(3,482)	(15,646)	(16,332)
Reclassification adjustment related to foreign exchange gains (losses) on investment securities (net of tax benefit of $163, tax benefit of $204 and tax expense of $1,160, respectively)	(262)	(319)	1,815
Net gain (loss) recognized in other comprehensive income (net of tax benefit of $5,738, tax expense of $43,638 and tax benefit of $16,590, respectively)	$ (5,199)	$ 68,076	$ (25,948)

21. EXTRAORDINARY GAIN

On October 6, 1999, the Board of Directors authorized the repurchase of some or all of the Company's Debentures for cash. During the year ended December 31, 1999, the Company repurchased $81.0 million aggregate principal amount at maturity of the Company's Debentures at a total purchase price of $49.8 million. This repurchase resulted in an extraordinary gain of $1.9 million, or $0.01 per share assuming full dilution (per share amount reflects the two−for−one stock split which occurred on March 15, 2002), net of tax expense totaling $1.2 million.

22. SUBSEQUENT EVENTS

6 3/8% Notes due 2012

On January 16, 2002, the Company issued $350.0 million aggregate principal amount at maturity of 6 3/8% Notes due January 15, 2012 (the "2002 Notes"). Interest on the 2002 Notes will accrue from January 16, 2002, and will be payable on January 15 and July 15 of each year, beginning on July 15, 2002. The net proceeds of this offering totaled approximately $348.9 million. The net proceeds from the sale of the 2002 Notes were used for the financing of the RightCHOICE merger discussed below.

RightCHOICE Acquisition

On January 31, 2002 WellPoint completed its merger, through its wholly owned subsidiary, RWP Acquisition Corp., with RightCHOICE Managed Care, Inc. ("RightCHOICE"), the parent company of Blue Cross and Blue Shield of Missouri, Inc., which serves approximately 2.2 million medical members. Under the terms of the transaction, total consideration paid to all holders of RightCHOICE common stock and holders of employee stock options in the merger was $379.0 million in cash and 8.3 million shares (on a pre−stock split basis) of WellPoint Common Stock. The Company currently expects that approximately 6.1 million shares (on a pre−stock split basis) will be issued from treasury stock and the remaining 2.2 million shares (on a pre−stock split basis) will be newly issued shares of WellPoint Common Stock. The total purchase price was approximately $1.4 billion.

Open Tax Issue relating to the WellPoint Recapitalization

During the quarter ended September 30, 1998 the Company received a private letter ruling from the IRS with respect to the treatment of certain payments made at the time of the Recapitalization and the acquisition of the commercial operations of BCC. The ruling allowed the Company to deduct as an ordinary and necessary business expense the $800 million cash payment made by BCC in May 1996 to one of two newly formed charitable foundations. As a result of and in reliance on the ruling, the Company experienced a reduction in its income tax expense of $85.5 million and the Company reduced its goodwill resulting from the Recapitalization by $194.5 million during the year ended December 31, 1998. The Company filed for refund claims of approximately $198.6 million of previous year income tax payments and reduced income tax payments during 1998 and 1999 by approximately $81.4 million. In August 1999, the Company received a cash refund (including applicable accrued interest) of approximately $183.0 million, which was reflected in the statement of cash flows for such year. The Company has refund claims pending of approximately $39.3 million.

In March 2002, the Company received a letter from the IRS notifying the Company that the IRS was considering revoking the September 1998 private letter ruling. The letter stated that the IRS was considering, in essence, reversing its earlier position and concluding that the $800 million payment was not an ordinary and necessary business expense. The letter further stated that the IRS was withdrawing

the private letter ruling and that the Company could no longer rely on the private letter ruling. Under Section 7805(b) of the Code, the IRS has discretionary authority to limit the retroactive effect of any revocation of a letter ruling. The Company has submitted a written request for such relief under Section 7805(b). According to regulations promulgated by the United States Treasury, such relief will be granted whenever a taxpayer meets all of five specified criteria, including that the taxpayer has relied in good faith on an earlier ruling and that the revocation of the ruling would be to the detriment of the taxpayer. The Company believes that it meets substantially all of these criteria. Therefore, although no assurances can be given, the Company currently expects that such relief will be granted. The Company's request for relief under Section 7805(b) is being made without prejudice to the Company's right to subsequently argue that the $800 million cash payment should continue to be treated as an ordinary and necessary business expense under the Code.

23. PENDING ACQUISITION

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to more than three million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

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EXHIBIT 10.12

BLUE CROSS LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their November 15, 2001 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as WellPoint Health Networks Inc. (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement, the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for−profit health care plan, or mutual health insurer operating on a not–for–profit or for−profit basis, under state law; financing access to health care services; providing health care management and administration; administering, but not underwriting, non−health portions of Worker's Compensation insurance; and delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: a) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and: b) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and c) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of subparagraph B but not subparagraph A of this paragraph, the entity, its owners, and persons with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean that a Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have:

A. The legal authority, directly or indirectly through wholly−owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for–profit Controlled Affiliate; or

B. The legal authority directly or indirectly through wholly−owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s). Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Amended as of June 11, 1998

3. The Plan may engage in activities not required by BCBSA to be directly licensed through Controlled Affiliates and may indicate its relationship thereto by use of the Licensed Name as a tag line, provided that the engaging in such activities does not and will not dilute or tarnish the unique value of the Licensed Marks and Name and further provided that such tag line use is not in a manner likely to cause confusion or mistake. Consistent with the avoidance of confusion or mistake, each tag line use of the Plan's Licensed Name: (a) shall be in the style and manner specified by BCBSA from time−to−time; (b) shall not include the design service marks; (c) shall not be in a manner to import more than the Plan's mere ownership of the Controlled Affiliate; and (d) shall be restricted to the Service Area. No rights are hereby created in any Controlled Affiliate to use the Licensed Name in its own name or otherwise. At least annually, the Plan shall provide BCBSA with representative samples of each such use of its Licensed Name pursuant to the foregoing conditions.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of November 20, 1997

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time−to−time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended November 18, 1999

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2–4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii) and 15(a)(i)−(viii) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three–fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three−fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing National Accounts, Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three−fourths of the Plans and of three−fourths of the total then current weighted vote of all the Plans.

Amended as of March 11, 1999

9. (d). The Plan may operate as a for−profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)−(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non−voting, non−convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b−2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d−1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D−G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

Amended as of September 17, 1997

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) ”Person” shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon six (6) months written notice to BCBSA.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three−fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of the Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended March 12, 1998

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of September 19, 1996

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the capital benchmark formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

Amended as of November 19, 1998

(iv) BCBSA shall have the right to audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with this paragraph 15(d).

(v) As to a breach of 15 (d) (i), (ii), (iii) or (iv), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii) or (iv) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

Amended as of November 20, 1997

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By /s/ Scott P. Serota

Title President

Date January 31, 2002

WellPoint Health Networks Inc.

By /s/ Leonard D. Schaeffer

Title Chairman and Chief Executive Officer

Date January 31, 2002

EXHIBIT 1

BLUE CROSS

CONTROLLED AFFILIATE LICENSE AGREEMENT

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2)above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:

Date

Plan:

By:

Date

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:

Date

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%

Standard 1A, 4

50%

Standard 1B, 4

100% and Primary Business is Government Non−Risk

Standard 4*,10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance

Standards 7A−7E

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 2 (Guidelines 1.1,1.2) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 6H

No

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates

Standard 2 (Guidelines 1.1,1.3) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates

Standard 6H

Controlled Affiliate's Primary Business is Government Non−Risk

Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes

Standard 3A

No

Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes

Standards 6A−6I

Controlled Affiliate is a former primary licensee

Standards 5,8,9,11

No

Controlled Affiliate is not a former primary licensee

Standards 5,8

Controlled Affiliate's Primary Business is Government Non−Risk

Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter−Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report"as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2000

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Captial (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their Novmeber 15, 2001 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as ("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non−exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or, anything in any other license to Controlled Affiliate notwithstanding, in its legal or trade name.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time–to–time.

Amended as of November 17, 1994

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time–to–time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly–owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for–profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time–to–time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted

hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all off Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time–to–time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

• An annual fee of five thousand dollars ($5,000) per license, plus

• .05% of gross revenue per year from branded group products, plus

• .5% of gross revenue per year from branded individual products plus

• .14% of gross revenue per year from branded individual annuity products.

Amended as of November 20, 1997

The foregoing percentages shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2000

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:

Date:

Controlled Affiliate:

By:

Date:

Plan:

By:

Date:

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 − Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 − State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 − Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement.The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 − Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then−current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 − Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 − Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

EXHIBIT 2

Membership Standards

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards. Compliance with any Membership Standard may be excused, at the Plans' discretion, if the Plans agree that compliance with such Standard would require the Plan to violate a law or governmental regulation governing its operation or activities.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise general and administrative expenses.

Standard 1: A Plan's Board shall not be controlled by any special interest group, and shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Plan shall maintain a governing Board, which shall control the Plan, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of November 19, 1998

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Biennial trade name and service mark usage material, including disclosure material under Standard 7;

C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

- Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year−end "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 15, 2001

E. Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report and Member Touchpoint Measures Index (MTM) starting 12/31/00 and semi−annually thereafter; and

• Plans that are a Shell Holding Company as defined in the Preamble hereto are not required to furnish any items identified in Paragraph E.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Transfer Program;

B. Inter−Plan Teleprocessing System (ITS);

C. BlueCard Program;

D. Electronic Claims Routing Process; and

E. National Account Programs, effective January 1, 2002

Amended as of November 15, 2001

Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter−Plan nature or where the Association is a party.

Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.

Standard 10: During each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts in the designated Service Area to promote and build the value of the Blue Cross and Blue Shield Marks.

Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 18, 1999

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision−making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended June 15, 2001

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non−Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non−Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non−BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

8. For claim payments in a Participating Plan's area (on non−BlueCard claims), Participating Plans are strongly encouraged, but not required, to pass along to the Control Plan part or all of local provider discounts and differentials for use by the Control Plan in negotiating financial arrangements with National Accounts. However, since the size, basis, form and use of local differentials can vary substantially among Plans and also by individual National Account characteristics, the degree and form of any discount or differential passed along to the Control Plan shall be strictly a matter of negotiated contractual agreement between a Participating Plan and the Control Plan and may also vary from one National Account to another. In order to facilitate the quotation of national account pricing and the offering of a variety of National Account delivery systems, all Plans are strongly encouraged to periodically publish to other Plans and the BCBSA their National Account contracting policies with respect to the handling of differentials.

The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account. The exact form and substance of this may vary from one National Account to another and shall be a matter of explicit negotiation and contractual relationship between the National Account and the Control Plan. The specifics in an agreement between the Control Plan and the National Account may vary in form (e.g., a guaranteed offset against retentions, or a direct pass through, or a guaranteed aggregate percentage discount, or no pass back at all, etc.), and the Control Plan has the responsibility and the Authority to negotiate precise arrangements. However, irrespective of the final arrangements between the Control Plan and the National Account, a Participating Plan's liability for passing along differentials shall be limited to the contractual agreement the Participating Plan has with the Control Plan on a specific National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expenditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan may use the Licensed Marks and Name outside its Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its service area;

d. issuing a small sign containing the legal name or trade name of the Plan or its licensed Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

Amended March 16, 2001

e. advertising in publications or electronic media solely to persons for employment;

f. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate.

h. negotiating rates with a health care provider for services to a specific member in case management, provided that:

(1) the health care provider does not contract with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Licensee(s) in whose Service Area the health care provider is located consent(s) in advance.

Amended November 15, 2001

EXHIBIT 5

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for−profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time−consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre−MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii.any request, if applicable, that one or more members of the Mediation Committee be disqualified from the proceeding and the grounds for such request;

ix. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

x. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on the BCBSA and on the complaining party (or parties) and on the Chairman of the Mediation Committee;

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation;

iv. any request, if applicable, that one or more members of the Mediation Committee be disqualified from the proceeding and the grounds for such request; and

v. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.B., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) and on the Chairman of the Mediation Committee, a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C.

2. Mediation

A. Mediation Committee

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has established a Mediation Committee. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged to exhaust the mediation procedure.

B. Election To Mediate

If any party elects first to pursue Mediation, and if it appears to the Corporate Secretary that the dispute falls within the jurisdiction of the Mediation Committee, as set forth in Exhibit 5−A hereto, then the Corporate Secretary will promptly furnish the Mediation Committee with copies of the Complaint, Answer, Counterclaim and Reply to Counterclaim, and other documents referenced in Paragraph 1, above.

C. Selection of Mediators

The parties shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of the mediator(s) who may include members of the Mediation Committee and/or experienced mediators from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties cannot agree upon the number of mediators desired, that number shall default to three. In the event the parties cannot agree upon the selection of mediator(s), the Chairman will select the mediator(s), at least one of which shall be an experienced mediator from an independent entity, consistent with the provisions set forth in this Paragraph. No member of the Mediation Committee who is a representative of any party to the Mediation may be

selected to mediate the dispute. The Chairman shall also endeavor not to select as a mediator any member of the Mediation Committee whom a party has requested to be disqualified. If, after due regard for availability, expertise, and such other considerations as may best promote an expeditious Mediation, the Chairman believes that he or she must consider for selection a member of the Mediation Committee whom a party has requested to be disqualified, the other members of the Committee eligible to be selected to mediate the dispute shall decide the request for disqualification. By agreeing to participate in the Mediation of a dispute, a member of the Mediation Committee represents to the party (or parties) thereto that he or she knows of no grounds which would require his or her disqualification.

D. Binding Decision

Before the date of the Mediation Hearing described below, the Corporate Secretary will contact the party (or parties) to determine whether they wish to be bound by any recommendation of the selected mediators for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

E. Mediation Procedure

The Chairman shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediators, unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. By no later than five (5) days prior to the date designated for the Mediation Hearing, each party shall supply and serve a list of all persons who will be attending the Mediation Hearing, and indicate who will have the authority to resolve the dispute.

iii. Each party will be given one−half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross−examination nor questioning of opposing representatives will be

permitted. At the close of each presentation, the selected mediators will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediators may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediators may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iv. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediators, will sit in on the negotiations.

v. After the close of the presentations, the selected mediators may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

vi. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vii. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediators, and decisions or recommendations in any Mediation proceeding shall be executed by each party.

viii. Upon request of the selected mediators, or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

F. Notice Of Termination Of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediators, or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within forty (40) days after the Complaint was served, whichever comes first, any party or any one of the selected mediators may so notify the Corporate Secretary, who shall promptly issue a Notice of termination of mediation to all parties, to the selected mediators, and to the MDR Administrator, defined below. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the selected mediators, the Mediation process may continue at the same time the MDR process is invoked. The Notice described above would serve to initiate the MDR proceeding and would not terminate the proceedings.

3. Mandatory Dispute Resolution (MDR)

If all parties elect not to first pursue Mediation, or if a notice of termination of Mediation is issued as set forth in Paragraph 2.F., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to MDR.

A. MDR Administrator

The Administrator shall be an independent entity such as the Center for Public Resources, Inc. or Endispute, Inc., specializing in alternative dispute resolution. The Administrator shall be designated initially, and may be changed from time to time, by the affirmative vote of a majority of the Plans present and voting and a majority of the total then current weighted vote of all the Plans present and voting.

B. Initial Conference

Within five (5) days after a Notice of Termination has issued, or within five (5) days after the time for filing and serving the Reply to any Counterclaim if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This Initial Conference may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph C shall be followed.

Amended September 21, 2000

C. Panel Selection Process

The Administrator shall designate at least seven potential arbitrators. The exact number designated shall be sufficient to give each party at least two peremptory strikes. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted two peremptory strikes. From the remaining designees, the Administrator shall select a three member Panel. The Administrator shall set the dates for exercising all strikes and shall complete the Panel Selection Process within fifteen (15) days of the Initial Conference. Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

D. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, appended as Exhibit "5−B" hereto, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

E. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE CROSS® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

F. Administrative Conference And Preliminary Arbitration Hearing

Within ten (10) days of the Panel being selected, the Presiding Arbitrator will schedule an Administrative Conference to discuss scheduling of the Arbitration Hearing and any other matter appropriate to be considered including: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on−site inspection by the Panel.

G. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served as of the date of the Administrative Conference as set forth in Paragraph 3.F., above. Within twenty (20) days after receipt of a request for documents, a party shall produce all relevant and non−privileged documents to the requesting party. In his or her discretion, the Presiding Arbitrator may require the parties to provide lists in such detail as is deemed appropriate of all documents as to which privilege is claimed and may further require in−camera inspection of the same.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to 21 days prior to the Arbitration Hearing. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

iii. **Depositions** As a general rule, the parties will not be permitted to take deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause, provided that no deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(b)(4)(A)(i) prior to the expiration of the discovery period.

v. ***Discovery cut−off***: The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed forty−five (45) days from its commencement, without the agreement of all parties.

vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator. The Presiding Arbitrator is authorized to resolve all discovery disputes, which resolution will be binding on the parties unless modified by the Arbitration Panel. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

H. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini−trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

I. Subpoenas On Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., a party may request the issuance of a subpoena on a third party, to compel testimony or documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

J. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

K. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party may submit to the other party (or parties) and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

L. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

M. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney−client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post−hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

N. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non−parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

O. Return Of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

B. Temporary Or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults And Proceedings In The Absence Of A Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification Or Disability Of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

G. Extensions of Time

Any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (i) the Chairman of the Mediation Committee if the proceeding is then in Mediation; (ii) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (iii) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (i) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (ii) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

Amended September 21, 2000

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

K. Recovery of Attorney Fees and Expenses

Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub−sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Section 3−N hereof, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have 20 days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

Amended September 21, 2000

EXHIBIT 5−A

MEDIATION COMMITTEE

REPORTS TO: Board of Directors

CHARGE: 1. Develop and implement processes for resolving misunderstandings or disagreements between Plans or between Plans and the Association under the following circumstances:

a. Matters at issue regarding relationships between Plans or between Plans and the Association.

b. Matters at issue regarding relationships between Plans or between Plans and the Association.

c. Matters at issue under the Inter−Plan Bank, Reciprocity, and Transfer Programs.

d. Matters at issue regarding contractor selection or performance under the Medicare Part A Program.

2. Determination of equalization allowances and/or cost allowances under FEP shall not be considered by this Committee.

MEMBERSHIP: Six to Eight

STAFF: Senior Vice President and General Counsel

QuickLinks −− Click here to rapidly navigate through this document

Exhibit 10.18

WELLPOINT
H NETWORKS

October 2001

WELLPOINT
H NETWORKS

Benefits for Your Life and Career

OFFICER BENEFITS ENROLLMENT GUIDE

How to Use This Guide

Your 2002 Officer Benefits Enrollment Guide contains information on the *Flex*Point Benefits Program and the *Flex*Exec Officer Benefits Program of WellPoint Health Networks, Inc. ("WellPoint") and it's affiliates. Your *Flex*Point Enrollment Worksheet lists your options and the costs associated with those options. Use this Enrollment Guide for:

• Enrollment Procedures for Newly−Hired Officers

Enrollment procedures for new Officers are on page 10 of this Guide.

• Open Enrollment

An overview of the 2002 *Flex*Point Benefits Program and enrollment procedures is on pages 5−9. **You must enroll through ASC Online at http://home.wellpoint.com or on the Intranet at http://asconline.wellpoint.com. You only need to enroll if you would like to change your benefit election(s), make corrections and/or elect Flexible Spending Account(s) for 2002.**

Read the *Flex*Point Enrollment Guide *carefully* to determine the benefits that best suit your needs for 2002. **Enroll for 2002 benefits from October 17, 2001 through November 2, 2001.**

• Benefit Information

Explanations of the 2002 benefits are included for your review.

***Flex*Point**

*Flex*Point benefits provide you and your family with health care and life insurance coverage options. You can change most of your benefits once a year in order to meet your needs for the upcoming year. Read this section *carefully* because ***you will not be able to change*** your elections during the year except as a result of a qualified mid−year change or if you meet special enrollment requirements.

***Flex*Exec**

An overview of the additional benefits provided to WellPoint Officers is included.

Balanced Life Benefits

WellPoint offers you a wide spectrum of benefits in addition to our *Flex*Point benefits to assist you in balancing your career and your personal life. You can take advantage of many of the benefits at any time during the year.

Financial Future and Retirement

Brief descriptions of the Pension Plan, 401(k) Retirement Savings Plan, and Employee Stock Purchase Plan are included.

• Mid−Year Changes

WellPoint Officers experience a number of *changes throughout the year* that could affect their benefits, including marriage, birth, and change of employment. Review this section to learn more about mid−year changes and what to do.

• COBRA

An explanation of COBRA coverage is included for your review.

• Important Information

An explanation of important legislation is included.

• Important Telephone Numbers and Claims Addresses

A listing of phone numbers for providers and addresses for submitting claims is included.

About This Guide

This Guide does not serve as a guarantee of continued employment or benefits. WellPoint policies on hiring, discharge, layoff, and discipline are in no way affected by the programs described here. In particular, nothing in this booklet alters WellPoint's at−will employment policy which provides that employment with WellPoint is not for a specified period of time and can be terminated by either WellPoint or the officer at any time, with or without cause or advance notice.

In addition, WellPoint reserves the right to amend or discontinue the WellPoint plans—or any part of them—with or without notice, at any time at WellPoint's sole discretion. If there is a discrepancy between this document and the plan documents, the provisions of the plan documents will govern.

2002 Officer Benefits Enrollment Guide

Benefits For Your Life & Career

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WELLPOINT
H NETWORKS

Your 2002 Benefits Program

Here's a quick look at the benefits offered to Officers of WellPoint Health Networks Inc.

***Flex*Point**

Plan	Options
Medical	WellPoint Preferred PPO, WellPoint Group, or HMOs Waive coverage
Dental	Dental Net (available only in California) Standard Dental Enhanced Dental Waive coverage
Vision	Vision Service Plan LensCrafters (available only to BCBSGA associates) Waive coverage
Life Insurance	$50,000 1 times your benefit salary 2 times your benefit salary 3 times your benefit salary 4 times your benefit salary Waive coverage
Accidental Death and Dismemberment (AD&D) Insurance	1 times your benefit salary 2 times your benefit salary 3 times your benefit salary 4 times your benefit salary
Dependent Life Insurance	
Spouse/Domestic Partner:	$5,000 1/2 your benefit salary 1 times your benefit salary Waive coverage

Each Child*:	$5,000 $10,000 $25,000 Waive coverage
Flexible Spending Accounts	Health care up to $5,000 Dependent daycare up to $5,000

* Amount payable depends on age of child. See page 24.

***Flex*Exec**

These benefit plans are provided for all WellPoint Officers automatically—no enrollment is required.

Plan	Options
Officer Physical Exams	Available to Vice Presidents and above with one year of service
Group Universal Life	2 times compensation* for Vice Presidents and General Managers 3 times compensation* for Senior Vice Presidents and above
Short−Term Disability	Maximum of 26 weeks salary continuance
Long−Term Disability	60% of compensation** for Vice Presidents and General Managers 70% of compensation** for Senior and Executive Vice Presidents

*
Base salary as of September 1, 2001 plus target management bonus

**
Base salary as of September 1, 2001 plus target management bonus and commissions received from 9/1/2000 through 8/31/2001

Comprehensive Executive Nonqualified Retirement Plan

Plan/Feature	Options
Supplemental 401(k) Deferral	You may defer 1% − 6% of your eligible compensation after contributing the annual maximum to the 401(k) plan and also before becoming eligible for the Company match; deferrals receive a Company matching contribution
Salary Deferral	You may defer 1% − 60% of your base salary
Management Bonus Deferral	You may defer 1% − 100% of your 2002 bonus to be paid in 2003
Car Allowance Deferral *(You may elect to defer your car allowance, receive it as taxable income, or decline it and receive mileage reimbursement.)*	$4,800 annually for Vice Presidents and General Managers $7,200 annually for Senior Vice Presidents $9,600 annually for Executive Vice Presidents and above
Supplemental Pension Plan	WellPoint automatically makes contributions for compensation in excess of $200,000; 5−year vesting applies

Additional Plans

Plan	Options
WellPoint 401(k) Retirement Savings Program	Highly compensated may defer 2% − 8% of your eligible compensation; Company match applies (see page 36 for details)
Employee Stock Purchase Plan	You may contribute between $20 and $817.30 per pay period (see page 37 for details)

*Flex*Point Eligibility

Officers

All full−time Officers are eligible for *Flex*Point benefits on the first of the month following or coinciding with one calendar month of employment. For example, if you begin work on July 15, you will be eligible to participate in *Flex*Point on September 1. If you begin work on July1, you will be eligible to participate on August 1.

If you are rehired within one year of termination, you are eligible for *Flex*Point benefits on the first of the month following your rehire date.

Dependents

You may only enroll your eligible dependents in *Flex*Point benefits. **Enrolling dependents that are not eligible is a violation of Company policy that is subject to disciplinary action up to and including termination of employment.** Domestic partner coverage is now available for health and life insurance benefits. See pages 6−7.

Eligible dependents include:

- Your spouse/domestic partner
- Your or your partner's unmarried children through age 18 who are your dependents for income tax purposes. Legally−adopted children, stepchildren, and any child for whom you or your spouse/ partner is a legal guardian are eligible under the same terms as your own natural children.
- Your or your partner's unmarried children, age 19 through 24, who are your dependents for income tax purposes and enrolled for 12 or more credits per semester (or equivalent full−time basis) in an accredited college, university, or post−high−school trade or technical school. You will be required to provide proof of full−time student status.
- Your or your partner's unmarried children who are your dependents for income tax purposes and who are declared by a physician to be incapacitated or disabled. A physician's note is required, and generally the child must have been covered under the plan at the time of disability.

Note: You may not be covered as an associate and as a dependent on WellPoint's medical, dental, vision, or life insurance plans. For example, if you and your spouse are both employed at WellPoint, you may elect to cover your spouse for medical, dental, and vision. However, your spouse may not also elect those coverages as an associate. Or, both you and your spouse may each elect to be covered as associates. Additionally, you may not have duplicate coverage for your children (i.e. both parents may not elect medical, dental, vision, and/or life insurance for the children).

When Coverage Ends

Your coverage under the medical, dental, and vision plans will end on the last day of the month of termination of your employment with WellPoint. You may be eligible to continue your WellPoint health coverage through COBRA (see page 41). Life insurance, AD&D, STD, LTD, and dependent life end on your last day of employment with WellPoint. You may be able to convert your life insurance. Other situations in which your coverage will be terminated are listed below, along with the same kind of information for your dependents.

All coverage will terminate at the earliest time specified below:

1.
For the medical, dental, and vision plans, on the last day of the month you cease to be an eligible associate (such as termination of employment, retirement, or for any other reason).

2.
For the life insurance, AD&D, STD, LTD, and dependent life plans, on the date you cease to be an eligible associate (such as termination of employment, retirement, or for any other reason).

3.
Upon discontinuation or termination of any plan, when such plan ends. The plans may be terminated or amended without notice to you.

4.
Upon non−payment of any required associate contribution.

Your dependent(s) coverage will cease at the earliest time specified below:

1.
When your coverage terminates.

2.
On the last day of the calendar month when your dependent(s) cease to be eligible, depending on plan provisions.

3.
Upon non−payment of any required associate contribution.

How *Flex*Point Works

Coverage Levels

In addition to deciding which medical, dental, and vision options you want for yourself, you may also decide if you want dependent coverage. WellPoint offers four levels of coverage. You can select coverage for:

- Yourself only
- Yourself *plus* Spouse/Domestic Partner
- Yourself *plus* Child(ren)
- Yourself *plus* Family (Spouse/Domestic Partner and Child(ren))

The Pretax Advantage

With *Flex*Point, you pay your share of the cost for most of your benefits on a pretax basis (excluding domestic partner coverage). This means your contributions will be deducted from your pay **BEFORE** Social Security, Medicare, federal, state, and local income taxes are calculated and withheld. This way, your taxable income is reduced and you pay less tax.

Pretax

- **Medical**
- **Dental**
- **Vision**
- **Flexible Spending Accounts—Health Care and Dependent Day Care**

Post−tax

- **Employee Life Insurance**
- **Dependent Life Insurance**
- **Accidental Death and Dismemberment (AD&D)**
- **Domestic Partner Coverage**

Coverage During a Leave of Absence

If you go out on an unpaid leave of absence, you are given the option to discontinue some or all of your *Flex*Point benefits as of the date the leave begins. You will have the option to reinstate these benefits when you return from the leave. If you continue your coverage during a leave of absence, it is your responsibility to make biweekly payments for the cost of your benefits to the Leave of Absence Unit.

Changes to Coverage During a Leave of Absence

- Changes to life insurance, spouse/partner life, child life, and AD&D do not become effective until the later of the following:
  - January 1, 2002, or
  - The date of your return to active employment status.
- Changes that may result in an increase in the amount or volume of life insurance will not take effect while on a leave of absence; they are delayed until your return to active employment.

Domestic Partner Coverage

*Flex*Point offers limited benefits coverage to domestic partners. Officers who are eligible for *Flex*Point may enroll their domestic partners and/or children of domestic partners in medical,* dental, vision, and life insurance coverage.

For the purpose of *Flex*Point, a domestic partnership consists of two adults of the same or opposite sex who have chosen to share their lives in a committed relationship equivalent to that of married persons, and who reside together and share a mutual obligation of support for the basic necessities of life.

Eligibility

To qualify for benefits, the associate and domestic partner must meet **ALL** of the following criteria:

- Each person is the other's sole domestic partner and intends to remain so indefinitely.
- Neither person is married or legally separated from anyone else.
- Each person is at least 18 years of age and mentally competent to consent to the terms of the Declaration of Domestic Partnership.
- The associate and domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside.
- Both persons currently reside in the same residence and intend to do so indefinitely.
- Both persons are jointly responsible for basic living expenses incurred during the domestic partnership.
- Neither partner has had a different domestic partner within the last six months from the date of the execution of the Declaration of Domestic Partnership (this condition does not apply if the previous domestic partner is deceased).
- Both persons have executed a domestic partnership agreement and/or registered as domestic partners in a jurisdiction that authorizes such agreements and/or registries **OR** at least TWO of the following statements are true:
    - Both persons have lived together continuously for the past 12 months;
    - The associate has designated the domestic partner as a beneficiary under his/her will, or the domestic partner has designated the associate as a beneficiary under his/her will;
    - The associate has granted his or her domestic partner powers under a durable power of attorney, or the domestic partner has granted the associate powers under a durable power of attorney;
    - The associate has previously designated the domestic partner as a beneficiary under his/her life insurance policy, or the domestic partner has previously designated the associate as a beneficiary under his/her life insurance policy;
    - Both persons share a joint bank account;
    - Both persons are cosigners of a lease or deed;
    - Both persons are named on the same car insurance policy.

* Not all HMOs offer domestic partner coverage (see page 18). This coverage is available in all states under the WellPoint Preferred PPO or WellPoint Group Plan.

Certification

If you wish to elect domestic partner benefits, you must complete a Declaration of Domestic Partnership and return it for approval before any domestic partner benefits can be activated. The declaration form will be mailed to you when you elect domestic partner benefits. Both you and your domestic partner are required to sign the declaration.

Eligible Dependents

In addition to health and life insurance coverage for your domestic partner, you may also elect health and life coverage for the qualified children of your domestic partner. Your domestic partner's children are eligible for coverage if they are:

- Unmarried;
- Primarily dependent on you or your domestic partner for support;
- Living with you and your domestic partner in a regular parent−child relationship;
- Within the age/student requirements of the plan benefits; and
- Eligible to be claimed by you or your domestic partner as a dependent as defined in Internal Revenue Code section 152.

Cost of Coverage

Coverage	Associate Biweekly Cost
• Associate & Domestic Partner • Associate & Spouse	Same
• Associate & Domestic Partner(s) Child(ren) • Associate & Associate's Child(ren) • Associate, Associate's Child(ren), & Domestic Partner's Child(ren)	Same
• Associate, Spouse, & Child(ren) • Associate, Domestic Partner, & Associate's Child(ren) and/or Domestic Partner's Child(ren)	Same

The portion of your contribution that is attributable to coverage for your domestic partner and/or your domestic partner's child(ren) will be paid on an after−tax basis.

Tax Consequences

The IRS has determined that if you receive health benefits for your domestic partner and/or his or her children, **AND** your domestic partner and his or her children are not your dependents as defined by the IRS, you must pay federal income tax on the value of the benefits you received. The IRS defines the value of these benefits as the amount it would cost you to obtain the insurance for your partner and each of your partner's children at group policy rates. Because there are tax consequences associated with domestic partner coverage, we recommend you consult a tax advisor before electing this coverage.

You may view and print a copy of the Domestic Partner Guide with the Declaration of Domestic Partnership from TAO or WorkSite. In TAO, go to "Bulletin Boards," select "__HR__Information," and then open "Domestic Partner Guide." From WorkSite (http://home.wellpoint.com) go to Department Links>Human Resources>Library>Benefits. If you are unable to view or print these materials, call the ASC at (877) 342−5272 to have a copy sent to you.

Open Enrollment Procedures for Current WellPoint Officers

Comprehensive Executive Nonqualified Retirement Plan

As in prior years, you will make your Comprehensive Executive Nonqualified Retirement Plan elections by completing a *Flex*Exec enrollment form. Web enrollment is not available for the Comprehensive Executive Nonqualified Retirement Plan.

***Flex*Point**

Your *Flex*Point elections for 2002 will be in effect from January 1 through December 31, provided you remain eligible for benefits. Each year, during the Open Enrollment period, you have the opportunity to change your coverage for the following plan year.

Open enrollment will be from, October 17, 2001 through November 2, 2001.

When you log on for Web enrollment to make changes, you must enter your user ID, as well as your password. Using your password serves as both your signature and your authorization to process benefit changes.

Before you enroll, give careful consideration to the benefits you will need for the 2002 calendar year. Unless you have a qualified mid−year change (see Mid−Year Changes on page 38), *you may not make any changes* to your enrollment selections until 2003.

If You Need to Make Changes...

1.
Review this *Flex*Point Enrollment Guide and select your benefit coverages. If you have specific questions about coverages, please contact the plan provider directly. Customer Service telephone numbers are listed in the Medical Comparison Chart (pages 13−16) and the Dental Comparison Chart (page 20).

2.
Complete the Enrollment Worksheet before making changes for 2002. Your 2001 elections are highlighted for your reference.

3.
Log on to ASC Online to make your 2002 benefit elections from October 17, 2001 through November 2, 2001.

4.
You will receive a Confirmation Statement along with any necessary forms at the end of the Open Enrollment period. If you do not receive a Confirmation Statement by December 10, 2001, please contact the Associate Service Center immediately.

5.
Check your Confirmation Statement *carefully*. If you need to make any changes or corrections, *call the Associate Service Center at (877) 342−5272 before December 14, 2001*.

Enroll Via ASC Online

During this Open Enrollment period, you can make *Flex*Point changes on ASC Online. Simply type http://home.wellpoint.com from your browser at work to access the enrollment site from the WellPoint Intranet. You can also access the enrollment site from home at http://asconline.wellpoint.com. You will be asked to enter your user ID as well as your password.

Important: After you scroll through and make the changes you want, you must click "Submit." *Your elections are not final until you click the "Submit" button and the summary of elections screen appears.*

If You Do Not Log On to ASC Online to Enroll

- If you don't log on to the Web, you will receive your 2001 benefit coverages (except for your Flexible Spending Accounts) at the new 2002 contribution levels.

- You will not participate in the Health Care or Dependent Day Care Flexible Spending Accounts. You ***must*** log on to ASC Online to authorize Health Care and Dependent Day Care Spending Account deductions for 2002.

ASC Online

Log on at work at
http://home.wellpoint.com

or at home at
http://asconline.wellpoint.com

Confirmation Statements

- A Confirmation Statement will be mailed to your home at the end of the enrollment period. You may also review your elections on−line at any time.

- Check your Confirmation Statement *carefully*. If you need to make any changes or corrections, or fix omissions, call the *Associate Service Center before December 14, 2001*. You cannot make changes or corrections after December 14, 2001.

Keep your Confirmation Statement for your records.

Forms

Depending upon your elections you may be required to complete and submit additional information.

- If you are newly enrolling or are adding a new dependent in an HMO or Dental Net (California associates only), you must complete an HMO and Dental Net enrollment form.

- A Declaration of Domestic Partnership is required if you are adding your domestic partner to your coverage for the first time.

- An Evidence of Insurability (EOI) form is required if you select a life insurance option that is two levels greater than your existing coverage. If you increase coverage for your spouse/domestic partner by one level or more, an EOI form is required. Should you increase child life insurance by two levels or more, you will need to complete an EOI form for each child.

  EOI forms will be sent to your home address after November 15, 2001.

For coverage to be effective for January 1, 2002, all forms must be returned by December 14, 2001.

Deductions and Pay Periods in 2002

There will be 26 pay periods in 2002. Your first benefit deductions for 2002 will begin with your January 4, 2002 paycheck. **If you notice any errors or omissions on this paycheck, contact the Associate Service Center immediately. No corrections can be made after January 15, 2002.**

Questions?

If you have any questions about your *Flex*Point options or procedures, contact the Associate Service Center. If you have specific medical or dental coverage questions, please call the Customer Service numbers listed in the Medical Comparison Chart (pages 13−16) and the Dental Comparison Chart (page 20).

Enrollment Procedures for Newly−Hired Officers

Comprehensive Executive Nonqualified Retirement Plan

You will make your Comprehensive Executive Nonqualified Retirement Plan elections by completing enrollment forms, which will be sent to you under separate cover. Web enrollment is not available for the Comprehensive Executive Nonqualified Retirement Plan.

*Flex*Point

Before you enroll, give careful consideration to the benefits you will need for the 2002 calendar year. Unless you have a qualified mid−year change (see Mid−Year Changes on page 38), *you may not make any changes* to your enrollment selections until 2003.

Enrollment will be conducted through ASC Online, a Web enrollment system where associates enter their benefit selections. This system will be available 24 hours a day, 7 days a week, during your enrollment period.

Steps

1.

Review this 2002 *Flex*Point Enrollment Guide and select your benefit coverages. To assist you in your provider selections, HMO and PPO directories are available at your local Human Resources office. If you have questions about medical or dental coverage, please contact the providers directly at the Customer Service phone numbers listed in the Medical Comparison Chart (pages 13−16) and Dental Comparison Chart (page 20).

2.

Complete the Enrollment Worksheet and select your coverage levels prior to enrolling.

3.

Log on to ASC Online to make your 2002 benefits elections. Simply type http://home.wellpoint.com from your browser at work to access the enrollment site from the WellPoint Intranet. You can also access the enrollment site from home at http://asconline.wellpoint.com. You will be asked to enter your user ID as well as your password. Using your password serves as both your signature and your authorization to process benefit elections.

4.

You will receive a Confirmation Statement after you complete your enrollment. If you do not receive a Confirmation Statement within two weeks of enrolling, contact the Associate Service Center.

Default Coverage—If You Don't Enroll

If you do not make your elections within the time period indicated on your Enrollment Worksheet, you will be assigned default coverage *automatically*. Default coverage provides minimal benefits for you only—not your dependents. With default coverage, you receive the following benefits:

- WellPoint Preferred PPO or WellPoint Group Medical, associate only coverage with $1,000 deductible
- $50,000 in life insurance
- One times your benefit salary in Accidental Death and Dismemberment (AD&D) insurance
- No Flexible Spending Account participation

If coverage is defaulted, you must wait until the next annual enrollment period to elect other coverage unless you qualify for a mid−year change that allows you to change some, but not all, coverages.

*Flex*Point Benefits Information

Your Medical Coverage

The medical options in *Flex*Point are designed to meet the needs of individuals with varying personal situations. Depending on where you live and work, you may be able to choose WellPoint Preferred—a preferred provider organization (PPO), a health maintenance organization (HMO), or WellPoint Group if you live where there is no PPO or HMO available. Your medical options are based on both your home address and your Company mail drop. Please carefully review provider directories (available at your local HR office) before making an election. In making your choice, it's important that you read and understand the benefits available to you, as well as the limitations and exclusions. The information in this Enrollment Guide is only a summary—refer to your Summary Plan Description for more information.

- Consider the way you now receive—or would like to receive—medical care, and identify your alternatives. HMOs generally require you to pay a small fee (copay) when you use network services and provide no benefits when you use a provider outside the network. With WellPoint Preferred, you also may have to satisfy a deductible and coinsurance. However, you may use a non−network provider if you are willing to share more of the cost.

- Also find out whether your current providers participate in an available HMO or PPO. If you're enrolling in an HMO and will be a new patient with a particular primary care physician, call the physician's office to determine whether he/she is accepting new patients.

Special Considerations

If you have coverage under another group medical plan, you have the option to waive your *Flex*Point medical coverage. If you waive medical coverage, you must certify coverage with another group plan. For example, you may be covered under your spouse's plan. You can waive coverage and receive a credit, which is taxable income in your paycheck. Part−time associates are not eligible for flex credits.

If you elect an HMO (for the first time), or add dependents to your HMO coverage, *you must submit an HMO Enrollment Form no later than December 14, 2001 (or the effective date of your coverage for 2002 new hires),* or you will be assigned a provider.

If you have a qualified mid−year change (see page 38), you must notify the Associate Service Center within 31 days of the change.

Claims Procedures

If you choose WellPoint Preferred PPO, your provider will file claims for you and your covered dependents when you receive care in−network. For non−network providers or if you choose the WellPoint Group Plan, your provider may use a universal claim form and mail it to the claims address on your ID card. You can obtain a claim form by calling Customer Service at (800) 234−0111 or by downloading a claim form from *Member Services* at www.bluecrossca.com or from WorkSite at http://home.wellpoint.com›Department Links›Forms›Benefits.

All WellPoint Preferred PPO and WellPoint Group claims should be mailed to: WellPoint Health Networks Inc., P.O. Box 4109, Woodland Hills, California 91365, Attn: Associate Claims Unit. Be sure to use a separate claim form for each patient and provider.

BCBSGA Associates

If you choose WellPoint Preferred PPO, your provider will file claims for you and your covered dependents when you receive care in−network. For non−network providers, your provider may use a universal claim form and mail it to the claims address on your ID card. You can obtain a claim form by calling Customer Service at (800) 441−2273 or by downloading a claim form from *Members Services* at www.bcbsga.com.

Claims should be mailed to: Blue Cross and Blue Shield of Georgia, P.O. Box 9907, Columbus, GA 31908−6007.

Medical Comparison Chart

The Medical Comparison Chart has been designed to help you understand the differences between plans. Carefully review this information before making your benefit selection.

Note: You continue to be responsible for all copays, even after you reach the out−of−pocket maximum.

Medical Comparison Chart

WellPoint Preferred (PPO)

Deductible(1)

	WP250	WP500	WP1000
Individual	$ 250	$ 500	$ 1,000
Family	$ 750	$ 1,500	$ 3,000

	WP250		WP500		WP1000	
Out−of−Pocket Maximum(2)	**Network**	**Non−Network**	**Network**	**Non−Network**	**Network**	**Non−Network**
Individual	$ 2,500	$ 6,900	$ 3,500	$ 7,100	$ 4,500	$ 7,600
Family	$ 7,500	$ 20,700	$ 10,500	$ 21,300	$ 13,500	$ 22,800

	Network Providers		**Non−Network Providers**
Hospital Services(3)			
Inpatient	80% after deductible (85% for WP 250)		60% after deductible
Outpatient	80% after deductible (85% for WP 250)		60% after deductible
Skilled Nursing Facility	80% after deductible; limited to 100 days/calendar year (85% for WP 250)		60% after deductible; limited to 100 days/calendar year
Professional Services			
Office Visits	WP 250	$15 copay	60% after deductible
	WP 500	$20 copay	60% after deductible
	WP 1000	80% after deductible	60% after deductible
Well Baby Care:			
• Office Visits	WP 250	$15 copay	60% after deductible
	WP 500	$20 copay	60% after deductible
	WP 1000	80% after deductible	60% after deductible
• Immunizations		$0 copay	60% after deductible
Annual Routine Exam *($300 maximum, including well woman exam)*	100% covered (does not apply toward deductible)		60% after deductible
Well Woman Exams: *($300 maximum, included in Annual Routine Exam)*			
• Office Visit	100% covered (does not apply toward deductible)		60% after deductible
• Mammogram	100% covered (does not apply toward deductible)		60% after deductible
• Pap smear	100% covered (does not apply toward deductible)		60% after deductible
X−ray and lab tests	80% after deductible (85% for WP 250)		60% after deductible
Emergency Medical Services			
Professional Services (*at hospital*)	80% after deductible (85% for WP 250)		80% after deductible
Hospital Emergency Room	80% after deductible (85% for WP 250)		80% after deductible
Maternity			
Hospital	80% after deductible (85% for WP 250)		60% after deductible
Office Visits	WP 250	$15 copay	60% after deductible
	WP 500	$20 copay	60% after deductible
	WP 1000	80% after deductible	60% after deductible
Infertility Diagnostic Procedures	80% after deductible (85% for WP 250)		60% after deductible
Mental Health Care/Substance Abuse			
Inpatient (*up to 30 days per calendar year*)	80% after deductible (85% for WP 250)		60% after deductible
Outpatient (*50 visit maximum/calendar year*)	80% after deductible (85% for WP 250)		60% after deductible
	$50 maximum/visit		$40 maximum/visit
Miscellaneous Services			
Chiropractic *(26 visit maximum/calendar year)*	WP 250	$15 copay	60% ($25 maximum/visit—after deductible has been met)
	WP 500	$20 copay	
	WP 1000	80% after deductible	
Acupuncture *(26 visit maximum/calendar year)*	WP 250	$15 copay	60% ($25 maximum/visit—after deductible has been met)
	WP 500	$20 copay	
	WP 1000	80% after deductible	
Physical Therapy/Physical Medicine	80% after deductible (85% for WP 250)		60% after deductible
Allergy Test	WP 250	$15 copay	60% after deductible
	WP 500	$20 copay	
	WP 1000	80% after deductible	
Allergy Treatment	80% after deductible (85% for WP 250)		60% after deductible
Prescription Drugs			
	$15 brand/$7 generic copay; 30−day supply		$15 brand/$7 generic copay; 30−day supply
	$30 brand/$14 generic copay; 90−day supply mail order		$30 brand/$14 generic copay; 90−day supply mail order
	Infertility drugs not covered		***Infertility drugs not covered***

Customer Service Number	**(800) 234−0111**

(1)

Deductible—Deductible expenses applied to the forth quarter of the previous year will be carried over. Copay amounts do not apply toward the deductible.

(2)

Satisfying the smaller in−network coinsurance and deductible will apply toward, but not satisfy, the larger out−of−network coinsurance and deductible, excluding any copays. Satisfying the larger out−of−network coinsurance and deductible will automatically satisfy the smaller in−network coinsurance and deductible, excluding any copays. Copays do not apply to the out−of−pocket maximum.

(3)

Hospital Services—Pre−certification is required. You must initiate; failure to do so will result in a $250 additional deductible for medically necessary care. Under no circumstances are benefits payable for unnecessary care.

No pre−existing conditions apply.

	WellPoint Group(1)			Blue Cross HMO (formerly CaliforniaCare)	Blue Choice Healthcare (GA)
Deductible	**Deductible(2)**			**Deductible**	**Deductible**
Individual	$ 250	$ 500	$ 1,000	There is no deductible; some services require a copay	There is no deductible;some services require a copay
Family	$ 750	$ 1,500	$ 3,000	There is no deductible; some services require a copay	There is no deductible; some services require a copay
Out−of−Pocket Maximum	**Out−of−Pocket Maximum**			**Out−of−Pocket Maximum**	**Out−of−Pocket Maximum**
Individual	$ 2,500	$ 3,500	$ 4,500	$1,500	None
Family	$ 7,500	$ 10,500	$ 13,500	$3,000 (2 family members) $4,500 (3 or more family members)	None
Hospital Services	**Hospital Services(3)**			**Hospital Services**	**Hospital Services**
Inpatient	80% after deductible			No charge	No charge
Outpatient	80% after deductible			No charge	No charge
Skilled Nursing Facility	80% after deductible (limited to 100 days/calendar year)			No charge (up to 100 days per year)	No charge (up to 30 days per year)
Professional Services	**Professional Services**			**Professional Services**	**Professional Services**
Office Visits	80% after deductible			$10 copay	$10 copay
Well Baby Care:					
• Office Visits	80% after deductible			$10 copay	$10 copay
• Immunizations	100% covered			No charge	No charge (office visit copay may apply)
Annual Routine Exam *($300 maximum, including well woman exam)*	100% covered (does not apply to deductible)			$10 copay	$10 copay
Well Woman Exams *(included in annual Routine Exam benefit):*					
• Office Visit	100% covered (does not apply to deductible)			$10 copay	$10 copay
• Mammogram	100% covered (does not apply to deductible)			No charge	$10 copay
• Pap smear	100% covered (does not apply to deductible)			No charge	$10 copay
X−ray and lab tests	80% after deductible			No charge	No charge
Emergency Medical Services	**Emergency Medical Services**			**Emergency Medical Services**	**Emergency Medical Services**
Professional Services (*at hospital*)	80% after deductible			No charge	No charge
Hospital Emergency Room	80% after deductible			$50 copay, waived if admitted	$50 copay, waived if admitted
Maternity	**Maternity**			**Maternity**	**Maternity**
Hospital	80% after deductible			No charge	No charge
Office Visits	80% after deductible			$10 copay	$10 copay (first visit only)
Infertility Diagnostic Procedures	80% after deductible			50% (copay will not be applied to out−of−pocket maximum)	$10 copay (artificial insemination and in−vitro fertilization are excluded)
Mental Health Care/Substance Abuse	**Mental Health Care/Substance Abuse**			**Mental Health Care/Substance Abuse**	**Mental Health Care/Substance Abuse**
Inpatient	80% after deductible (up to 30 days per calendar year)			$100/day copay, up to 30 days per year (copay will not be applied to out−of−pocket maximum)	No charge, up to 30 visits per year; 6 day limit for substance abuse
Outpatient	80% after deductible; $50 maximum/visit (50 visit maximum/calendar year)			$35 copay, up to 20 visits per year, when ordered by PCP (psychoanalysis excluded)	$25 copay, up to 20 visits per year
Miscellaneous Services	**Miscellaneous Services**			**Miscellaneous Services**	**Miscellaneous Services**
Chiropractic	80% after deductible (26 visit maximum/calendar year)			Generally not covered; $10 copay, when approved by PCP	Not covered
Acupuncture	80% after deductible (26 visit maximum/calendar year)			Generally not covered; $10 copay, when approved by PCP	Not covered
Physical Therapy/Physical Medicine	80% after deductible			$10 copay, up to 60 visits per year	$10 copay, up to 20 visits per year
Allergy Test	80% after deductible			$10 copay	$10 copay
Allergy Treatment	80% after deductible			$10 copay	$10 copay
Prescription Drugs	**Prescription Drugs**			**Prescription Drugs**	**Prescription Drugs**
	$15 brand/$7 generic copay; 30−day supply			$15 brand/$7 generic copay; 30−day supply	$15 brand/$7 generic copay; 30−day supply
	$30 brand/$14 generic copay; 90−day supply mail order			$30 brand/$14 generic copay; 90−day supply ***Infertility drugs not covered***	$30 brand/$14 generic mail order copay; 90−day supply ***Infertility drugs not covered***
Customer Service Number	**(800) 234−0111**			**(800) 234−0111 or www.bluecrossca.com**	**(800) 441−2273 or www.bcbsga.com** **TDD: (404) 842−8073**

(1) This plan is for associates who live in an area where neither a PPO network nor an HMO network is available.

(2) The deductible is included in the out−of−pocket maximum.

(3) Hospital Services—Pre−certification is required. You must initiate; failure to do so will result in a $250 additional deductible for medically necessary care. Under no circumstances are benefits payable for unnecessary care.

	UNICARE HMO (Illinois)	HMO Blue (MA)	Blue Care Network of S.E. Michigan
Deductible	**Deductible**	**Deductible**	**Deductible**
Individual	There is no deductible; some services require a copay	There is no deductible; some services require a copay	There is no deductible; some services require a copay
Family	There is no deductible; some services require a copay	There is no deductible; some services require a copay	There is no deductible; some services require a copay
Out−of−Pocket Maximum	**Out−of−Pocket Maximum**	**Out−of−Pocket Maximum**	**Out−of−Pocket Maximum**
Individual	$1,500	None	None
Family	$3,000	None	None
Hospital Services	**Hospital Services**	**Hospital Services**	**Hospital Services**
Inpatient	$250 room & board copay per admission	No charge	No charge
Outpatient	No charge	No charge	No charge
Skilled Nursing Facility	No charge (up to 60 days per year)	No charge (up to 100 days per year)	No charge (up to 45 days per year)
Professional Services	**Professional Services**	**Professional Services**	**Professional Services**
Office Visits	$10 copay	$10 copay	$10 copay
Well Baby Care:			
• Office Visits	$10 copay	$10 copay	$10 copay
• Immunizations	No charge (office visit copay may apply)	No charge (office visit copay may apply)	No charge (office visit copay may apply)
Annual Routine Exam *($300 maximum, including well woman exam)*	$10 copay	$10 copay	$10 copay
Well Woman Exams *(included in annual Routine Exam benefit):*			
• Office Visit	$10 copay	$10 copay	$10 copay
• Mammogram	$10 copay (if doctor's office visit)	No charge (office visit copay may apply)	No charge (office visit copay may apply)
• Pap smear	$10 copay (if doctor's office visit)	No charge (office visit copay may apply)	No charge (office visit copay may apply)
X−ray and lab tests	No charge	No charge	No charge (office visit copay may apply)
Emergency Medical Services	**Emergency Medical Services**	**Emergency Medical Services**	**Emergency Medical Services**
Professional Services (*at hospital*)	No charge	No charge	No charge
Hospital Emergency Room	$50 copay	$50 copay	$25 copay
Maternity	**Maternity**	**Maternity**	**Maternity**
Hospital	No charge	No charge	No charge
Office Visits	$10 copay (first visit only)	No charge	$10 copay
Infertility Diagnostic Procedures	No charge (4 attempts for actual infertility per lifetime)	$10 per visit	$10 copay for first visit, then 50% of covered charges
Mental Health Care/Substance Abuse	**Mental Health Care/Substance Abuse**	**Mental Health Care/Substance Abuse**	**Mental Health Care/Substance Abuse**
Inpatient	No charge, up to 30 days per year	No charge, up to 60 days per year for mental health care and up to 30 days per year for substance abuse	No charge, up to 30 days per year for mental health care and 50% copay for detoxification
Outpatient	$20 copay, up to 20 visits per year	20 visits per year ($10 copay for visits 1−10; $15 copay for visits 11−20)	50% copay, up to 20 visits per year
Miscellaneous Services	**Miscellaneous Services**	**Miscellaneous Services**	**Miscellaneous Services**
Chiropractic	Not covered	Not covered	Covered when referred by PCP
Acupuncture	Not covered	Not covered	Not covered
Physical Therapy/Physical Medicine	$10 copay, up to 60 visits per year	$10 copay, up to 60 visits per year	$5 copay, up to 60 days
Allergy Test	No charge (office visit copay may apply)	$10 copay	50% copay for testing
Allergy Treatment	No charge (office visit copay may apply)	No charge	$5 copay for injections (office visit copay may apply)
Prescription Drugs	**Prescription Drugs**	**Prescription Drugs**	**Prescription Drugs**
	$15 brand/$7 generic copay; 30−day supply $30 brand/$14 generic copay 90 day supply, mail order	$20 brand/$10 generic copay (at HMO Blue−participating pharmacies)—30−day supply $20 brand/$10 generic mail order copay—90−day supply	$5 copay—30−day supply
Customer Service Number	**(800) 234−0111**	**(800) 588−5509 or www.bcbsma.com** **TDD: (800) 522−1254**	**(800) 662−6667 or www.bcbsm.com** **TDD: (800) 257−9980**

	BlueCare Health Plan (Connecticut)	HealthKeepers of Virginia	HMO Blue Cross (Dallas/Ft. Worth) and HMO Blue Texas (Houston)
Deductible	**Deductible**	**Deductible**	**Deductible**
Individual	There is no deductible; some services require a copay	There is no deductible; some services require a copay	There is no deductible; some services require a copay
Family	There is no deductible; some services require a copay	There is no deductible; some services require a copay	There is no deductible; some services require a copay
Out−of−Pocket Maximum	**Out−of−Pocket Maximum**	**Out−of−Pocket Maximum**	**Out−of−Pocket Maximum**
Individual	None	$1,500	$1,000
Family	None	$3,000	$2,000
Hospital Services	**Hospital Services**	**Hospital Services**	**Hospital Services**
Inpatient	No charge	No charge	No charge
Outpatient	No charge	$50 copay	No charge
Skilled Nursing Facility	No charge (up to 90 days per year)	No charge (up to 100 days per year)	No charge (up to 60 days per year)
Professional Services	**Professional Services**	**Professional Services**	**Professional Services**
Office Visits	$5 copay	$10 copay	$10 copay
Well Baby Care:			
• Office Visits	No charge	$10 copay	$10 copay (under age 2)
• Immunizations	No charge	$10 copay	No charge
Annual Routine Exam *($300 maximum, including well woman exam)*	No charge	$10 copay (one physical per year)	$10 copay
Well Woman Exams *(included in annual Routine Exam benefit):*			
• Office Visit	$5 copay	$10 copay	$10 copay
• Mammogram	No charge (office visit copay may apply)	No charge (office visit copay may apply)	No charge (office visit copay may apply)
• Pap smear	No charge (office visit copay may apply)	No charge (office visit copay may apply)	No charge (office visit copay may apply)
X−ray and lab tests	No charge (office visit copay may apply)	$10 copay	No charge
Emergency Medical Services	**Emergency Medical Services**	**Emergency Medical Services**	**Emergency Medical Services**
Professional Services (*at hospital*)	No charge	No charge	No charge
Hospital Emergency Room	$50 copay, waived if admitted	No charge	$100 copay
Maternity	**Maternity**	**Maternity**	**Maternity**
Hospital	No charge	No charge	No charge
Office Visits	$5 copay (first visit only)	No charge	$10 copay for first visit only
Infertility Diagnostic Procedures	$5 copay (only diagnostic covered)	Not covered	No charge
Mental Health Care/Substance Abuse	**Mental Health Care/Substance Abuse**	**Mental Health Care/Substance Abuse**	**Mental Health Care/Substance Abuse**
Inpatient	No charge, up to 60 days per year for mental health and up to 45 days for substance abuse	No charge, up to 30 days per year/90 days per lifetime, for mental health and substance abuse combined	$50 copay per day, up to 30 days per year, for mental health; no charge, up to 3 treatments per lifetime, for substance abuse
Outpatient	$5 copay per visit; 40 visit maximum for substance abuse	$15 or $30 copay per therapy session, up to 20 visits per year, for mental health and substance abuse combined	No charge, up to 20 visits per year, for mental health; no charge, up to 3 treatments per lifetime, for substance abuse
Miscellaneous Services	**Miscellaneous Services**	**Miscellaneous Services**	**Miscellaneous Services**
Chiropractic	$5 copay with PCP approval	Not covered	$10 copay with PCP approval
Acupuncture	Not covered	Not covered	Not covered
Physical Therapy/Physical Medicine	$5 copay, up to 60 visits per year	$10 copay, up to 90 days from date of injury	$10 copay
Allergy Test	$5 copay	$10 copay	50% copay
Allergy Treatment	No charge (office visit copay may apply)	$10 copay	50% copay
Prescription Drugs	**Prescription Drugs**	**Prescription Drugs**	**Prescription Drugs**
	$5 generic copay $15 brand copay (formulary) $25 brand copay (non−formulary) $5/$15 mail order copay	$5 generic $10 brand (with generic equivalent) $25 brand (without generic equivalent) $10 mail order (generic) $20 brand mail order (with generic equivalent) $50 brand mail order (without generic equivalent)	$5 generic copay $10 brand copay (formulary) $25 brand copay (non−formulary) $5/$10/$25 mail order copay—30 day supply
Customer Service Number	(800) 922−1742 in Conn; (800) 426−8531 elsewhere or www.anthem.com	(800) 421−1880 or www.trigon.com TDD: (800) 228−2909	Dallas/Ft. Worth: (888) 558−2393 Houston: (888) 882−2390 or www.bcbstx.com

Pre−Certification

If you are covered under WellPoint Preferred PPO or the WellPoint Group Medical Plan and need care from a hospital (inpatient only), ambulatory surgical center (outpatient only), or a chemical dependency rehabilitation facility, you must obtain a pre−certification. This ensures you obtain the maximum benefits available under the Plan.

You must call for pre−certification *three days before your scheduled admission or care*. For an emergency admission, you must call within 48 hours after the start of the confinement. To obtain a pre−certification, call the toll−free phone number listed on your ID card. If treatment will be provided by a network physician, your physician may make the call for you, but you are responsible if this call does not occur.

Notes:

- ***If a pre−certification is not obtained, an additional deductible of $250 will apply.***
- ***The Plan will not cover services that are not deemed medically necessary.***

Pre−Existing Conditions

Pre−existing condition exclusions have been eliminated from the WellPoint Preferred PPO and the WellPoint Group Medical Plans.

Reasonable and Customary Charges

The term "reasonable and customary" applies to the WellPoint Preferred PPO (if you use an out−of−network provider) and WellPoint Group Plans. If you are covered by an HMO, please contact the HMO directly for its definition of reasonable and customary.

At the time of service, the Claims Administrator determines whether or not the charges are reasonable and customary. Because of the changing nature of medicine, the definition of reasonable and customary charges may change over time.

With WellPoint Preferred PPO, you have the choice of receiving care from network providers, who accept lower negotiated rates, or from non−network providers.

Medically Necessary

The WellPoint Preferred PPO and WellPoint Group Plans cover expenses deemed "medically necessary." Medically necessary services or supplies must meet certain requirements established by the Claims Administrator. The fact that a doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make it "medically necessary" or make the charge a covered expense, even if it has not been listed as an exclusion.

Additional Information About HMO Coverage

Coverage When Traveling

As a member of a Blue Cross/Blue Shield HMO, you and your enrolled dependents are eligible for Away From Home Care benefits. These benefits cover urgent care, those not so serious illnesses that need medical attention, for you and your enrolled family members when traveling outside your HMO service area.

To access Away From Home Care, call the toll−free number printed on your ID card.

Coverage for Temporary Residency Outside of California

You can maintain your HMO benefits even when temporarily residing outside California with Guest Membership. It's available to long−term travelers for out−of−state work assignments, students and other enrolled family members who will be living away from home for three to six months.

To apply for Guest Membership, call Blue Cross HMO Customer Service to discuss your changing circumstances. If a participating HMO is available, you or your dependent will become a guest member of that HMO.

Additional Information About All *Flex*Point Medical Options

Coordination of Benefits

If you have coverage under more than one group medical plan, benefits under the plans will be coordinated such that payments for both programs will be provided up to, but not in excess of, 100% of charges for actual covered services.

Binding Arbitration

Any dispute between you and the Claims Administrator will be resolved by binding arbitration and not by lawsuit or resort to court process, except as applicable state laws provide for judicial review of arbitration proceedings or where prohibited by law.

Questions?

If you have specific benefit questions, please call the Customer Service number listed in the Medical Comparison Chart.

Your local Human Resources office can provide you with HMO or PPO directories.

HMOs and Domestic Partner Coverage

Blue Cross HMO (formerly CaliforniaCare)	Domestic Partner Coverage Allowed
UNICARE HMO (IL)	Domestic Partner Coverage Allowed
Blue Choice Healthcare (GA)	Domestic Partner Coverage Allowed
HMO Blue (MA)	Domestic Partner Coverage Allowed
Blue Care Network of S.E. Michigan	Same Sex Domestic Partner Coverage Allowed
BlueCare Health Plan (CT)	Domestic Partner Coverage Allowed
HealthKeepers of Virginia	No Domestic Partner Coverage
HMO Blue Cross (TX)	No Domestic Partner Coverage
HMO Blue Texas	No Domestic Partner Coverage

Your Dental Coverage

*Flex*Point gives you a choice of dental options. In making your choice, consider how much you can afford to pay out of your own pocket toward dental expenses. Also, are there any procedures you know you or a family member will need in the upcoming year? Is orthodontic coverage necessary?

The information in this Enrollment Guide is only a summary—refer to your Summary Plan Description for more information.

If You Live in California...

You may choose Dental Net, the WellPoint Standard Dental Plan or the WellPoint Enhanced Dental Plan. You also have the option to waive dental coverage.

Dental Net Plan

When you enroll in Dental Net, you and each covered dependent must select your own participating dental office. If you do not use a Dental Net provider, your dental services will not be covered. Dental Net provider directories are available from your local Human Resources office. The first time you need care, let your dentist know that you're a member of Dental Net. If you are newly enrolling in Dental Net or adding a new dependent, you must complete an HMO and Dental Net form. You may change your Dental Net provider by calling the Dental Net Customer Service number listed in the Dental Comparison Chart.

If you are currently receiving treatment for orthodontia, you cannot change to the WellPoint Enhanced Dental Plan to continue that treatment. You must be enrolled in the Enhanced Dental Plan at the beginning of orthodontic treatment for any expenses to be covered under this plan.

If You Live Outside of California...

You can choose the WellPoint Standard Dental Plan or WellPoint Enhanced Dental Plan.

WellPoint Standard and Enhanced Dental Plans

The WellPoint Standard and Enhanced Dental Plans give you the choice to select virtually any licensed dentist, but if you choose a PPO participating dentist, you take advantage of negotiated discounts. If you use a dentist who does not participate in the National Dental PPO plan network, you may pay more for dental care. For non−network providers, the maximum covered expense is the reasonable and customary (R&C) charge. You will be responsible for any billed charges that exceed R&C. If you use a network provider, the maximum covered expense is the negotiated rate. Network providers will not bill you more than the negotiated rate. Orthodontic coverage is available under the Enhanced Dental Plan.

Associates can now benefit from the addition of a national PPO dental network. UNICARE dental provider listings are available on the Web enrollment site and at your local Human Resources office.

Claims Procedures

If you use a Dental Net or PPO network provider, your provider will file claims for you and your covered dependents.

If you use a non−network provider, you may be required to complete a dental claim form and mail it to WellPoint Health Networks Inc., P.O. Box 9066, Oxnard, California 93031−9066. BCBSGA associates should mail dental claim forms to Blue Cross and Blue Shield of Georgia, P.O. Box 9907, Columbus, GA 31908−6007.

Questions?

If you have specific benefit questions you may call the Customer Service number listed in the Dental Comparison Chart below.

Your local Human Resources office can provide you with Dental Net or Dental PPO directories.

Dental Comparison Chart

	In California	National (including California)	
	Dental Net	**Standard Plan(1)**	**Enhanced Plan(1)**
Annual Deductible	None	$50/individual $150/family	$50/individual $150/family
Annual Maximum	$500/child for pediatric dentist only	$1,000/individual	$2,000/individual
Diagnostic/Preventive Care	100%	100% of covered expenses	100% of covered expenses
Oral Surgery	100%	80% after deductible	80% after deductible
Restorative Care (such as fillings)	100%	80% after deductible	80% after deductible
Extractions	100%	80% after deductible	80% after deductible
Surgical Extractions	$25—$50 copay	80% after deductible	80% after deductible
Endodontic Care (such as root canal)	$60—$100 copay	80% after deductible	80% after deductible
Periodontics (such as scaling)	$9—$120 copay	80% after deductible	80% after deductible
Crowns	$85—$120 copay	Not covered	50% after deductible
Bridges	$120 copay	Not covered	50% after deductible
Partial Dentures	$160 copay	Not covered	50% after deductible
Complete Dentures	$140 copay	Not covered	50% after deductible
Orthodontia	$1,850 copay for adults (age 18+) or $1,450 for children; treatment limited to 24 months(2)	Not covered	50% with a $1,250 lifetime benefit/individual
Customer Service	(800) 627−0004	(800) 627−0004	(800) 627−0004
BCBSGA Customer Service		(800) 411−2273	(800) 411−2273

Note: Covered expenses are paid based on reasonable and customary charges. Charges in excess of reasonable and customary are your responsibility.

(1) If your dental provider anticipates the expense for any course of treatment to exceed $350, you should submit a benefit estimation form before treatment begins. This excludes Dental Net.

(2) You must obtain a written referral from Dental Net Customer Service before receiving treatment. Dental Net will not accept patients who are "banded" prior to the effective date of coverage. Extra fees may be charged for X−rays, models, retention, etc. over and above the copay.

YourVision Coverage

If you elect vision coverage, you have a choice of network or non−network providers each time you need eye care services or products. Vision coverage is optional. In making your election, think about how much you can afford to pay out of pocket for vision expenses in the coming year. Also consider whether you or a family member will need eyeglasses or contacts in the coming year.

Keep in mind that vision coverage is designed to cover medically necessary eye care. As a result, there are extra charges for the following:

- Blended lenses
- Oversize lenses
- Photochromatic or tinted lenses
- Frames that exceed the Plan allowance

Claims Procedures

VSP

- If you use a VSP provider, he/she will confirm your eligibility and file claims for you and your covered dependents.
- If you use non−VSP providers, file a claim with VSP to receive your benefits. Claims should be mailed to: Vision Service Plan, P.O. Box 997100, Sacramento, California 95899−7100. You will be responsible for paying any charges above the limits shown in the chart below.

To obtain a list of VSP providers in your area, call (800) 622−7444 or visit www.vsp.com.

LensCrafters (BCBSGA associates)

- All LensCrafters locations in the state of Georgia and in Chattanooga, Tennessee (excluding LensCrafters Optiques) will confirm your eligibility and file claims for you and your covered dependents.
- If you use a non−LensCrafters provider, you are responsible for paying the charges at the time of service and for filing the claim for reimbursement. To obtain a Routine Vision Service Report claim form, please call (800) 377−6436.

Questions?

If you have any questions about your vision coverage, call VSP at (800) 622−7444. BCBSGA associates can call LensCrafters at (800) 377−6436.

Your Vision Benefits at a Glance—VSP(1,2)

	VSP Providers	Non−VSP Providers
Your annual copayment	$25	$25
What the Plan Pays		
Eye examinations (once every 12 months)	100% after copay	$40 maximum
Lenses (once every 12 months)(3)		
Single	100% after copay	$40 maximum
Bifocal	100% after copay	$60 maximum
Trifocal	100% after copay	$80 maximum
Lenticular	100% after copay	$125 maximum
Frames (once every 24 months)(3)	100% up to a determined maximum	$45 maximum
Contacts (including disposables)		
If medically necessary	100% with prior approval	up to $210, in lieu of other benefits
If elective	up to $105, in lieu of other benefits	up to $105, in lieu of other benefits

(1) VSP members have access to the Laser VisionCare Program, in which laser vision correction is available at a discounted fee. To learn more visit VSP's Laser VisionCare Program at www.vsp.com/lvc/html/index.htm.

(2) You must pay your annual copayment the first time you receive services whether you use a VSP or non−VSP provider.

(3) You and your family may select either one pair of glasses or contact lenses in a calendar year.

Your Vision Benefits at a Glance—LensCrafters (BCBSGA Associates)

	In−Network	Out−of−Network
Your annual copayment	$20	N/A
What the Plan Pays		
Eye examinations (once every 12 months)	100% (no copay)	Up to $35
Lenses (once every 12 months)		
Single	100%(1)	Up to $25
Bifocal	100%(1)	Up to $35
Trifocal	100%(1)	Up to $45
Frames (once every 24 months)	100%; up to $150	Up to $40
Contacts (including disposables)	100%; up to $200(2)	Up to $90(2)

(1) Based on the mid−range cost of frames and lenses, as defined by the network.

(2) Applicable to one pair of contact lenses or the equivalent of one year's supply of disposable contact lenses.

Your Life Insurance Coverage

This section describes the coverage available to you under the *Flex*Point life insurance plan.

As an Officer of WellPoint, you receive life insurance under the Group Universal Life policy (see *Flex*Exec on page 29). You should consider your level of *Flex*Point life insurance coverage in light of the Group Universal Life coverage you receive as an Officer.

Benefit Salary

Benefits are based on your benefit salary, which is your annual base pay as of September 1, 2001 plus commissions or sales incentives paid from September 1, 2000 through August 31, 2001. For Officers hired on or after September 1, 2001, your benefit salary is your annual base pay excluding any commissions. Your benefit salary does not change mid−year with salary increases. It will be recalculated on September 1, 2002 for an effective date of January 1, 2003.

Life insurance benefits are rounded to the next higher multiple of $1,000 unless your salary is an even multiple of $1,000. For example, if your benefit salary is $29,300 and you elect one times your benefit salary, your coverage would be rounded up to $30,000. The *maximum* amount of your coverage cannot exceed $1,000,000.

Your benefit is reduced when you reach age 70 and again at age 75. If you become totally disabled prior to age 60, you will need to apply for a premium waiver. If approved, no premium payments will be required during this period of disability.

You can choose from the following life insurance options:

- $50,000
- 1 times your benefit salary (*WellPoint provides this level of coverage at no cost to you.*)
- 2 times your benefit salary
- 3 times your benefit salary
- 4 times your benefit salary
- Waive coverage

If you are on a leave of absence on January 1, 2002 and you elect to increase life coverage for 2002, that new coverage level will not take effect until you return from the leave and an Evidence of Insurability has been approved (if applicable).

We offer life insurance coverage when you first become eligible without an Evidence of Insurability form. Increasing your life insurance amount by more than one level during Open Enrollment requires an Evidence of Insurability form and is subject to approval by the Claims Administrator.

If, during Open Enrollment, you select a life insurance option that is two levels greater than your existing coverage, you will need to provide an Evidence of Insurability form. If approved, your increase in coverage and deductions will take effect on January 1, 2002 or the first of the month after insurance company approval is received, whichever is later.

If your request is denied, your 2001 level of coverage will remain in effect for 2002 with the corresponding 2002 cost.

Life insurance greater than one times your benefit salary can be purchased only on an after−tax basis.

Life insurance coverage is a fully insured plan administered by BC Life & Health Insurance Company.

Imputed Income

The IRS Code states that employee group term life insurance benefits in excess of $50,000 and dependent life insurance may result in taxable income to the associate. This is known as "imputed income." Imputed income must be reported on your W−2 and is included as earnings in your paycheck. Imputed income is subject to federal, state, and FICA taxes.

Your Dependent Life Insurance Coverage

Dependent life insurance enables you to insure the lives of your spouse/domestic partner and eligible dependent child(ren).

If, during Open Enrollment, you add or increase your dependents' coverage, your dependents must complete an Evidence of Insurability form. When approved, the increase in coverage and deductions will take effect on January 1 or the first of the month after insurance company approval is received, whichever is later. If your request is denied, the current level of coverage will remain in effect for 2002 with the corresponding 2002 costs.

If you are on a leave of absence on January 1, 2002, and you elect to increase dependent life insurance for 2002, the new coverage level will not take effect until you return from the leave and an Evidence of Insurability has been approved.

The information in this Enrollment Guide is only a summary—refer to your Summary Plan Description for more information.

Spouse/Domestic Partner Life Insurance

Spouse/domestic partner life insurance is based on your benefit salary (see page 23 for a definition of benefit salary), and the cost is based on your age as of January 1, 2002. Benefits are paid directly to you. This coverage cannot exceed the lesser of 50% of your life insurance amount or $125,000. Spouse/domestic partner coverage will be reduced when your life insurance is reduced—at age 70 and again at 75.

Spouse/domestic partner life insurance benefits are rounded down to a multiple of $1,000. For example, if your benefit salary was $29,300 and you elected spouse life of one times your benefit salary, your spouse's/domestic partner's coverage would be rounded down to $29,000.

You may choose from the following options for spouse/domestic partner life insurance:

- $5,000
- 50% of your benefit salary
- 1 times your benefit salary
- Waive coverage

Child Life Insurance

Child life insurance is a fixed amount depending on the age of your child(ren).

You have the following options for child life insurance, or you can waive coverage:

For Each Dependent Child	Option 1 (1 unit)	Option 2 (2 units)	Option 3 (5 units)
Birth to age 14 days	$ 500	$ 1,000	$ 2,500
14 days to six months of age	$ 2,500	$ 5,000	$ 12,500
6 months through age 18 years of age (24 if full−time student)	$ 5,000	$ 10,000	$ 25,000

As with spouse/domestic partner life insurance, benefits are paid to you, and this coverage cannot exceed 50% of your life insurance amount. All of your eligible children and your domestic partner's children may be covered if you choose this benefit. If you do not elect to cover a child or if a child does not meet the Evidence of Insurability requirement, that child will not be covered.

You must notify the Associate Service Center when dependents no longer qualify for coverage (e.g. an ex−spouse after a divorce) or when they reach the limiting age of 19 (or 25 if a full−time student).

If both you and your spouse/domestic partner, or you and your child/parent, are employed at WellPoint, you may not elect multiple coverage under the same plans. For example, you cannot elect spouse/domestic partner life coverage if your spouse/domestic partner works for WellPoint.

If you are on a leave of absence on January 1, 2002, any new elections or increases you make to dependent life will not take effect until you return from the leave and any applicable Evidences of Insurability have been approved.

Your Accidental Death and Dismemberment (AD&D) Coverage

Accidental death and dismemberment (AD&D) coverage protects you if you die or are dismembered as the result of an accident. The plan does not pay benefits if you die from natural causes. This benefit is designed to supplement your life insurance coverage and is a separate election. AD&D coverage is not available for dependents.

The information in this Enrollment Guide is only a summary—refer to your Certificate of Insurance for more information.

AD&D benefits are rounded to the next higher multiple of $1,000 unless your benefit salary is an even multiple of $1,000. For example, if your benefit salary is $29,300 and you elect one times your benefit salary, your coverage would be rounded up to $30,000.

You can choose from the following AD&D options (see page 23 for a definition of benefit salary):

- 1 times your benefit salary *(WellPoint provides this level of coverage at no cost to you.)*
- 2 times your benefit salary
- 3 times your benefit salary
- 4 times your benefit salary

The maximum amount of AD&D coverage cannot exceed $1,000,000. You cannot waive AD&D coverage. You do not need to submit an Evidence of Insurability form if you increase your level of coverage during Open Enrollment.

The AD&D plan pays the full benefit amount to your beneficiary if you die as the result of an accident. Your beneficiary will be the same as listed on your life insurance beneficiary form. The plan pays the full amount or a percentage of the full amount if you suffer a dismemberment as the result of an accident. The percentages vary by the seriousness of the injury—refer to the Certificate of Insurance.

If you are on a leave of absence on January 1, 2002, and you elect to increase AD&D coverage for 2002, the new coverage level will not take effect until you return from leave.

Your Flexible Spending Accounts

Flexible Spending Accounts provide an opportunity for you to save money on your out−of−pocket health care or dependent daycare expenses throughout the year. You are not taxed on the money you contribute, nor on the reimbursements you receive.

Tax Savings

For most associates who elect flexible spending accounts, the tax savings are as much as 35 cents on the dollar—28 cents in federal income tax, 7.65 cents in Social Security and Medicare taxes, plus any applicable state or local income tax. Your tax savings will be based on your actual tax circumstances.

How Flexible Spending Accounts Work

You elect an annual amount of money to be deducted from your biweekly paychecks on a pretax basis. Based on your annual election, a prorated amount is subtracted from your paycheck each pay period. When you have an eligible expense, you file a claim and are reimbursed without paying taxes on this amount.

The full annual amount you elect to defer under the Health Care Spending Account is available on the effective date of your coverage. So, if you elect $1,000 for the year and have an eligible expense of $900 in January, you will be reimbursed the full $900 even though you have only accumulated $38.46 thus far. Contributions, however, will continue to be deducted for the remainder of the year. Under the Dependent Day Care Spending Account, you can be reimbursed only for the amount actually in your account at the time you submit the claim.

The amount you elect to contribute to your accounts over the course of the year is irrevocable. Once you make your election, you must continue to contribute at that amount until the end of the calendar year, or you experience a qualified mid−year change, or termination of employment.

Your Health Care Spending Account

If you choose to participate, you decide how much to deposit in the Health Care Spending Account to pay for expenses for you and your dependents that are not covered by your medical, dental, and vision plans. For example, health plan deductibles and copayments, mileage and parking expenses while you're receiving health care, and contact lens solution are normally not reimbursed by your insurance plan. But they may be eligible for reimbursement under a Health Care Spending Account.

Some additional examples of eligible expenses are:

- Uninsured medical, dental, vision, and prescription drug expenses and copays
- Chiropractic expenses
- Hearing aids and batteries
- Mental health expenses
- Prescription glasses and sunglasses
- Orthodontia expenses

For a complete list of expenses eligible for reimbursement, please contact UniAccount at (888) 209−7976.

You have through March 31, 2003 to file Health Care Spending Account claims for expenses incurred on or before December 31, 2002. If you terminate employment prior to December 31, 2002, your claims must be for expenses incurred on or before your termination with WellPoint.

Please note that you are eligible for reimbursement of domestic partner expenses only if your domestic partner (or child of the domestic partner) is your dependent for IRS purposes.

How Much Can I Elect?

	Minimum		Maximum	
	Pay Period	Annually	Pay Period	Annually
Health Care Account	$ 10	$ 260	$ 192.31	$ 5,000
Dependent Day Care Account(1)	$ 10	$ 260	$ 192.31	$ 5,000

(1) Married associates filing a separate tax return can only elect $2,500 per year. Married associates filing a joint return have a combined maximum of $5,000 per year from all available plans.

For purposes of this section, "deductions" are salary reductions used to pay an equivalent amount of your eligible health care and/or dependent daycare expenses. Additionally, although this section refers to "your accounts," all the deductions are held as part of the general assets of the Company.

You can participate in the Health Care Spending Account even if you waive medical coverage. Once you enroll in a spending account, you cannot change your election or contributions for the remainder of that calendar year. The only exception is if you have a qualified mid−year change (such as the birth of a child). Refer to the Mid−Year Changes section of this Enrollment Guide for more details.

As you consider participating in the Health Care Spending Account, think about the following:

- Do you anticipate any expenses not covered by your (or your spouse's) medical, dental, or vision care plans?
- Do you anticipate any large out−of−pocket expenses such as orthodontics, crowns, hearing aids, or the birth of a baby? Do you need eyeglasses, contact lenses, and/or prescription sunglasses?

Your Dependent Day Care Spending Account

You can participate in this account if you need dependent daycare services to enable you to work or, if you are married, for both you and your spouse/ domestic partner (if also your dependent) to work. A dependent must be under age 13 or a spouse/ domestic partner, child or parent that is physically or mentally incapable of caring for himself or herself and spends at least eight hours per day in your home.

If your spouse/domestic partner (if also your dependent) does not work, your dependent daycare expenses may be reimbursable if your spouse/ domestic partner is a full−time student or physically or mentally unable to provide care for himself or herself.

In general, any expense that qualifies for the Federal Dependent Care Tax Credit may be reimbursed. When filing your dependent daycare claims, you will need to submit the Tax Payer Identification Number or Social Security Number of the person or entity who provides care. You cannot participate in a Dependent Day Care Spending Account and file for a Federal Dependent Care Tax Credit.

This account is for reimbursement of child/elder daycare expenses. **It does not provide reimbursement for medical expenses of a spouse/domestic partner or dependent (see "Your Health Care Spending Account" above).**

Note: According to IRS regulations, deductions by highly compensated associates may be subject to limitations. You will be notified if you are affected by these limitations.

As you consider participating in the Dependent Day Care Spending Account, think about the following:

- Will you incur expenses from a licensed daycare center or nursery school?
- Will your child(ren) attend an eligible daytime summer camp or before−school or after−school activities?
- Would you save more money from the Federal Dependent Care Tax Credit?
- Do you have an aging dependent parent who may require care?

"Use It or Lose It" Rule

Under this rule, you must use the money in your Health Care and/or Dependent Day Care Account for eligible expenses you incur during the year in which the contributions are made.

You have until March 31 of the following year to request your reimbursement. **If you terminate during the year, you can request reimbursement of the balance in your Dependent Day Care Account after you terminate if you incur an eligible expense any time during the calendar year, up to the amount you had withheld from your paycheck. Under the Health Care Account, if you terminate, you can only request reimbursement for expenses incurred through your termination date. See the COBRA section for participation and continuing contributions.**

If you have a balance left in your Flexible Spending Accounts after the deadline for requesting reimbursement, the IRS requires it to be forfeited. Any forfeited amounts are applied to the administration of the Flexible Spending Accounts.

How to File a Claim

Health Care Spending Account

If you are covered under the WellPoint Preferred PPO or WellPoint Group medical plan, or Standard or Enhanced Dental Plans, expenses which are only partially covered by your plan(s) are automatically processed under your Health Care Flexible Spending Account.

You must submit an FSA claim form for unreimbursed expenses if you do not elect medical and/or dental coverage from WellPoint and for unreimbursed expenses from an HMO or vision care provider (be sure to include an itemized statement from the provider of services or an explanation of benefits form).

Dependent Day Care Spending Account

To obtain reimbursement for qualifying dependent daycare expenses, you must submit an FSA claim form (be sure to include an itemized statement from the provider of services and tax identification number—you cannot substitute a cancelled check for a statement from the provider).

Claim Form

After you enroll, claim forms will be mailed to you. However, if you wish, you may obtain a claim form by calling (888) 209−7976 or, if you have access to TAO, you may print a copy from the TAO FSA bulletin board. You may also obtain a claim form from WorkSite.

Mail claims to: UniAccount
P.O. Box 4381
Woodland Hills, CA 91365−4381

Fax claims to: (818) 234−4730

Reimbursements are mailed to your home 7−10 business days after we receive the necessary paperwork for your claim.

You may view your UniAccount Flexible Spending Account balances and payment history via the Internet using the Blue Cross of California Member Services website. You may obtain a personal identification number for direct access at the site (http://www.bluecrossca.com/memberservices/).

Questions

If you have questions about enrolling in a Flexible Spending Account, contact the Associate Service Center. If you have questions about filing a claim or reimbursements, please contact UniAccount directly at (888) 209−7976 or by e−mail at UNIACCOUNT.FSA@WellPoint.com.

*Flex*Exec

WellPoint provides a number of benefit programs for its Officers. The following information briefly outlines your WellPoint benefits. The legal plan documents prevail in any conflict of interpretation, and the Company reserves the right to modify or terminate the programs at any time without notice.

In addition to the *Flex*Point benefits, the Company provides the following benefits to Officers:

- Officer Physical Exams
- Group Universal Life Insurance
- Short−Term Disability
- Long−Term Disability
- Comprehensive Executive Nonqualified Retirement Plan

To enroll in the Comprehensive Executive Nonqualified Retirement Plan, you need to complete the *Flex*Exec enrollment form and return it to Charles Thorburn in the WellPoint Compensation Department at 4553 La Tienda Drive, Thousand Oaks, CA 91362, Mail Stop T1−1C7.

Officer Physical Exams

In addition to your medical options under *Flex*Point, Vice Presidents and above with at least one year of service participate in the Officer Physical Exam Program.

You are eligible to receive a physical exam at no cost to you according to this schedule:

Your Age	**How Often You Can Have a Physical Exam***
44 and younger	Every 24 months
45 and older	Every 12 months

* Any exceptions to this schedule must be recommended by a physician and approved by the Company.

WellPoint recommends medical centers for the physical exams:

- Cedars−Sinai Medical Center Executive Medical Services in Los Angeles
- Scripps Center for Executive Health in La Jolla

Both facilities offer a comprehensive one−day program. The findings of your exam will remain confidential between you and your physician.

To make an appointment, call the medical center of your choice:

Cedars−Sinai Executive Medical Services	(310) 423−2374
Scripps Center for Executive Health	(858) 626−4460

Group Universal Life Insurance

In addition to your life insurance options under *Flex*Point, the Company provides you with a supplemental life insurance benefit based upon your total compensation (September 1, 2001 base annual salary plus target management bonus).

- Vice Presidents and General Managers — 2 times total compensation
- Senior Vice Presidents — 3 times total and above compensation

How do I enroll in this coverage?

All current Officers who have completed an application for this coverage in the past are automatically covered. If the amount of coverage increases by more than 10% from the prior year due to an increase in total compensation, the insurance company may require an Officer to go through medical underwriting for the amount over 10% before providing the full coverage increase.

Newly−hired Officers will receive an application in the mail from Clarke Bardes Consulting/CRG. Coverage will not take effect until the first of the month following receipt and acceptance of the application by the carrier.

How does Universal Life Insurance work?

In addition to receiving a fixed life insurance benefit, you also have the opportunity to make additional premium payments to increase the amount of your insurance and/or make investments with the earnings accumulating on a tax−deferred basis.

What is the cost of this benefit?

The Company pays the entire cost of this life insurance benefit. Your only cost will be the income tax on the premium paid for the coverage.

What happens at termination?

You will receive an individual policy, which can be continued by paying the premium contributions or surrendered for the cash value, if any.

Who do I contact for additional information?

Contact Rick Davenport at (925) 979−3255 with any questions concerning your Group Universal Life Insurance policy.

Your Disability Coverage

Short−term disability (STD) and long−term disability (LTD) insurance work together to provide you with income if you become disabled by illness or injury and are unable to work. Officers are automatically enrolled in these plans.

Short−Term Disability

In the event you are disabled and unable to perform all the essential duties of your job, the Company will continue your base annual salary for up to 26 weeks. All disabilities are subject to review. This benefit payment will be reduced by any benefits payable under Workers' Compensation and/or any other state or federal disability benefits you are eligible to receive.

Benefits received under this program are considered taxable income.

Long−Term Disability

If you are disabled longer than 26 weeks, you may be eligible for a Long−Term Disability benefit based upon your total compensation (September 1, 2001 benefit salary (see page 23 for definition) plus 2001 target management bonus).

Your disability benefits will be subject to pre−existing condition limitations. No benefits will be payable during the first 12 consecutive months of coverage if you become disabled as the result of a condition for which treatment was rendered, prescribed, or recommended within three months immediately preceding the date your benefit option became effective.

Amount of Benefit

- Vice Presidents and General Managers — 60% of Compensation
- Senior and Executive Vice Presidents — 70% of Compensation

What is the cost of this benefit?

The Company pays the entire cost of this coverage. As such, if you receive any LTD benefits, they are fully taxable.

What happens at termination/retirement?

Coverage ceases and cannot be continued or converted.

Comprehensive Executive Nonqualified Retirement Plan

This Plan provides Officers with an opportunity to defer a portion of their compensation for retirement or other future needs. The Plan also provides an opportunity to recover Company contributions limited due to IRS regulations.

Eligibility

Unless otherwise notified, an Officer of the Company whose base annual salary plus target management bonus exceeds $125,000 per year is eligible to participate in the Plan. Generally, deferral elections must be made before the calendar year in which the compensation is earned and cannot be changed until the next calendar year. Associates promoted to an Officer position or newly hired Officers may elect within 30 days to participate in the Plan for the remaining portion of the calendar year.

Deferral Elections

There are six basic components to the Plan.

1. Supplemental 401(k) Deferral

This component allows you to receive a Company match on eligible compensation when you have reached the maximum match or are not yet eligible for a match under the qualified 401(k) plan.

This component works in two ways:

- It replaces deferrals limited due to IRS regulations on contributions to the 401(k) plan. For 2002, the IRS limits eligible 401(k) compensation to $200,000 with a maximum contribution of $11,000. You may defer up to 6% of your compensation earned after reaching $200,000 or after deferring $11,000 into the 401(k) plan, whichever occurs first.

- It allows newly hired Officers to receive a matching contribution during their first year of service. Newly hired Officers may defer up to 6% of eligible compensation earned before becoming eligible for the 401(k) match. *Please note: newly hired Officers who elect to defer under this component need to enroll in the 401(k) Plan with Vanguard when they reach one year of service in order to continue their contributions and receive the Company match.*

2. Salary Deferral

This component allows you to defer up to 60% of your base salary.

For example:

	Before March Increase	After March Increase
Base salary	**$ 140,000**	**$ 147,000**
Base salary deferral election	**20%**	**20%**
Annual deferred	**$ 28,000**	**$ 29,400**
	÷ 26	**÷ 26**
Amount deferred per pay period	**$ 1,076.92**	**$ 1,130.77**

Using the above example, before the March increase, you may elect to defer between 1%—60% of $140,000. The deferral will take place on a per−pay−period basis and will reflect the base salary paid during that pay period. If you elected to defer 20% of the $140,000, you would defer $1,076.92 per pay period. Additionally, if you were to receive a 5% salary increase in March, bringing your base salary to $147,000, your deferral would increase to $1,130.77 per pay period ($29,400 ÷ 26 = $1,130.77).

3. Bonus Deferral

This component allows you to defer all or a portion (1%—100%) of your management bonus. This election is for the management bonus that will be *earned in the next calendar year, but not paid until the following year*.

4. Bonus Restricted Stock Award Deferral

Under the Company's bonus plans, if your earned bonus award is more than $3,000 over 150% of the target award, then any amounts in excess of 150% of the target award will be paid in restricted stock, which generally vests over three years. You may defer all or a portion (1—100%) of the restricted stock award payable to you for the 2002 performance year. This election is for the management bonus that will be *earned in the 2002 calendar year, but not paid until the following year*.

5. Car Allowance

This component allows you to defer your car allowance.

	Annual*
• **Vice Presidents and General Managers**	$ 4,800
• **Senior Vice Presidents**	$ 7,200
• **Executive Vice Presidents and above**	$ 9,600

You may elect to defer all of this amount. If you do not defer your car allowance, you will receive it as taxable income each pay period over the calendar year.

You may also elect to be paid for mileage in lieu of the set dollar car allowance.

6. Supplemental Pension Deferral

This component replaces deferrals limited due to IRS regulations on contributions to the Pension Accumulation Plan. The Company will automatically contribute 3%, 4%, or 5% (based on service) of your earnings in excess of $200,000 per year. **There is no election necessary**. This component has a vesting feature identical to the Pension Accumulation Plan: if you leave prior to completing five years of credited service, no benefit is payable.

Plan Options

Once you decide to make deferral elections under the Comprehensive Executive Nonqualified Retirement Plan, you have a number of options, which are summarized below.

Investment Funds

Money deferred under the six components of this Plan is invested in an account with Vanguard. The same 11 Vanguard funds offered in the WellPoint 401(k) Retirement Savings Plan are available for your nonqualified deferrals in this Plan. New participants must make investment elections on the enrollment form. Current participants can change their investment allocation for new contributions or for existing balances by calling Vanguard at (800) 523−1188.

Distribution of Benefits

Officers currently enrolled in this Plan have made payment elections for their Plan accounts which are on file with the Company. If you are enrolling for the first time, you must elect the timing of when to receive the deferral account balance and what form of payment you want to receive. Please complete and submit the Distribution and Beneficiary Election Form. Note that the distribution date is the day the distribution processing begins and not the day you will receive funds.

The timing options are:

- Termination/retirement date
- Date of death
- A specific date (must be at least 12 months from date of election and not later than your 65th birthday)
- The earliest of your termination/retirement date, date of death or a specific date
- Other: this option is used when you elect to receive the distribution at different intervals (e.g. $25,000 on 7/1/2004, with the balance at retirement or one year after termination/retirement).

The payment options are:

- Lump sum
- Annual installments not to exceed 15
- Other: this option is used if you want a combination of the above (e.g. $25,000 in a lump sum with the balance in 10 annual installments).

Distribution Processing

The Company will begin processing your distribution on the date specified in your distribution election. Investments must be sold, money transferred to the trustee, and a check generated by the trustee must be processed by WellPoint. Please allow a minimum of two weeks after your distribution date to receive your funds.

Changing your Distribution Election

You may change an existing distribution election by submitting a written request at least 12 months BEFORE you are originally scheduled to receive the distribution. The new election date must be at least 12 months after the date we receive your new election form. Please contact Charles Thorburn in the WellPoint Compensation Department for a new form.

Accelerated Distributions

- **Hardship Withdrawal:** If you have an immediate and heavy financial need and have no other resources reasonably available to you, you may request a hardship withdrawal. The 401(k) provisions regarding hardship withdrawal will be applied. The amount is limited to the portion of your account attributable to your salary, management bonus, and supplemental 401(k) deferrals.

- **Forfeiture:** Absent a demonstration of immediate and heavy financial need, you may elect to receive 85% of your entire vested account in an early distribution at any time upon 30 days written request. The remaining 15% will be forfeited. If you elect to receive a forfeiture distribution, your participation in the Plan will be suspended and you may not again participate in the plan until the Plan Year that is at least 12 months following the Plan Year in which such distribution occurred.

Withholding

The Company will deduct amounts required by law to be withheld for taxes with respect to benefits under this Plan.

Beneficiary Election

Officers currently enrolled in this Plan have a beneficiary election on file. New enrollees must make a beneficiary election. Your beneficiary election may be changed at any time.

Suspension of Your Salary, Bonus, and Car Allowance Deferral Elections

You may suspend your election for the salary, bonus, and car allowance deferral portions of the Plan. You will be eligible to elect deferrals again for the calendar year following 12 months of suspension.

You may limit this suspension to either salary and car allowance deferrals or bonus deferrals; in either case, future elections will only be limited for the suspended deferrals.

For the bonus deferral, a suspension will affect multiple bonuses: any bonus deferral that has already been elected and the bonus deferral that would be elected within 12 months of suspension.

Suspension of Your Supplemental 401(k) Deferral

You may separately suspend your election for the supplemental 401(k) deferral. You will be eligible to elect deferrals again for the calendar year following 12 months of suspension.

Your Balanced Life Benefits

WellPoint knows that you want a career, but you also want balance with your personal life. For this reason, the Company provides a wide range of benefit programs to assist you in balancing your life and career.

The following information briefly outlines some of these current benefits. Please refer to your Associate Handbook for more details. The legal plan documents are controlling in any conflict of interpretation, and the Company reserves the right to modify or terminate the programs at any time without notice.

Employee Assistance and Work/Life Program

WellPoint offers an Employee Assistance and Work/Life Program to help you find solutions to the problems and difficulties of daily life. WellPoint offers its Employee Assistance Program (EAP) free of cost, through WellPoint Behavioral Health (WBH). This program is available to all associates from date of hire.

The EAP provides confidential, professional assistance when personal problems affect your life and work. EAP counseling and referral services can assist you with emotional difficulties, relationship issues, family concerns, alcohol and drug abuse, and financial and legal concerns. Associates and eligible family members (including domestic partners and their children) may receive up to six sessions per incident.

In addition to offering confidential counseling, the program is designed to help you make the right decisions about your dependent care needs. Work/Life benefits include resources and referrals for child care needs and elder care needs offered through Harris Rothenberg International (HRI). Counselors can be reached through your EAP toll−free number.

EAP professionals are available 24 hours a day, 7 days a week. For assistance, call the EAP at (888) 777−6665.

MedCall

MedCall is a 24−hour, 7−day a week nurse line. There is no cost for using this service. All associates and their families have access to nurse counselors who can provide a variety of information including:

- Assistance in determining if you need to see a doctor,
- What level of care would be the most appropriate (e.g. hospital vs. urgent care facility),
- Information on various health conditions and diagnoses,
- Information on medical procedures,
- Information on various support groups, medications, and possible side effects, and
- General health information.

MedCall also provides guidance regarding questions you should ask your provider and access to an audio library of over 200 health−related topics. MedCall can be reached at (888) 629−4000. Your custom MedCall ID # is 1005.

These services are available to BCBSGA associates and dependents by calling BlueChoice On Call at (888) 724−BLUE (2583).

Tuition Assistance

WellPoint encourages you to increase your knowledge and develop your career. All active, full−time regular associates who complete six months of service are eligible to request tuition assistance. Classes must begin after the 6−month waiting period. To participate in the program, applications for tuition assistance must be approved by your supervisor prior to enrolling in any course.

The benefit is 75% of tuition and related expenses up to a $3,000 maximum reimbursement per year. This benefit may be reduced by any grants or scholarships you receive. (Per current IRS rules, reimbursement for undergraduate courses is not included in income, but graduate level course reimbursement is taxable income.)

Academic courses and degree programs either must be related to a currently held job or to a position at the Company for which you are preparing to qualify. Courses must be taken at an accredited institution based in the U.S. Upon successful completion of the course (a "C" grade or better for undergraduate courses and a "B" grade or better for graduate courses−or "pass" where the course is "pass/fail"), you will be reimbursed for registration, tuition, laboratory fees, required books, and required software. Requests for reimbursement must be completed within 90 days of completing the course. Tuition assistance applications are available at your local Human Resources office.

For a more detailed description of the policy on the Tuition Assistance Program, please refer to the TAO bulletin board under _HR_INFORMATION or the Intranet at WorkSite>Department Links>Human Resources>Library and Forms>Training and Education. If you have any questions, contact your supervisor or the Associate Service Center at (877) 342−5272.

Work On Wellness (WOW)

Practicing a healthy lifestyle cuts down on stress and reduces the likelihood of illness and injury. To support this philosophy, the Company offers Work On Wellness (WOW) to all active, regular full−time associates following six months of active employment. WOW provides reimbursement for individual membership dues in a recognized health club, smoking cessation program or weight management program, up to a maximum of $35 per month. Reimbursement is taxable income and is treated as "other" income and reported on your W−2 form. Reimbursement is made quarterly through your paycheck.

You must submit a WOW reimbursement form to the Associate Service Center within 30 days of the close of the calendar quarter for which you are requesting reimbursement. You may print a copy of the WOW form from HR Information on TAO and on WorkSite.

Time Off

Time off includes Company holidays and paid time off ("PTO"), which can be used for vacation, illnesses, leaves of absence, and other reasons.

Holidays

WellPoint provides eligible Officers 10 paid Company holidays each year. The scheduled days vary somewhat each year because holidays fall on different days of the week from one year to the next. The Company holiday schedule for 2002 is in the Associate Handbook.

Paid Time Off

The Officers' paid time off accrual schedule will be communicated in the 2002 Associate Handbook.

Leaves Of Absence

The Company provides different leave plans to accommodate associates when certain situations arise that would temporarily make working unduly burdensome. The plans include Medical/Pregnancy Disability Leave, Family Care/Bonding Leave, Military Leave, and Personal Leave. The Company administers leaves of absence in accordance with the Family Medical Leave Act, the Americans with Disabilities Act, and all other federal and state laws governing leaves of absence. The plans are discussed in detail in your Associate Handbook.

Your Financial Future and Retirement Benefits

Pension Accumulation Plan

On the January 1 or July 1 following one year of service and reaching age 21, you automatically participate in the Pension Accumulation Plan. Benefits under the Plan are fully paid by the Company and are based on earnings and length of service. For new Officers, the Company contribution is generally 3% of eligible earnings for less than 10 years of service; 4% of earnings during years 10 through 19; and 5% of earnings for any years of service after 20. Officers who complete five years of credited service are fully vested. There is no partial vesting for less than five years of service. Statements will be mailed to your home address on an annual basis.

WellPoint 401(k) Retirement Savings Plan

WellPoint's 401(k) Retirement Savings Plan is a retirement plan designed to help you save for long−term financial goals, especially retirement. You contribute to the Plan through automatic payroll deductions and benefit from special tax advantages.

Contributions

You may start contributions on the first of the month following one month of completed service. An enrollment package will be mailed to your home from Vanguard, our plan trustee. Please refer to the enrollment material, Summary Plan Description/ Prospectus, and plan document for a description of this Plan and before making any decision to participate in the Plan.

Contributions are made on a pretax basis and are based on your eligible compensation. You can contribute between 2% and 15% of your eligible compensation, subject to the following limitations:

- Officers who earn more than $85,000 are considered by the IRS to be highly compensated. This limit will be adjusted periodically by the IRS. This plan currently limits highly compensated Officers to a maximum contribution of 8% of eligible compensation and may be adjusted as necessary.
- The IRS limits pretax contributions to an annual limit of $11,000 in 2002. This limit will be adjusted periodically by the IRS.
- You may continue your contributions, subject to the $11,000 limit, until your eligible earnings reach $200,000, or as adjusted by the IRS.

Company Match

Generally, after one year of employment, the Company matches a portion of your eligible contributions. Beginning with the pay period in which you reach one year of employment, the Company will generally match 75% on the first 6% of your eligible earnings contributed to the plan. One−third of the Company match will be invested in the WellPoint Common Stock Fund. You determine the investment direction for the rest of the Company match. In order to maximize the Company match, you must contribute 6% to the Plan.

Example:	
Eligible Biweekly Compensation:	**$400**
Contribution of 6%:	**$24**
Company Match of 4 1/2% (75% of 6%)	**$18 ($6 invested in WellPoint Common Stock; $12 you choose how to invest)**

Vesting

You are 100% vested in pretax contributions as well as the Company matching contributions. So, when you retire or terminate employment, you may receive all the assets in your Plan account. The portion of the Company match directed to the WellPoint Common Stock Fund must be maintained in that fund for the period specified in the Plan.

Investment Choices

When you enroll in the Plan, you choose how to invest your contributions. There are many investment choices available. You may change your fund selection or transfer contributions between funds daily by calling Vanguard's VOICE Network at (800) 523−1188, 24 hours a day or by visiting Vanguard's web site at www.Vanguard.com. If you prefer, a Vanguard associate can assist you with investment changes during normal business hours (M−F from 8:30 a.m. to 9 p.m. Eastern Time). To access your account, you must have your Social Security number and your assigned Personal Identification Number (PIN).

Access to Your Savings

The Plan is designed to encourage long−term savings, but you may access money from the Plan under certain circumstances. The Plan offers loans and hardship withdrawals. Please see your enrollment materials and the Summary Plan Description/Prospectus for details and before making any decision to participate in the Plan.

Employee Stock Purchase Plan

You may enroll in the Employee Stock Purchase Plan if you are employed on the day preceding the first day of the offering period. Enrollment is twice a year—in December, reflecting the January to June offering period, and in June, reflecting the July to December offering period. At the end of each offering period, your contributions are used to purchase WellPoint Common Stock at a rate discounted from the market price at the time of purchase.

Shares are purchased at 85% of the lower of the Company stock price on the first day of the offering period or on the last day of the offering period.

You may choose to keep or sell your shares and are responsible for brokerage fees, capital gains, and any other costs associated with the sale.

You should refer to the Summary Plan Description/ Prospectus for a complete description of the Plan before making a decision to participate.

Mid−Year Changes

Generally, you will not be able to change your *Flex*Point elections until the next Open Enrollment period. However, IRS rules and the plans allow you to change your elections during the year if you have a qualified mid−year change.

Qualified Mid−Year Changes

Examples of qualified mid−year changes for which you can change some of your benefits during the year include:

- Marriage, change in domestic partner status, divorce, legal separation, or annulment
- Birth or adoption of a child, or a change in a child custody arrangement
- Death of your spouse/domestic partner or dependent
- A change in your spouse's/domestic partner's/dependent's employment status
- A significant change in your spouse's/domestic partner's/dependent's employer's health care coverage, not including Open Enrollment
- A change in a dependent's eligibility status because of marriage, age, or loss of dependent status for federal tax purposes
- A change in the cost of your dependent daycare
- Unpaid leaves of absence

The coverage change must be consistent with the qualifying event.

If a qualified mid−year change occurs, it is your responsibility to contact the Associate Service Center within 31 days of the qualifying event. After you report the event to the Associate Service Center, you will receive an Enrollment Worksheet for your use in making changes to your benefits. Failure to act promptly could result in not having coverage for which you or your dependents would otherwise be eligible.

Continuing coverage for a dependent who is no longer eligible (i.e. divorce, termination of domestic partnership, a dependent child reaching the maximum age, etc.), is a violation of Company policy and subject to disciplinary action up to and including termination of employment. WellPoint pays for a portion of coverage for these individuals. You may be liable for premiums and all expenditures including, but not limited to, claims costs and any fees necessary to be reimbursed for any paid claims, as well as legal fees.

If you move to an area where an HMO, Dental Net, or a PPO is not available, you must change your option to one that is available in your new location. However, no other benefit changes will be allowed.

The chart on the following pages shows the changes you can make during the year. For allowable domestic partner changes, refer to the Domestic Partner Guide.

Qualified Mid−Year Changes

Event*	Election Changes You Can Make Within 31 Days of the Event	Coverage/Change Effective Date	Documentation Required
You get married	• Enroll yourself, spouse, and your spouse's dependent children in Medical, Dental, and/or Vision (may not change existing plans) • Cancel Medical, Dental, and/or Vision for yourself and dependent children if you are electing coverage under your new spouse's plan • Add Spouse Life • Enroll in/increase Health Care Spending Account • Enroll in/cancel/change amount of contribution to Dependent Day Care Spending Account	Date of the event	Copy of marriage certificate
You get divorced, legally separated, or have your marriage annulled	• Enroll yourself and dependent children in Medical, Dental, and/or Vision if you and your dependent children lose coverage under your former spouse's plan(s) • Required to cancel spouse in Medical, Dental, and Vision (COBRA coverage will be available for your spouse) • Required to cancel Spouse Life and Child Life for stepchildren • Enroll in/change contribution to Health Care Spending Account • Enroll in/cancel/change amount of contribution to Dependent Day Care Spending Account	Date of the event	Copy of court documents
You gain a dependent child through birth, adoption or placement for adoption, or gain legal guardianship	• Enroll yourself, spouse, and dependent children in Medical, Dental, and/or Vision • Add new dependent child to existing Child Life coverage or enroll an only child • Enroll in/increase Health Care Spending Accounts • Enroll in/increase Dependent Day Care Spending Account	Date of the event	Copy of birth certificate from hospital, copy of adoption papers, or copy of court documents for legal guardianship
Your and/or your spouse's dependent child becomes ineligible (i.e. marriage, over maximum age, becomes a WellPoint associate, etc.) or you lose legal custody of a child	• Required to cancel dependent child in Medical, Dental, Vision, and Child Life (may be eligible for COBRA) • Cancel (if ineligible dependent is only person covered) or decrease Dependent Day Care Spending Account	End of the month	Copy of court documents for legal custody None required for marriage, over maximum age, etc.
Your spouse dies	• Required to cancel spouse in Medical, Dental, Vision, and Spouse Life • Enroll yourself and dependent children in Medical, Dental, Vision, and Health Care Spending Account if you and your dependent children lose coverage under your deceased spouse's plan(s) • Change amount of Health Care Spending Account • Enroll in/change amount of Dependent Day Care Spending Account	Date of death	Copy of death certificate
Your dependent child dies	• Required to cancel dependent child in Medical, Dental, Vision, and Child Life • Decrease Health Care Spending Account • Decrease Dependent Day Care Spending Account	Date of death	Copy of death certificate

* For allowable domestic partner changes, refer to the Domestic Partner Guide.

Event*	Election Changes You Can Make Within 31 Days of the Event	Coverage/Change Effective Date	Documentation Required
Your spouse begins employment or increases his/her work hours and gains Medical, Dental, and/or Vision coverage through his/her employer	• Cancel yourself, spouse, and/or dependent children in Medical, Dental, and/or Vision • Change contribution to Health Care Spending Account • Enroll in/increase Dependent Day Care Spending Account	Date of the event	Documentation from spouse's employer (i.e. benefits enrollment form, employment offer letter, etc.)
Your spouse ends employment or loses eligibility for benefits and you/your spouse/your dependent children lose Medical, Dental, and/or Vision coverage through his/her employer	• Enroll yourself, spouse, and/or dependent children in Medical, Dental, and/or Vision • Enroll in/change contribution to Health Care Spending Account • Cancel/decrease Dependent Day Care Spending Account	Date of the event	Documentation from spouse's employer (i.e. COBRA notice, HIPAA notice, etc.)
Your and/or your spouse's dependent ends employment or loses eligibility for benefits through his/her employer	• Enroll dependent in Medical, Dental, and/or Vision • Change contribution to Health Care Spending Account	Date of the event	Documentation from dependent's employer (i.e. COBRA notice, HIPAA notice, etc.) and proof of full−time student status
Your spouse or dependent child begins full−time employment at WellPoint	• Required to cancel Spouse/Child Life	Date spouse or dependent child qualifies for benefits	None—Provide name and Social Security Number of spouse/dependent child
Your and/or your spouse's dependent's dependent child begins employment enrollment or increases work hours and gains coverage through his/her employer	• Cancel Medical, Dental, Vision, and Child Life for dependent child • Change contribution to Health Care Spending Account	Date of the event	Documentation from employer (i.e. benefits form, employment offer letter, etc.)
You move outside HMO or PPO Service Area	• Required to elect new Medical plan in new location	Date of the event	Address change
You move outside Dental Net Service Area	• Enroll in new Dental plan	Date of the event	Address change
Your job status changes from part−time to full−time	• Enroll in Medical, Dental, Vision, Employee Life, AD&D, Spouse Life, Child Life, STD, and LTD • Enroll in/increase Health Care Spending Account • Enroll in/increase Dependent Day Care Spending Account	First of the month following job status change	None—Human Resources action
Your job status changes from part−time (under 20 hours/week) to part−time at least 20 hours/week	• Enroll yourself, spouse, and dependent children in Medical • Enroll in Health Care Spending Account • Enroll in Dependent Day Care Spending Account	First of the month following job status change	None—Human Resources action
Your job status changes from full−time to part−time (at least 20 hours/week)	• Change Medical plan • Required to cancel Dental, Vision, STD, LTD, Employee Life, AD&D, Spouse Life, and Child Life (COBRA may be available) • Enroll in/cancel/change contribution to Health Care Spending Account • Cancel/decrease Dependent Day Care Spending Account	First of the month following job status change	None—Human Resources action
Your job status changes from full−time to part−time (less than 20 hours/week)	• Required to cancel Medical, Dental, Vision, STD, LTD, Employee Life, Spouse Life, Child Life, Health Care and Dependent Day Care Spending Account (COBRA may change be available)	First of the month following job status	None—Human Resources action

Important Note: The allowable changes are permitted only if they are consistent with and on account of your change in status as determined under IRS regulations.

* For allowable domestic partner changes, refer to the Domestic 40 Partner Guide

Continuing Health Care Coverage ("COBRA")

This is a summary of your rights and obligations under the COBRA continuation coverage provisions. **Both you and your spouse, if any, should take the time to read this notice carefully.** Domestic partners and children of domestic partners are not eligible for COBRA continuation.

COBRA requires that most Officers of WellPoint and its related companies and their families receive the opportunity for a temporary extension of health care coverage, called "continuation coverage," at group rates in certain instances where coverage under the WellPoint Companies' Group Health Plans ("Health Plans") would end. For this purpose, the term "Health Plans" includes the WellPoint Companies' medical, dental, vision, employee assistance, and health care flexible spending account plans, and the term "qualified beneficiary" is used below to refer to individuals who are eligible to receive COBRA continuation coverage.

Qualifying Events For Officers

If you are an Officer of the WellPoint Companies covered by a Health Plan, you have the right to choose COBRA continuation coverage if you lose your Health Plan coverage because of the following:

- A reduction in your hours or employment, or
- The termination of your employment (for reasons other than gross misconduct on your part).

Qualifying Events for Spouse and Dependent Children

If you are the spouse or a dependent child of an Officer covered by a Health Plan, you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of your spouse
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare
- You reach the maximum age allowed to be considered a dependent child
- You are no longer considered a dependent child.

There is no COBRA continuation coverage for domestic partners or their children.

Deadline for Election

When the Plan Administrator is notified that one of these qualifying events has happened, the Administrator will, in turn, notify you that you have the right to choose continuation coverage. Under COBRA, you have 60 days from the date you receive the notice or 60 days from the date that you would lose coverage because of one of the qualifying events described above (if later) to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group Health Plan coverage will end.

Type of Coverage

If you choose continuation coverage, the WellPoint Companies are required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Officers or family members.

Length of Coverage

COBRA requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost Health Plan coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

The 18−month period may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social

Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11−month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18−month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

The 18− or 29−month period may be extended if other qualifying events (for example, divorce, death, or entitlement to Medicare) occur during the period. In no event will coverage last beyond 36 months from the date of the qualifying event that originally made you eligible to elect COBRA continuation coverage.

A child who is born to or placed for adoption with the covered Officer during a period of COBRA coverage will be eligible to become a qualified beneficiary if the Plan Administrator is notified within 31 days of the birth or placement for adoption.

Early Termination of Coverage

COBRA provides that your continuation coverage may be shortened for *any* of the following five reasons:

- The WellPoint Companies no longer provide group health coverage to any of their associates;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation for any pre−existing condition that affects the qualified beneficiary;
- The qualified beneficiary becomes entitled to Medicare;
- The qualified beneficiary has already received 18 months of coverage due to disability, and there has been a final determination that the qualified beneficiary is no longer disabled.

The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for COBRA.

Cost of Coverage

You do not have to show that you are insurable to choose continuation coverage. However, the law provides for payment by the qualified beneficiary of 100% of the premium for continuation coverage plus an administrative fee. The cost of continuation will be 102% of the premiums. However, if you are eligible to extend continuation of coverage for an additional 11 months due to disability, the cost of continuation for any additional months will be 150% of the premiums. There is a grace period of 30 days for the regularly scheduled premium.

Cancellation for Non−Payment

- Premiums are due on the last day of the calendar month preceding coverage.
- Coverage will be cancelled if payment is not received within 30 days of the due date.
- It is the participant's responsibility to make sure premiums are received by the due date, allowing sufficient mail time.
- Once coverage is cancelled for non−payment, it will not be reinstated.

Additional Information

If you have any questions about COBRA, please contact the Associate Service Center.

Important Information

Actively At Work

If you are not actively at work on a full−time basis on the day your coverage or an increase in your benefits would otherwise begin, then your coverage or an increase in benefits will not begin until the date you return to active work on a full−time basis.

If you elect a medical plan offered by WellPoint, coverage will become effective under the Plan even if you are hospitalized or on medical leave on the effective date.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Pre−existing conditions exclusions have been eliminated from the WellPoint Preferred and Group Medical Plans (for pre−existing conditions on LTD/STD, please see page 30). Special enrollment provisions for associates declining medical coverage have been adopted.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in the future in a medical plan offered by WellPoint, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent or other person eligible under our plans as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and other eligible persons, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Newborn's and Mother's Protection Act

The minimum stay for mothers and newborn children is 48 hours following a normal delivery and 96 hours following a cesarean section. Providers are not required to obtain authorization from the Plans or the insurance issuer for prescribing a length of stay within the above periods.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was enacted on October 21, 1998 and requires that all health plans cover post−mastectomy breast surgery if they provide medical and surgical coverage for mastectomies. If you and/or your eligible dependents receive these benefits under a WellPoint−sponsored medical plan, the plan must cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Benefits required under the Women's Health and Cancer Rights Act will be provided in consultation between the patient and attending physician. These benefits are subject to the same health plan deductibles, copayments, and coinsurance that apply to any other benefit under the specific plan and cannot be denied or reduced on the grounds that they are cosmetic in nature or that they otherwise do not meet the plan's definition of "medically necessary."

If you are enrolled in an HMO offered by WellPoint, please be aware that several states have enacted similar laws requiring coverage for treatment related to mastectomies. If the similar law of the state in which your HMO is located is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Important Telephone Numbers

Associate Service Center		(877) 342−5272
Medical		
	WellPoint Preferred PPO	(800) 234−0111
	WellPoint Group	(800) 234−0111
	BCBSGA PPO	(800) 441−2273
HMOs		
	CA: Blue Cross HMO	(800) 234−0111
	CT: BlueCare Health Plan	(800) 922−1742 in CT; (800) 426−8531 elsewhere
	GA: Blue Choice Healthcare	(800) 441−2273
	IL: UNICARE HMO (Illinois)	(800) 234−0111
	MA: HMO Blue	(800) 588−5509
	MI: Blue Care Network of S.E. Michigan	(800) 662−6667
	TX: HMO Blue Cross (Dallas/Ft. Worth)	(888) 558−2393
	HMO Blue Texas (Houston)	(888) 882−2390
	VA: HealthKeepers of Virginia	(800) 421−1880
Dental		
	Dental Net	(800) 627−0004
	WellPoint Standard Dental	(800) 627−0004
	WellPoint Enhanced Dental	(800) 627−0004
	BCBSGA Dental	(800) 441−2273
Vision		
	VSP	(800) 622−7444
	LensCrafters (BCBSGA associates)	(800) 377−6436
UniAccount (Flexible Spending Accounts)		(888) 209−7976
MedCall (ID # 1005)		(888) 629−4000
BlueChoice On Call (BCBSGA associates)		(888) 724−BLUE (2583)
Group Universal Life Insurance		(925) 979−3255
Comprehensive Nonqualified Retirement Plan		(805) 557−5801
Employee Assistance and Work/Life Program		(888) 777−6665
Vanguard's Voice Network		(800) 523−1188
Employee Stock Purchase Plan		
	AST—Stock Plan Administrator	(888) 980−6456
	National Discount Brokers	(888) 302−7764

Important Addresses for Claims

Medical—PPO

WellPoint Health Networks Inc.
P.O. Box 4109
Woodland Hills, California 91365
Attn: Associate Claims Unit

Dental

WellPoint Health Networks Inc.
P.O. Box 9066
Oxnard, California 93031−9066
Attn: Associate Claims Unit

Vision

Vision Service
Plan P.O. Box 997100
Sacramento, California 95899−7100

BCBSGA Associates

Medical and Dental
Blue Cross and Blue Shield of Georgia
P.O. Box 9907
Columbus, GA 31908−6007

Vision
BCBSGA Vision
P.O. Box 9907
Columbus, GA 31908−6007

Pharmacy Drugs

WellPoint Pharmacy
P.O. Box 4165
Woodland Hills, California 91365−4165

Spending Accounts

UniAccount
P.O. Box 4381
Woodland Hills, California 91365−4381

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Exhibit 10.22

WELLPOINT HEALTH NETWORKS INC.
OFFICER CHANGE−IN−CONTROL PLAN
(As amended and restated through December 4, 2001)

This WellPoint Health Networks Inc. Officer Change−in−Control Plan (the "Plan") is designed to provide officers of WellPoint Health Networks Inc. ("WellPoint" or the "Company") and/or Affiliates of WellPoint with benefits in the event of a Change−in−Control. Except to the extent provided herein, the Plan, which was originally adopted by the Board of Directors as of February 12, 1998, replaced any similar plan previously in effect as of such date of adoption providing for monetary or other compensation to any officer in the event of a change in control. This Plan has been further amended and restated as of October 27, 1998, as of October 18, 2001, and, as provided herein, as of December 4, 2001.

ARTICLE I
DEFINITIONS

Unless otherwise indicated, capitalized terms used herein shall have the following meaning:

"Affiliate" means an entity that is linked to WellPoint by a 51% or greater chain of ownership. For this purpose, ownership is determined by applying the principles of Section 414 of the Code and by substituting a 51% control test for an 80% control test.

"Affiliated Group" means WellPoint and all of its Affiliates.

"Base Salary" means a Participant's highest annualized base salary, in the aggregate, payable from one or more member of the Affiliated Group at any time during the period commencing five years before the announcement of the relevant Change in Control and ending immediately preceding the Participant's Termination Date or, if earlier and solely for purposes of computing the Change in Control Completion Bonus under section 2.3, the date of the Change in Control.

"CEO" means the Chief Executive Officer of WellPoint or his delegate.

"Change in Control" shall mean one or more of the following that occurs within the term of the Plan:

(i) The acquisition, directly or indirectly by any person or related group of persons (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), but other than WellPoint or a person that directly or indirectly controls, is controlled by, or is under, control with the Company, of beneficial ownership (as defined in Rule 13d−3 of the Exchange Act) of securities of the Company that results in such person or related group of persons beneficially owning securities representing 40% or more of the combined voting power of the Company's then−outstanding securities;

(ii) A merger, recapitalization, consolidation or similar transaction to which WellPoint is a party or the sale, transfer or other disposition of all or substantially all of the Company's assets if, in either case, the beneficial owners of WellPoint's securities immediately before the transaction do not have, immediately after the transaction, beneficial ownership of securities representing at least 60% of the combined voting power of the then−outstanding securities of the surviving entity or the entity acquiring WellPoint's assets, as the case may be, or a parent thereof;

(iii) A merger, recapitalization, consolidation or similar transaction to which WellPoint is a party or the sale, transfer or other disposition of all or substantially all of the Company's assets if,

in either case, the directors of WellPoint immediately prior to consummation of the transaction do not, upon consummation of the transaction, constitute at least a majority of the board of directors of the surviving entity or the entity acquiring WellPoint's assets, as the case may be, or a parent thereof (for this purpose, any change in director composition that is anticipated or pursuant to an understanding or agreement in connection with a transaction will be deemed to have occurred at the time of the transaction); or

(iv)

A change in the composition of the Board of Directors of WellPoint (the "Board") over a period of thirty−six (36) consecutive months or less such that a majority of the Board members ceases by reason of one or more contested elections for Board membership, to be comprised of individuals who either (a) have been Board members since the beginning of such period or (b) have been elected or nominated for election as Board members during such period by at least a majority of the Board members described in clause (a) who were still in office at the time the Board approved such election or nomination.

"Code" means the Internal Revenue Code of 1986, as amended.

"Committee" shall mean the Compensation Committee of the Board of Directors of WellPoint, whose membership shall be comprised solely of independent directors of WellPoint and to which the CEO shall report periodically regarding actions taken under this Plan.

"Constructive Termination" means one or more of the following:

(i)

A material reduction in the duties, responsibilities, status, reporting responsibilities, titles or offices that a Participant had with the Affiliated Group immediately before such reduction;

(ii)

Reduction by more than 10% of the total annual cash compensation (including base salary and target bonuses) that a Participant was eligible to receive from all members of the Affiliated Group immediately before the reduction except a reduction that both (a) is part of, and consistent with, an across−the−board reduction in the salaries of senior officers of the Affiliated Group and (b) is not implemented on or after, or in contemplation of, a Change−In−Control;

(iii)

A change in the Participant's principal place of employment with the Affiliated Group such that the Participant's one−way commute will be increased by more than 35 miles; or

(iv)

A requirement that the Participant spend an average of two or more days per week at a place of employment other than his or her principal place of employment if the average ground commute to such additional place of employment from the Participant's primary residence, during normal commute hours, is longer than two hours; provided that the Participant has not, in advance and in writing, agreed to such requirement in connection with assuming or retaining a specific position;

(v)

The failure of any successor to WellPoint by merger, consolidation or acquisition of all or substantially all of the business of WellPoint to assume WellPoint's obligations under this Plan.

However, a Constructive Termination will not be deemed to have occurred unless (A) within sixty (60) days of the occurrence that the Participant deems to be a Constructive Termination, the Participant notifies WellPoint in writing that he or she has experienced a Constructive Termination, which notice describes the event that the Participant believes constitutes a Constructive Termination, (B) WellPoint has not, within fifteen (15) days of receipt of such notice, corrected the circumstance that would otherwise result in a Constructive Termination, and (C) the Participant terminates his or her employment within ninety (90) days of such 15−day period.

"Exchange Act" means the Securities Exchange Act of 1934, as amended.

"Involuntary Termination" means actual termination of a Participant's employment with the Affiliated Group other than (i) Termination for Cause, (ii) termination due to the Participant's total and permanent disability, as that term is defined in the WellPoint long−term disability plan in effect on the date in question, or (iii) termination due to the Participant's death.

"Participant" means any person holding the title of Staff Vice President, Regional Vice President or Vice President or higher with WellPoint or any member of the Affiliated Group and any other person as may be designated from time to time by the CEO; provided, however, that it shall not include (i) any person covered by an employment agreement with any member of the Affiliated Group on his or her Termination Date unless such person's employment agreement otherwise provides; and (ii) unless otherwise designated by the CEO, any other position, whether or not the position contains the phrase "Vice President, which is not considered to be an officer position of the Affiliated Group or is not entitled to participate in benefits generally reserved for officers of the Affiliated Group.

"Plan Bonus" means, for each Participant, an amount equal to an amount equal to (i) multiplied by (ii) multiplied by (iii) where:

(i) equals the Participant's Base Salary;

(ii) equals the percentage, for the fiscal year occurring in whole or in part during the period commencing five years before the announcement of the relevant Change in Control and ending immediately before the Participant's Termination Date (or, if earlier and solely for purposes of determining the Change in Control Completion Bonus under Section 2.3, the date of the Change in Control) for which such percentage is the highest, that the Participant's Target Bonus for such fiscal year represents as a percentage of such Participant's annual base salary for such fiscal year; and

(iii) equals the greater of (A) 100% or (B) the average percentage, for the two consecutive fiscal years within the period commencing five years before the announcement of the relevant Change in Control and ending immediately before the Participant's Termination Date (or, if earlier and solely for purposes of determining the Change in Control Completion Bonus under Section 2.3, the date of the Change in Control) for which such average percentage is the highest, that the Participant's actual annual bonus for a fiscal year represented as a percentage of the participant's annual base salary for such fiscal year.

"Target Bonus" means the Participant's target bonus for any fiscal year under WellPoint's then−applicable annual management incentive plan, or any other similar annual incentive plan maintained by a member of the Affiliated Group.

"Termination Date" is the first date that a Participant is subject to a Constructive Termination or an Involuntary Termination.

"Termination for Cause" means termination of the Participant's employment with the Affiliated Group by reason of (i) willful engagement by a person in gross misconduct injurious to WellPoint or the commission by a person of any act of gross negligence or malfeasance with respect to a person's duties incident to employment; (ii) willful failure by a person to attend to the material duties assigned to such person by such person's supervisor; (iii) a commission by a person of any act of fraud, embezzlement or dishonesty against any member of the Affiliated Group; or (iv) conviction of a person for any criminal offense involving fraud or dishonesty or any similar conduct which is injurious to the reputation of WellPoint.

ARTICLE II
BENEFITS UPON A CHANGE IN CONTROL

2.1 *Prior Bonuses and Incentive Pay.* If a Change in Control occurs, each Participant shall be entitled to receive as soon as practicable, subject to any election to defer such amount made by such Participant under a WellPoint deferral program, any bonus or other incentive compensation for a prior period that was earned but theretofore remained unpaid. To the extent possible, the determination of such amount shall be made by the WellPoint Board of Directors before the Change in Control and, to the extent that this is not possible, it shall be determined as soon as practicable following the Change in Control by those continuing members of the \board of directors of the continuing or successor company that were members of the board of directors of WellPoint immediately before such Change in Control.

2.2 *Guaranteed Annual Bonus.* If a Change in Control occurs, each Participant shall be entitled to a bonus for the fiscal year in which the Change in Control occurs equal to the greatest of (i) the Participant's Target Bonus for such fiscal year, (ii) the average of the annual (or annualized) bonus paid to the Participant for the preceding two fiscal years (or such shorter period as the Participant may have been eligible for such an award) under WellPoint's then−applicable annual management incentive plan, or any other similar annual incentive plan maintained by a member of the Affiliated Group or (iii) the bonus that is determined in the ordinary course under such a plan for the Participant for the fiscal year in which the Change in Control occurs. However, if the Participant terminates employment by reason of an Involuntary Termination or Constructive Termination after the announcement of, or the execution of a definitive agreement for, a Change in Control and before the end of the fiscal year in which the Change in Control occurs, the bonus payable under this Section 2.2.shall be prorated based on the Participant's actual period of employment with WellPoint or an Affiliate during the fiscal year in which the Change in Control occurs. Any bonus payable under this Section 2.2 will be paid in a lump sum cash payment upon the earlier of the normal time for payment of a bonus under the applicable incentive plan or as soon as practicable following the Participant's Termination Date.

2.3 *Change in Control Completion Bonus.* If a Change in Control occurs, each Participant will be entitled to payment of a Change in Control Completion Bonus equal to 100% of the Participant's Base Salary and Plan Bonus. One−half of the Completion Bonus will be paid one year following consummation of the Change in Control provided the Participant remains employed with WellPoint, an Affiliate or successor through such date and the remaining one−half will be paid two years after consummation of the Change in Control provided the Participant remains employed with WellPoint, an Affiliate or successor through such date. However, if a Participant terminates employment before the scheduled payment date for an installment of such Completion Bonus, the Participant shall not be entitled to receive such installment.

ARTICLE III
SEVERANCE BENEFITS UPON A CHANGE IN CONTROL

3.1 *Eligibility.* If (i) on, or within 36 full calendar months after, a Change in Control, a Participant is subject to an Involuntary Termination or a Constructive Termination or (ii) on or after the execution of a definitive agreement for a Change in Control and before the consummation of such Change in Control a Participant is subject to an Involuntary Termination, the Participant will be eligible for the Plan benefits provided in Article III hereof (subject to the terms and conditions of this Plan); provided, however, that such Participant will not be eligible for Plan benefits if the Participant has already received benefits under this Plan due to a previous Constructive Termination or a previous Involuntary Termination.

3.2. *Basic Benefit.*

(a) The Basic Benefit for each Participant will be as provided in this Section 3.2 based upon the Participant's position as of the Termination Date as follows; provided, however, that in no event will the Basic Benefit be less than the lowest Basic Benefit for the highest position held by the Participant with a member of the Affiliated Group at any time during the period commencing five years before the announcement of the relevant Change in Control and ending immediately before the Participant's Termination Date:

(i) *Executive Vice President:* 3.00 times Base Salary, plus 3.00 times Plan Bonus.

(ii) *Senior Vice President:* 2.50 times Base Salary, plus 2.50 times Plan Bonus.

(iii) *General Manager or Vice President:* 2.00 times Base Salary, plus 2.00 Times Plan Bonus.

(iv) *Regional or Staff Vice President:* 1.50 times Base Salary, plus 1.50 times Plan Bonus.

However, the amount of a Participant's Basic Benefit under this Section 3.2 will be reduced by the amount of any Change in Control Completion Bonus paid to the Participant under Section 2.3 of the Plan.

(b) The Basic Benefit will be paid to the Participant in a lump sum as soon as reasonably practicable after the Participant's Termination Date.

3.3. *Outplacement Benefit.* Each Participant shall receive the Outplacement Benefit, which shall consist of outplacement services consistent with WellPoint's then−current outplacement policy for persons holding the Participant's title. The fee for this service will be paid directly by WellPoint (and/or by an Affiliate controlled by WellPoint) to the outplacement service vendor.

3.4 *Pension and 401(k) Match Contribution.* Each Participant shall be entitled to a special contribution amount equal to the sum of the additional Annuity Credits and Matching Contributions to which the Participant would have been entitled under WellPoint's Pension Accumulation Plan, 401(k) Retirement Savings Program and Comprehensive Executive Non−Qualified Retirement Plan had the Participant remained employed with WellPoint for that number of additional number of years set forth below and the Participant's Basic Benefit were payable over such period and treated as eligible compensation under such plans:

(i) *Executive Vice President:* three years;

(ii) *Senior Vice President:* two and one−half years;

(iii) *General Manager or Vice President:* two years;

(iv) *Regional or Staff Vice President:* one and one−half years.

The amount of such special contribution amount shall be computed assuming the Participant was eligible, and made the maximum salary deferrals and supplemental salary deferrals eligible for matching and supplemental matching contributions, under the 401(k) Retirement Savings Program and Comprehensive Executive Non−Qualified Retirement Plan, respectively. Such special contribution amount shall be paid to the Participant in a lump sum cash payment as soon as practicable after the Participant's Termination Date, unless the Participant is entitled to participate in WellPoint's Comprehensive Executive Non−Qualified Retirement Plan, in which case the contribution shall be credited to such Participant's account under such plan as an additional fully vested amount.

3.5 *Financial Planning.* Each participant who is an Executive Vice President or Senior Vice president shall be entitled to a continuation of financial planning benefits for the number of years set forth below:

(i) *Executive Vice President:* three years; and

(ii) *Senior Vice President:* two and one−half years.

3.6 *Additional SERP Credit.* Each Participant who is eligible to participate in WellPoint's Supplemental Executive Retirement Plan will be deemed to have five Years of Vesting Service thereunder and shall be credited with that number of additional Years of Benefit Service, and shall be deemed to be that number of years older, as is set forth below:

(i) *Executive Vice President:* three additional years;

(ii) *Senior Vice President:* two and one−half additional years;

(iii) *General Manager or Vice President:* two additional years; and

(iv) *Regional or Staff Vice President:* one and one−half additional years.

3.7. *Other Severance Benefits.* Each Participant shall receive health, vision, dental and life insurance benefits at employee rates until the earlier to occur of:

(i) the Participant becoming eligible for such benefits under the health and welfare benefit plan or plans maintained by the Participant's successor employer; and

(ii) depending on the title of the Participant, the following periods:

(a) in the case of Executive Vice Presidents, three years;

(b) in the case of Senior Vice Presidents, two and one−half years;

(c) in the case of General Managers and Vice Presidents, two years; and

(d) in the case of Regional and Staff Vice Presidents, one and one−half years.

In lieu of providing the benefits described in this Section 3.7, WellPoint may, in its discretion, elect to make cash payments to Participant in amounts sufficient, on an after−tax basis, for Participant to otherwise purchase such benefits.

3.8. *Offset for Other Payments Received.* The Worker Adjustment and Retraining Notification Act (commonly known as the WARN Act) requires that advance notice of certain layoffs be given to employees. Other laws may impose similar notice requirements or require that pay in−lieu of notice, severance pay or similar benefits be paid. WellPoint and/or its Affiliates shall be entitled to deduct from any benefits otherwise payable to a Participant under this Plan due to a Constructive Termination or an Involuntary Termination any other amount that a member of the Affiliated Group is legally required to pay to the Participant under such laws due to the same Constructive Termination or Involuntary Termination, plus any compensation and any benefits paid to the Participant following distribution of such a legally required notice to the Participant due to such Constructive Termination or Involuntary Termination. Similarly, benefits paid under this Plan will be applied to satisfy any legal obligations that a member of the Affiliated Group may have under such laws or similar laws due to the Constructive Termination or the Involuntary Termination for which Plan benefits are paid.

3.9. *Coordination with Other Plans.* If a Participant is covered under any other severance plan or arrangement (including WellPoint's Officer Severance Plan) of a member of the Affiliated Group under which benefits are payable on the Participant's Termination Date (each, a "Severance Plan"), then the Participant will receive benefits under the Severance Plan or Plans in lieu of benefits under this Plan unless the Participant waives his or her benefits under the Severance Plan or Plans with regard to the

Constructive Termination or the Involuntary Termination. For these purposes, such a written waiver must be submitted to the CEO within 30 days of the date, following the Change in Control, on which the Participant is specifically notified by the CEO that the Participant must waive all benefits payable under the Severance Plan or Plans with regard to the Constructive Termination or the Involuntary Termination in order to receive benefits under this Plan with regard to that Constructive Termination or Involuntary Termination.

ARTICLE IV
EXCESS PARACHUTE PAYMENTS

If any employee of WellPoint or an Affiliate (i) is, at the effective time of a Change−in−Control (or any other corporate transaction) or the date of termination of such employee's employment, an Executive Vice President or Senior Vice President and (ii) receives compensation from WellPoint or an Affiliate or a successor thereto (under this Plan or otherwise) that subjects the employee to an excise tax under Section 4999 of the Code (relating to excess parachute payments), WellPoint shall make an additional payment to such employee that, net of all taxes thereon, fully reimburses or "grosses up" the employee for the amount of such excise tax. If any other employee is a Participant in this Plan and reasonably determines that (i) compensation payable under this Plan, either alone or when aggregated with other compensation payable to such Participant, would subject such Participant to an excise tax under Section 4999 of the Code and (ii) the net amount that the Participant would realize from such payments on an after−tax basis would be greater if the benefit payable hereunder were limited, then the benefit payable hereunder shall be limited in the manner reasonably determined by the Participant to maximize such Participant's net payment received on an after−tax basis. Except to the extent expressly provided in a written agreement between WellPoint and a Participant, the foregoing provisions of this Article shall apply only to Participants who are also Participants in the WellPoint Health Networks Inc. Officer Severance Plan (as adopted October 27, 1998). With respect to all other Participants under this Plan, if the CEO reasonably determines that any benefit under this Plan, alone or when aggregated with other compensation payable to the Participant, would constitute an excess parachute payment within the meaning of Section 280G of the Code, the amount payable under this Plan will be limited only to the extent necessary to avoid creation of an excess parachute payment.

ARTICLE V
MISCELLANEOUS

5.1. *Withholding.* WellPoint and/or the appropriate member of the Affiliated Group may withhold taxes and other payroll deductions from Plan benefit payments.

5.2. *Effect on Other Plans.* Payments under this Plan will not be treated as compensation for purposes of any other employee benefit plan, unless the other employee benefit plan expressly provides otherwise.

5.3. *Assignment and Source.* Plan benefits are not assignable and will be paid when due from the general assets of WellPoint and/or from the general assets of an Affiliate controlled by WellPoint.

5.4. *Compliance with Agreements.* Plan benefits are conditioned on an eligible Participant's compliance with any confidentiality agreement or release that the Participant has entered into with any member of the Affiliated Group.

5.5. *Claims Procedure.* If an individual believes that he or she is entitled to a benefit under this Plan or to a Plan benefit that is greater than the benefit which such person has received, the individual may submit a signed, written application to the CEO within 60 days of the date of the individual's Constructive Termination or Involuntary Termination, as the case may be. The individual will generally be notified of the approval or denial of this application within 90 days of the date that the CEO receives the application. If the individual is not so notified the individual may, but need not, treat the

claim as denied. If the individual's claim is denied, the notification will state specific reasons for the denial and the individual will have 60 days to file a signed, written request for a review of the denial with the CEO. This request should include the reasons the individual is requesting a review, facts supporting the individual's request, and any other relevant comments. The CEO will generally make a final, written determination of the individual's eligibility for Plan benefits within 60 days of receipt of the individual's request for review.

5.6. *Arbitration.* If an individual is denied part or all of a Plan benefit pursuant to Section 5.5, the individual's sole remedy will be to appeal the matter to an impartial arbitrator. Arbitration will be in accordance with the Model Employment Arbitration Procedures of the American Arbitration Association (the "AAA") before an arbitrator who is familiar with employee benefit matters and who is licensed to practice law in the state in which the arbitration is convened (the "Arbitrator"). The Arbitrator will be selected by alternate striking from a list of eleven arbitrators drawn by the AAA from its panel of labor and employment arbitrators. The arbitration will take place in or near the city in which the individual is or was last employed by WellPoint and/or an Affiliate controlled by WellPoint or in such other location as may be acceptable to both the individual and WellPoint. The Arbitrator will have the exclusive authority to resolve any factual or legal claim relating to the Plan or relating to the interpretation, applicability or enforceability of this arbitration provision, including but not limited to, any claim that all or any part of this provision is void or voidable. The arbitration will be final and binding upon all parties. The costs of the Arbitration will be split equally between the parties to the arbitration.

5.7. *Amendment or Termination of Plan.* The Committee shall have the authority to amend or terminate the Plan at any time; provided, however, that no termination of the Plan or amendment thereto that adversely affects the rights of the Participants shall be effective sooner than three years after the approval of such amendment or termination by the Committee.

5.8. *No Right to Continued Employment.* This Plan does not provide a Participant with any right to continue employment with any member of the Affiliated Group or affect the right of any individual or any member of the Affiliated Group to terminate the services of such individual at any time with or without cause, subject to the terms of any written employment agreement executed by both parties thereto.

5.9. *Governing Law.* This Plan is intended to be an unfunded welfare benefit plan for a select group of management or highly compensated employees within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and Department of Labor Regulation 2520.104−24. To the extent applicable and not preempted by ERISA, the laws of the State of California will govern this Plan.

5.10. *Effective Date.* This Plan is restated herein is effective on or after December 4, 2001.

WELLPOINT HEALTH NETWORKS INC.

BY: /s/ LEONARD D. SCHAEFFER DATE: December 4, 2001

LEONARD D. SCHAEFFER

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Exhibit 10.23

WELLPOINT HEALTH NETWORKS INC.
OFFICER SEVERANCE PLAN
(as adopted December 4, 2001)

This WellPoint Health Networks Inc. Officer Severance Plan (the "Plan") is designed to provide each officer of WellPoint Health Networks Inc. ("WellPoint" or the "Company") and/or its affiliates with certain benefits in the event that such officer is involuntarily terminated from employment from WellPoint or one of its affiliates. Except to the extent provided herein, the Plan replaces any similar plan previously in effect as of the date of adoption providing for monetary or other compensation to any officer in the event that such officer is involuntarily terminated from employment with WellPoint or one of its affiliates.

ARTICLE I
DEFINITIONS

Unless otherwise indicated, capitalized terms used herein shall have the following meaning:

"Affiliate" means an entity that is linked to WellPoint by a 51% or greater chain of ownership. For this purpose, ownership is determined by applying the principles of Section 414 of the Code and by substituting a 51% control test for an 80% control test.

"Affiliated Group" means WellPoint and all of its Affiliates.

"Base Salary" means a participant's highest annual rate of base salary paid by a member of the Affiliated Group during the twelve calendar months immediately preceding the Participant's Termination Date.

"CEO" means the Chief Executive Officer of WellPoint or such person's delegate.

"Code" means the Internal Revenue Code of 1986 as amended.

"Committee" shall mean the Compensation Committee of the Board of Directors of WellPoint, whose membership shall be comprised solely of independent directors of WellPoint and to which the CEO shall report periodically regarding actions taken under this Plan.

"Constructive Termination" means a change in the Participant's principal place of employment such that the Participant's one−way commute will be increased by more than 35 miles. However, a Constructive Termination will not be deemed to have occurred unless (i) within sixty (60) days of the occurrence that the Participant deems to be a Constructive Termination, the Participant notifies WellPoint in writing that he or she has experienced a Constructive Termination, which notice describes the event that the Participant believes constitutes a Constructive Termination, (ii) WellPoint has not, within fifteen (15) days of receipt of such notice, corrected the circumstance that would otherwise result in a Constructive Termination, and (iii) the Participant terminates his or her employment within ninety (90) days of such 15−day period.

"Involuntary Termination" means actual termination of a Participant's employment with a member of the Affiliated Group initiated by one or more members of the Affiliated Group, other than (i) Termination for Cause, (ii) termination due to the Participant's total and permanent disability, as that term is defined in the WellPoint long−term disability plan in effect on the date in question, or (iii) termination due to the Participant's death. Involuntary Termination shall also mean the resignation by a Participant in lieu of discharge from employment by mutual agreement between such Participant and the member of the Affiliated Group.

"Participant" means any person holding the title of Staff Vice President, Regional Vice President, Vice President or higher with WellPoint or any member of the Affiliated Group; provided, however, that it shall not include (i) any person covered by an employment agreement with any member of the Affiliated Group on his or Termination Date unless such person's employment agreement provides

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otherwise; and (ii) unless otherwise designated by the CEO, any other position (whether or not such position contains the phrase "Vice President") which is not considered to be an officer position of the Affiliated Group or is not entitled to participate in benefits generally reserved for officers of the Affiliated Group.

"Service" means the number of years from a Participant's latest or adjusted hire date, whichever is longer. An adjusted hire date shall apply to any Participant who is reinstated with the Affiliated Group and who has had a break in service with the Affiliated Group of a duration of less than one year. Participants who have a break in service of one year or greater shall not accrue any service credit for the period prior to such break in service.

"Termination Date" is the first date that a Participant is subject to a Constructive Termination or an Involuntary Termination.

"Termination for Cause" means (i) a commission by a Participant of any act of fraud, embezzlement or dishonesty against any member of the Affiliated Group; (ii) the conviction of a Participant for any criminal offense involving fraud or dishonesty or any similar conduct that is injurious to the reputation of WellPoint or any member of the Affiliated Group; or (iii) willful engagement by a Participant in gross misconduct injurious to WellPoint or any member of the Affiliated Group.

ARTICLE II
ELIGIBILITY

A Participant who is subject to a Constructive Termination or an Involuntary Termination from the Affiliated Group will be eligible for the Plan Benefits provided in Article III hereof (subject to the terms and conditions of this Plan).

ARTICLE III
PLAN BENEFITS

3.1. *Basic Benefit.* (a) The Basic Benefit for each Participant will be as provided in the Schedule attached hereto applicable to such Participant based upon the Participant's position as of the Termination Date; provided, however, that in no event will the Basic Benefit be less than the lowest Basic Benefit for the highest position held by the Participant with a member of the Affiliated Group at any time during the 12 calendar months immediately preceding the Participant's Termination Date.

(b) For purposes of calculating the Basic Benefit, the term "Target Bonus" referred to in the applicable Schedule is an amount equal to (i) the target bonus percentage (if any) for the Participant for the fiscal year immediately preceding his or her Termination Date under WellPoint's then−applicable annual management incentive plan, or any other cash incentive plan maintained by a member of the Affiliated Group, multiplied by (ii) the Participant's Base Salary at the time of termination.

3.2. *Other Benefits.* Each Participant shall receive health, vision, dental and life insurance benefits comparable (including the Participant responsibility for the employee contribution required at such time) to those generally provided to employees of WellPoint or its Affiliates until the earlier to occur of:

(i) the Participant becoming eligible for such benefits under the health and welfare benefit plan or plans maintained by any successor employer of the Participant; and

(ii) depending on the title of the Participant, the period set forth in the applicable Schedule attached hereto.

In lieu of providing the benefits described in this Section 3.2, WellPoint may, in its discretion, elect to make cash payments to Participant in amounts sufficient, on an after−tax basis and after taking into

account the employee contribution required at such time, for Participant to otherwise purchase such benefits.

3.3. *Excess Parachute Payments.* If any Participant determines that (i) any benefit under this Plan, either alone or when aggregated with other compensation payable to such Participant, would subject such Participant to an excise tax under Section 4999 of the Code (relating to excess parachute payments) and (ii) the net amount that the Participant would realize from such payments on an after−tax basis would be greater if the benefit payable hereunder were limited, then the benefit payable hereunder shall be limited in the manner reasonably determined by such Participant to maximize such Participant's net payments received on an after tax basis, *unless* under a separate written agreement, plan or program, such Participant is entitled to an additional payment that, net of all taxes thereon, fully reimburses or "grosses up" the Participant for the amount of such excise tax.

3.4. *Offset for Other Payments Received.* The Worker Adjustment and Retraining Notification Act (commonly known as the WARN Act) requires that advance notice of certain layoffs be given to employees. Other laws may impose similar notice requirements or require that pay in−lieu of notice, severance pay or similar benefits be paid. WellPoint and/or its Affiliates shall be entitled to deduct from any benefits otherwise payable to a Participant under this Plan any other amount that a member of the Affiliated Group is legally required to pay to the Participant under such laws plus any compensation and any benefits paid to the Participant following distribution of such a legally required notice to the Participant. Similarly, benefits paid under this Plan will be applied to satisfy any legal obligations that a member of the Affiliated Group may have under such laws or similar laws for which Plan benefits are paid.

3.5. *Form of Payment.* The Basic Benefit will be paid to the Participant in a lump sum as soon as reasonably practicable after the later to occur of the Participant's Termination Date and WellPoint's receipt of an executed general release from the Participant provided pursuant to Section 3.10 hereof.

3.6. *Withholding.* WellPoint and/or the appropriate member of the Affiliated Group may withhold taxes and other payroll deductions from Plan benefit payments.

3.7. *Effect on Other Plans.* Payments under this Plan will not be treated as compensation for purposes of any other employee benefit plan, unless the other employee benefit plan expressly provides otherwise.

3.8. *Coordination with Other Plans.* Any person otherwise eligible as a Participant under this Plan shall not be considered a Participant if such person is then covered under any other severance plan or arrangement maintained by a member of the Affiliated Group, under which benefits are payable as a result of Participant's Constructive Termination or Involuntary Termination (a "Severance Plan"), other than WellPoint's Officer Change−in−Control Plan. Such person shall only be considered a Participant hereunder upon receipt by the Company of a duly executed termination agreement, in a form acceptable to the Company, with respect to such person under such Severance Plan or Plans. In any event, any benefits otherwise payable to a Participant hereunder upon a Constructive Termination or Involuntary Termination shall be reduced on a dollar−for−dollar basis for any benefits received by the Participant from any other Severance Plan or Plans (whether maintained by the Company, any member of the Affiliated Group or any former or successor employers of the Participant), including WellPoint's Officer Change−in−Control Plan.

3.9. *Effect of Divestitures or Other Significant Corporate Transactions.* A Participant shall not be deemed to have suffered a Constructive Termination or Involuntary Termination solely by virtue of the Company or any member of the Affiliated Group consummating a divestiture, sale or other similar transaction (whether by asset sale, stock sale or otherwise) (a "Divestiture") with respect to a member of the Affiliated Group or business unit or division (a "Transferred Unit") so long as the Participant shall continue in his or her employment with the Transferred Unit or shall be offered a position having

a substantially similar title, responsibilities, compensation and benefits with the entity acquiring such Transferred Unit. Notwithstanding the foregoing, in the event that a Participant shall suffer an Involuntary Termination or Constructive Termination from the Transferred Unit within the time period after completion of the Divestiture specified in the applicable Schedule, such Participant shall be entitled to receive the benefits specified in Sections 3.1 and 3.3 hereof (subject to the terms and conditions of this Plan, including Sections 3.8 and 3.10 hereof).

3.10. *Execution of General Release.* It shall be a condition to receipt of any benefit under this Plan that Participant shall have executed a general release of all claims that the Participant may have against WellPoint and all members of the Affiliated Group and their respective employees and agents. Such general release shall be in the form customarily used by WellPoint.

ARTICLE IV
MISCELLANEOUS

4.1. *Assignment and Source.* Plan benefits are not assignable and will be paid when due from the general assets of WellPoint and/or from the general assets of an Affiliate controlled by WellPoint.

4.2. *Compliance with Agreements.* Plan benefits are conditioned on an eligible Participant's compliance with any confidentiality agreement that the Participant has entered into with any member of the Affiliated Group.

4.3. *Claims Procedure.* If a Participant believes that he or she is entitled to a benefit under this Plan or to a Plan benefit that is greater than the benefit which such person has received, the Participant may submit a signed, written application to the CEO within 60 days of the Participant's Termination Date. The Participant will generally be notified of the approval or denial of this application within 90 days of the date that the CEO receives the application. If the Participant is not so notified the Participant may, but need not, treat the claim as denied. If the Participant's claim is denied, the notification will state specific reasons for the denial and the Participant will have 60 days from the date of such notification to file a signed, written request for a review of the denial with the CEO. This request shall include the reasons the Participant is requesting a review, facts supporting the Participant's request and any other relevant comments. The CEO will generally make a final, written determination of the Participant's eligibility for Plan benefits within 60 days of receipt of the Participant's request for review.

4.4. *Arbitration.* If a Participant is denied part or all of a Plan benefit pursuant to Section 4.3, the Participant's sole remedy will be to appeal the matter to an impartial arbitrator. Arbitration will be in accordance with the Model Employment Arbitration Procedures of the American Arbitration Association (the "AAA") before an arbitrator who is familiar with employee benefit matters and who is licensed to practice law in the state in which the arbitration is convened (the "Arbitrator"). The Arbitrator will be selected by alternate striking from a list of eleven arbitrators drawn by the AAA from its panel of labor and employment arbitrators. The arbitration will take place in or near the city in which the Participant is or was last employed by WellPoint or an Affiliate controlled by WellPoint or in such other location as may be acceptable to both the Participant and WellPoint. The arbitrator will not be allowed to consider or include any claims of other Participants. The Arbitrator will have the exclusive authority to resolve any factual or legal claim relating to the Plan or relating to the interpretation, applicability or enforceability of this arbitration provision, including but not limited to, any claim that all or any part of this provision is void or voidable. The arbitration will be final and binding upon all parties. The costs of the Arbitration will be split equally between the parties to the arbitration.

4.5. *Amendment or Termination of Plan.* The Committee shall have the authority to amend or terminate the Plan at any time; provided, however, that no termination of the Plan or amendment thereto that adversely affects the rights of Participants shall be effective sooner than the January 1 that

next occurs after the first anniversary of the approval of such amendment or termination by the Committee.

4.6. *No Right to Continued Employment.* This Plan does not provide a Participant with any right to continued employment with any member of the Affiliated Group or affect the right of any member of the Affiliated Group to terminate the services of any Participant at any time with or without cause or notice, subject to the terms of any written employment agreement executed by both parties thereto.

4.7. *Governing Law.* This Plan is intended to be an unfunded welfare benefit plan for a select group of management or highly compensated employees within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and Department of Labor Regulation 2520.104−24. To the extent applicable and not preempted by ERISA, the laws of the State of California will govern this Plan.

4.8. *Effective Date.* This Plan as restated herein is effective on and after December 4, 2001.

WELLPOINT HEALTH NETWORKS INC.

BY: /s/ LEONARD D. SCHAEFFER DATE: December 4, 2001

LEONARD D. SCHAEFFER

Schedule of Benefits
Applicable To Executive Vice Presidents

Basic Benefit. (Section 3.1)

12 months Base Salary and 100% of Target Bonus (or, if greater, the time period and percentages set forth in any officer severance agreement in effect on October 27, 1998). Participants with over five years of Service will receive one additional week of salary continuation for each completed year of Service in excess of five years, up to a maximum of 13 additional weeks of salary continuation.

Other Benefits. (Section 3.2)

12 Months (or, if greater, the time period set forth in any officer severance agreement in effect on October 27, 1998)

Effective of Divestitures or Other Significant Corporate Transactions. (Section 3.9)

The period referred to in the final sentence of Section 3.9 shall be 12 months (or, if greater, the period referred to under "Other Benefits. (Section 3.2)" directly above).

Schedule of Benefits
Applicable To Senior Vice Presidents

Basic Benefit. (Section 3.1)

9 months Base Salary and 75% of Target Bonus. Participants with over five years of Service will receive one additional week of salary continuation for each completed year of Service in excess of five years, up to a maximum of 13 additional weeks of salary continuation.

Other Benefits. (Section 3.2)

9 Months

Effective of Divestitures or Other Significant Corporate Transactions. (Section 3.9)

The period referred to in the final sentence of Section 3.9 shall be 9 months.

Schedule of Benefits
Applicable To General Managers / Vice Presidents

Basic Benefit. (Section 3.1)

6 months Base Salary and 50% of Target Bonus. Participants with over five years of Service will receive one additional week of salary continuation for each completed year of Service in excess of five years, up to a maximum of 13 additional weeks of salary continuation.

Other Benefits. (Section 3.2)

6 Months

Effective of Divestitures or Other Significant Corporate Transactions. (Section 3.9)

The period referred to in the final sentence of Section 3.9 shall be 6 months.

Schedule of Benefits
Applicable to Staff Vice Presidents / Regional Vice Presidents

Basic Benefit. (Section 3.1)

3 months Base Salary. Participants with over five years of Service will receive one additional week of salary continuation for each completed year of Service in excess of five years, up to a maximum of 13 additional weeks of salary continuation.

Other Benefits. (Section 3.2)

3 Months

Effective of Divestitures or Other Significant Corporate Transactions. (Section 3.9)

The period referred to in the final sentence of Section 3.9 shall be 3 months.

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Exhibit 10.33

WELLPOINT HEALTH NETWORKS INC.
2000 EMPLOYEE STOCK OPTION PLAN

ARTICLE ONE

GENERAL PROVISIONS

1.1 **PURPOSE OF THE PLAN**

This WellPoint Health Networks Inc. 2000 Employee Stock Option Plan ("*Plan*") was originally adopted effective February 17, 2000, (the "*Effective Date*"), to enable WellPoint Health Networks Inc. (the "*Company*") to offer stock options to non−executive officers of the Company or any affiliate. The Plan was amended and restated effective as of October 19, 2001.

1.2 **ELIGIBILITY**

The following individuals ("*Eligible Individuals*") are be eligible to be granted stock options under the Plan: Each employee of the Company or of an affiliate ("*Affiliate*") of the Company linked to the Company by a 50% or greater chain of ownership or in which the Company has a significant ownership interest, directly or indirectly (as determined by the Committee, as defined below) who, on the date of grant or such date before the grant as the Committee shall specify for administrative purposes is not an executive officer of the Company.

1.3 **ADMINISTRATION OF THE PLAN**

A. *Committee.* The Plan will be administered by a committee or committees appointed by the Board of Directors of the Company (the "*Board*") and consisting of two or more members of the Board. If no committee is appointed, the Board will serve as the committee. The term "*Committee*," when used in this Plan, refers to the committee that has been delegated authority with respect to a matter, or to the Board if no committee has been delegated such authority. Members of a committee will serve for such term as the Board may determine, and may be removed by the Board at any time.

B. *Authority.* The Committee has full authority to administer the Plan within the scope of its delegated responsibilities, including authority to interpret and construe any relevant provision of the Plan, to adopt rules and regulations that it deems necessary, to determine which individuals are Eligible Individuals, to determine which Eligible Individuals shall be granted options under the Plan, to determine the amount and/or number of shares subject to such options, and to determine the terms of such an option (which terms need not be identical). Decisions of a Committee made within the discretion delegated to it by the Board are final and binding on all persons.

1.4 **STOCK SUBJECT TO THE PLAN**

A. *Number of Shares.* Shares of the Company's Common Stock ("*Common Stock*") available for issuance under the Plan will be drawn from the Company's authorized but unissued shares of Common Stock or from reacquired shares of Common Stock, including shares purchased by the Company on the open market. The number of shares of Common Stock that may be issued under the Plan will not exceed 4,500,000, subject to adjustment in accordance with Paragraph C below.

B. *Share Counting.* In determining whether the number of shares issued under the Plan exceeds the maximum number set forth in Paragraph 1.4.A., only the net number of shares actually issued under an option shall count against the limit. Thus, if any outstanding option under the Plan expires, is terminated, is cancelled or is forfeited for any reason before the full number of shares governed by the option grant are issued, those remaining shares will not be charged against the limit in Paragraph 1.4.A. above and will be available for subsequent option grants under the Plan. If shares held by an optionee are delivered to the Company, or are withheld from shares otherwise issuable under the option, in

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payment of all or a portion of the exercise price or tax withholding obligations under the option, only the net number of shares issued by the Company (i.e., the gross number less the shares delivered or withheld) shall be counted toward the limit of Paragraph 1.4.A.

C. *Adjustments.* If any change is made to the Common Stock issuable under the Plan by reason of any stock split, stock dividend, recapitalization, combination of shares, exchange of shares or other change affecting the outstanding Common Stock as a class without receipt of consideration, then the Committee shall make appropriate adjustments to (i) the maximum number and/or class of securities issuable under the Plan and (ii) the number and/or class of securities and price per share in effect under each option outstanding under the Plan. The purpose of these adjustments will be to preclude the enlargement or dilution of rights and benefits under the options.

ARTICLE TWO

TERMS OF OPTIONS

2.1 **TERMS AND CONDITIONS OF OPTIONS**

A. *Type and Term.* All options granted under the Plan shall be non−qualified options not intended to satisfy the requirements for incentive stock options under Section 422 of the Internal Revenue Code.

B. *Price and Exercisability.* The option price per share and the period or periods within the term of an option that such option may be exercised will be fixed by the Committee.

C. *Exercise and Payment.* After any option granted under the Plan becomes exercisable, it may be exercised by notice to the Company at any time before termination of the option. The option price will be payable in full in cash or check made payable to the Company or, subject to such limitations as the Committee may determine, in one or more of the following alternative forms:

(1) in shares of Common Stock valued as of the Exercise Date (defined below) and held by the optionee for the requisite period to avoid a charge to earnings; or

(2) through a sale and remittance procedure under which the option holder delivers in such form as the Committee shall authorize an exercise notice and irrevocable instructions to a broker to promptly deliver to the Company the amount of sale proceeds to pay the option price.

For purposes of Subparagraph (2) immediately above, the "*Exercise Date*" is the date on which notice, in such form as the Committee shall authorize, of the exercise of the option is delivered to the Company. In all other cases, the Exercise Date is the date on which notice and actual payment is received by the Company.

An option may provide, subject to such restrictions as the Committee may specify, that, to the extent that the exercise price of an option (or the Federal, State and local income and employment tax withholding obligations attributable thereto) is paid in shares of Common Stock (whether delivered to the Company by the holder or withheld from shares otherwise issuable upon exercise), the holder will automatically be granted a new option covering the number of shares so delivered or withheld; the terms of the new option shall generally be the same as the option so exercised, except that the per share exercise price of the new option shall be the fair market value of one share of Common Stock on the date of grant of the new option and the term of the new option shall be equal to the remaining term of the option so exercised.

D. *Stockholder Rights.* An option holder will have no stockholder rights with respect to any shares covered by an option before the Exercise Date of the option, as defined in the immediately preceding Paragraph.

E. *Separation from Service.* The Committee will determine and set forth in each option whether the option will continue to be exercisable, and the terms of such exercise, on and after the date that an optionee ceases to be employed by or to provide services to the Company or an Affiliate. The date of termination of an optionee's employment or services will be determined by the Committee, which determination will be final.

F. *Transferability.* During the lifetime of the optionee, options will be exercisable only by the optionee and will not be assignable or transferable by the optionee otherwise than by will or by the laws of descent and distribution following the optionee's death. However, if and to the extent that the Committee so authorizes at the time an option is granted or amended, an option may be assigned in whole or in part during the optionee's lifetime to one or more members of the optionee's family or an entity in which the optionee or a member of the optionee's family holds an interest.

2.2 **CORPORATE TRANSACTIONS**

The Committee may determine and set forth in each option, either at the time of grant or by amendment thereafter, the effect, if any, that any sale of stock or assets, merger, combination, spinoff, reorganization, or liquidation of the Company will have upon the term, exercisability and/or vesting of outstanding options, provided that any options that are continued, assumed or replaced with comparable awards in connection with any transaction will be adjusted as provided in Section 1.4.C. The grant of options under this Plan will in no way affect the right of the issuer of Common Stock to adjust, reclassify, reorganize, or otherwise change its capital or business structure or to merge, consolidate, dissolve, liquidate or sell or transfer all or any part of its business or assets.

ARTICLE THREE

MISCELLANEOUS

3.1 **AMENDMENT**

A. *Board Action.* The Board may amend, suspend or discontinue the Plan in whole or in part at any time; provided, however, that (1) such action shall not adversely affect a holder's rights and obligations with respect to options at the time outstanding under the Plan and (2) the Board may condition any amendment upon the approval of the Company's stockholders, if and to the extent that the Board determines that stockholder approval is required by applicable law or regulatory standards or is otherwise advisable.

B. *Modification of Options.* The Committee has full power and authority to modify or waive any or all of the terms, conditions or restrictions applicable to any outstanding option under the Plan, to the extent not inconsistent with the Plan; provided, however, that no such modification or waiver shall, without the consent of the holder of the option, adversely affect the holder's rights thereunder.

3.2 **TAX WITHHOLDING**

A. *Obligation.* The Company's obligation to deliver shares or cash upon the exercise of options under the Plan is subject to the satisfaction of all applicable Federal, State and local income and employment tax withholding requirements.

B. *Stock Withholding.* The Committee may require or permit, in its discretion and upon such terms and conditions as it may deem appropriate, any or all holders of outstanding options under the Plan to elect to have the Company withhold, from the shares of Common Stock otherwise issuable pursuant to such option, one or more of such shares with an aggregate Fair Market Value equal to the Federal, State and local income and employment taxes ("Taxes") incurred in connection with the acquisition of such shares. Holders of options under the Plan may also be granted the right to deliver previously acquired shares of Common Stock held for the requisite period to avoid a charge to earnings

in satisfaction of such Taxes. The withheld or delivered shares will be valued at Fair Market Value on the applicable determination date for such Taxes.

3.3 **VALUATION**

For all purposes under this Plan, the fair market value per share of Common Stock on any relevant date under the Plan ("*Fair Market Value*") will be determined as follows:

(1) *National Exchange.* If the Common Stock is at the time listed or admitted to trading on any national stock exchange, then the Fair Market Value will be the closing selling price per share of Common Stock on the day before the date in question on the stock exchange determined by the Committee to be the primary market for the Common Stock, as such price is officially quoted in the composite tape of transactions on such exchange. If there is no reported sale of Common Stock on such exchange on the day before the date in question, then the Fair Market Value will be the closing selling price on the exchange on the last preceding date for which such quotation exists.

(2) *NASDAQ.* If the Common Stock is not at the time listed or admitted to trading on any national stock exchange but is traded in the over−the−counter market, the fair market value will be the mean between the highest bid and lowest asked prices (or, if such information is available, the closing selling price) per share of Common Stock on the date in question in the over−the−counter market, as such prices are reported by the National Association of Securities Dealers through its NASDAQ system or any successor system. If there are no reported bid and asked prices (or closing selling price) for the Common Stock on the date in question, then the mean between the highest bid price and lowest asked price (or the closing selling price) on the last preceding date for which such quotations exist will be determinative of fair market value.

(3) *Committee.* Notwithstanding the foregoing, if the Committee determines that, as a result of circumstances existing on any date, the use of the above rules is not a reasonable method of determining Fair Market Value on that date or if Common Stock is not at the time listed or admitted to trading as outlined above, the Committee may use such other method as, in its judgment, is reasonable.

3.4 **EFFECTIVE DATE AND TERM OF PLAN**

A. *Effective Date.* This Plan becomes effective on the Effective Date.

B. *Term.* The Committee may grant options under the Plan at any time after the Effective Date of the Plan and before the Plan is terminated by the Board.

3.5 **REGULATORY APPROVALS**

The implementation of the Plan, any option grants under the Plan, and the issuance of stock pursuant to any option granted under the Plan is subject to the procurement by the Company of all approvals and permits required by regulatory authorities having jurisdiction over the Plan, option grants made under the Plan, and stock issued pursuant to the Plan.

3.6 **NO EMPLOYMENT/SERVICE RIGHTS**

Neither the establishment of this Plan, nor any action taken under the terms of this Plan, nor any provision of this Plan will be construed to grant any individual the right to remain in the employ or service of the Company (or any subsidiary or parent of the Company) for any period of specific duration, and the Company (or any subsidiary or parent of the Company retaining the services of such individual) may terminate such individual's employment or service at any time and for any reason, with or without cause; provided that nothing contained in this Plan or in any option granted under this Plan

will affect any contractual rights of the Company or an employee pursuant to a written employment agreement executed by the parties thereto.

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Exhibit 10.35

WELLPOINT HEALTH NETWORKS INC.
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN
(As restated effective December 4, 2001)

ARTICLE I
PURPOSE

The purpose of the WellPoint Health Networks Inc. Supplemental Executive Retirement Plan is to provide additional retirement benefits to selected executives of WellPoint Health Networks Inc. and its affiliates and to provide additional incentives for them to remain in employment with WellPoint and its affiliates. The Plan was adopted effective June 1, 2000 and restated effective December 4, 2001.

This Plan is intended to be a plan that is unfunded and that is maintained by WellPoint Health Networks Inc. primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA").

ARTICLE II
DEFINITIONS

In this Plan, the following terms have the meanings indicated below:

2.1 *"Committee"* means the Compensation Committee of the Board of Directors of the Company, as constituted from time to time. The Committee has full discretionary authority to administer and interpret the Plan, to determine eligibility for Plan benefits, to select employees for Plan participation, and to correct errors. The Committee may delegate its duties and responsibilities and, unless the Committee expressly provides to the contrary, any such delegation will carry with it the Committee's full discretionary authority to accomplish the delegation. Decisions of the Committee and its delegate will be final and binding on all persons.

2.2 *"Company"* means WellPoint Health Networks Inc. and any successor to substantially all of the assets or business of WellPoint Health Networks Inc. that, by appropriate action, adopts this Plan.

2.3 *"Final Average Pay"* means for each Participant the average annual salary and target annual bonus for the last five (5) Years of Benefit Service (or the total Years of Benefit Service if fewer than five (5)).

2.4 *"Other Plan Offset Amount"* means the benefit which is payable to a Participant (or his or her spouse) from (i) the WellPoint Health Networks Inc. Pension Accumulation Plan, as amended from time to time, (ii) the Supplemental Pension Benefit portion of the WellPoint Health Networks Inc. Comprehensive Executive Non−Qualified Retirement Plan, as amended from time to time, (iii) any other defined benefit pension plan maintained at any time by a WellPoint Company or an entity that is or was acquired by a WellPoint Company, or which merges or consolidates with a WellPoint Company, or which acquires a WellPoint Company, (iv) if determined by the Committee at the time that an individual commences participation in the Plan, under a defined benefit pension plan of a predecessor employer of the Participant or (v) any annuity contract acquired under or upon termination of such plan. If any such benefit is payable other than in the form of a single life annuity or at a different time than the benefits payable under this Plan, the Other Plan Offset attributable thereto will be adjusted using the applicable actuarial assumptions that would be in effect under the WellPoint Health Networks Inc. Pension Accumulation Plan with respect to that Participant' s benefits on the date that benefits under this Plan become payable.

2.5 *"Participant"* means a current or former officer of a WellPoint Company who has been selected by the Committee for participation in this Plan and has received written notice of such participation. An individual who becomes a Participant shall remain a Participant so long as he or she

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retains an accrued benefit under the Plan, but further accrual of benefits will be subject to the terms of the Plan.

2.6 *"Plan"* means this WellPoint Health Networks Inc. Supplemental Executive Retirement Plan, as amended from time to time.

2.7 *""WellPoint Company"* means the Company and any other entity while that entity is a parent or a subsidiary of the Company.

2.8 *"Years of Benefit Service"* means the total of a Participant's Years of Service, provided that (i) when the individual first becomes a Participant, the Committee may exclude certain Years of Service rendered before he or she becomes a Participant, (ii) the Committee may include all or a portion of a Participant's service rendered to an entity before it becomes a WellPoint Company, and (iii) the Committee may at any time cease future accrual of Years of Benefit Service for a Participant. A Participant may be credited with fractional Years of Benefit Service.

2.9 *"Year of Service"* means each 365 days of service rendered by a Participant for a WellPoint Company.

2.10 *"Year of Vesting Service"* means each Year of Service rendered by a Participant for a WellPoint Company after the later of January 1, 2000 or the date that the individual commences participation in the Plan.

ARTICLE III
AMOUNT OF BENEFIT

3.1 *Retirement Benefit.*

(a) *Normal Retirement.* If a Participant terminates employment on or after attaining age sixty−two (62) and after completing five (5) full years of vesting service, the Participant shall be entitled to receive an annual retirement benefit for life, payable in monthly installments beginning on the first day of the month on or after such termination that, before reduction for the Other Plan Offset Amount, equals (i) his or her Applicable Retirement Percentage multiplied by (ii) his or her Final Average Pay and (iii) if the Participant has less than fifteen (15) Years of Benefit Service, multiplied by a fraction the numerator of which is the Participant's full Years of Benefit Service and the denominator of which is fifteen (15). The Applicable Retirement Percentage for each Participant shall be either fifty (50%) or sixty (60%) as designated by the Committee at the time that the Participant is selected for participation in the Plan; provided that the Committee may, in its sole discretion after participation commences, either change the Applicable Percentage applicable to future Years of Benefit Service from 50% to 60% or vice versa or increase the percentage from 50% to 60% applicable to all Years of Benefit Service.

(b) *Early Retirement.* If a Participant terminates employment before attaining age sixty−two (62), but after completing five (5) full Years of Vesting Service, the Participant may elect to receive benefits on the first day of any month beginning on or after the later of the date of termination or attainment of age fifty−five (55), but not later than the first day of the month on or after attainment of age sixty−two (62). The annual retirement benefit (before reduction for the Other Plan Offset Amount) shall be the benefit computed in accordance with subsection (a), based on the number of Years of Benefit Service the Participant has actually completed as of commencement of retirement benefits, reduced by 6.75% for each year (or .5625% for each full calendar month) that benefits commence before the first day of the month on or after the Participant would attain age sixty−two (62).

(c) *Other Plan Offset Amount.* The amount of the single life annuity payable to a Participant pursuant to subparagraph (a) or (b) above shall be further reduced by the Other Plan Offset Amount.

3.2 *Other Terminations.* Except as provided in Section 3.3 below, if a Participant terminates employment with all WellPoint Companies before completing five (5) full Years of Vesting Service, no benefits shall be payable under the Plan to or on behalf of such Participant.

3.3 *Certain Terminations.* If a Participant's employment is terminated under circumstances that would make such Participant eligible for benefits under the WellPoint Health Networks Inc. Officer Change−in−Control Plan, as in effect on the date of adoption of this Plan or such termination, then (i) such Participant shall be deemed to have five (5) full Years of Vesting Service at the time of such termination for purposes of Sections 3.1 and 3.2 and (ii) such Participant shall, for purposes of this Plan, be credited with such number of additional Years of Benefit Service, and shall be deemed to be older by such number of years, as is set forth in the Officer Change in Control Plan.

ARTICLE IV
DISTRIBUTIONS

4.1 *Distribution of Benefits.* A Participant must elect the manner in which his or her benefits will be paid out by following the procedures described below and by satisfying such additional requirements as the Committee may reasonably determine.

(a) *Elections.* When a Participant first confirms his initial participation in the Plan, the Participant must elect, in writing, which of the distribution options described below will govern payment of the Participant's benefits.

(b) *Timing.* A Participant's benefits will be distributed, based on the Participant's election under (a) above, beginning with the first day of the month beginning after the later of the Participant's termination of employment with all WellPoint Companies or attainment of age fifty−five (55) or, if later, the date, if any, specified by the Participant in his election. Any date specified by the Participant must be at least twelve (12) full calendar months from the date of the election and in no event later than the date on which the Participant would attain age sixty−two (62).

(c) *Form.* A Participant's benefits will be distributed, based on the Participant's election under (a) above, in one of the following forms: (i) a single life annuity payable to the Participant during his or her lifetime and ending with the date of the Participant's death; or (ii) a joint and survivor annuity payable to the Participant during his or her lifetime and ending with the date of the Participant's death, with provision for the continuance of retirement benefits to the spouse to whom the Participant is married on the date that benefit distributions begin under this Plan during the lifetime of such spouse in an amount equal to fifty percent (50%) or one hundred percent (100%) of the monthly benefit paid to the Participant prior to the Participant's death. If the Participant elects a joint and survivor annuity, the amount payable during the Participant's lifetime and the amount on which the continuing survivor benefit will be based will be determined using the actuarial assumptions that would be in effect for the Participant under the WellPoint Health Networks Inc. Pension Accumulation Plan on the date that benefits under this Plan become payable.

(d) *Subsequent Elections.* Subject to approval by the Committee and to the requirements of Sections 4.1(b) and 4.1(c) above, a Participant may change a distribution election as to timing or form by submitting the change to the Committee in writing. A subsequent election will be valid only if the distribution commences more than twelve (12) months after the date of such

subsequent election and if the prior specified distribution date would have commenced more than twelve (12) months after the date of the election change.

(e) *Default.* If the Committee does not have a proper distribution election on file for a Participant, the Participant's benefits will begin in the form of a single life annuity on the first day of the month beginning after the later of the Participant's termination of employment with all WellPoint Companies or the Participant's attainment of age fifty−five (55).

4.2 *Withholding.* The Company will deduct from Plan payouts, or from other compensation payable to a Participant or his or her spouse, amounts required by law to be withheld for taxes with respect to benefits under this Plan.

ARTICLE V
PRE−RETIREMENT DEATH BENEFIT

If a Participant who has completed at least five (5) full Years of Vesting Service dies before commencement of retirement benefits under the Plan, the spouse (if any) to whom the Participant is married on the date of his or her death shall be entitled to receive an annual survivor benefit payable in monthly installments beginning on the first day of the month beginning after the later of the date of the Participant's death or the date the Participant would have attained age fifty−five (55) and ending with the date of the surviving spouse's death. The annual survivor benefit will be equal to the survivor benefit that the spouse would have received had the Participant commenced receipt of benefits on the date that such survivor benefits begin in the form of a fifty percent (50%) joint and survivor annuity.

ARTICLE VI
NON−COMPETITION REQUIREMENT

Notwithstanding any other provision of the Plan, if a Participant at any time without the prior written approval of the Committee, engages, directly or indirectly (including, but not limited to, as a director, principal, partner, venturer, employee, consultant or agent), or has any direct or indirect interest, in any business similar to or competitive with that being carried on by a WellPoint Company or affiliate at the time of the Participant's termination of employment in any area of the world where any WellPoint Company or an affiliate carries on such business, no further benefit payments shall be made under the Plan to the Participant or his or her spouse after the Participant first so engages in, or acquires an interest, in such business. Included within the meaning of an indirect interest for purposes of this Article VI is, by way of example only, an interest in a trust, corporation, venture or partnership which, in turn, owns an interest in any such business, or an interest in any such business through a nominee, agent, option or other device. However, nothing in this Article VI will prevent a Participant from serving on boards of companies for which he serves as a director on the date that he or she becomes a Participant, or from owning an interest in a mutual fund or an interest of no more than one percent (1%) of the outstanding equity interest of a corporation whose stock is listed on a national stock market. If any of the provisions of this Article VI would contravene or be invalid under any applicable law, such contravention or invalidity shall not invalidate all of the provisions of this Article VI, but rather this Article VI shall be construed insofar as such law is concerned as not containing the particular provision or provisions held to be invalid in said state and the rights and obligations shall be construed and enforced accordingly.

ARTICLE VII
MISCELLANEOUS

7.1 *Limitation of Rights.* Participation in this Plan does not give any individual the right to be retained in the service of any entity. Subject to the terms of any written employment agreement executed by both parties thereto, both the WellPoint Companies and each Participant reserve the right

to terminate the Participant's employment at any time for any or no reason and with or without advance notice.

7.2 *Claims Procedure.* If a Participant or his or her spouse ("Claimant") believes that he or she is entitled to a greater benefit under the Plan, the Claimant may submit a signed, written application to the Committee. The Claimant will generally be notified of the approval or denial of this application within 90 days of the date that the Committee receives the application. If the claim is denied, the notification will state specific reasons for the denial and the Claimant will have 60 days to file a signed, written request for a review of the denial with the Committee. This request will include the reasons for requesting a review, facts supporting the request and any other relevant comments. The Committee, operating pursuant to its discretionary authority to administer and interpret the Plan and to determine eligibility for benefits under the terms of the Plan, will generally make a final, written determination of the Claimant's eligibility for benefits within 60 days of receipt of the request for review.

After satisfaction of the claims procedures described above, any remaining dispute shall be subject to arbitration.

7.3 *Assignment.* To the fullest extent permitted by law, benefits under the Plan and rights thereto are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or his spouse.

7.4 *Inability to Locate Recipient.* If a benefit under the Plan remains unpaid for two years from the date it becomes payable, solely by reason of the inability of the Committee to locate a Participant or his or her spouse entitled to the payment, the benefit shall be treated as forfeited. Any amount forfeited in this manner shall be restored without interest upon presentation of an authenticated written claim by the person entitled to the benefit.

7.5 *Amendment and Termination.* The Company may amend or terminate the Plan at any time, provided that no amendment or termination may adversely affect a Participant's rights under the Plan with respect to benefits already accrued based on Years of Benefit Service rendered before, and Final Average Pay determined as of, the date of such amendment or termination, without the Participant's written consent. Notwithstanding the above, upon termination of the Plan, the Company may satisfy its obligations to each Participant hereunder by making a current single sum cash payment equal to the present value of the Participant's then accrued benefit, based on reasonable actuarial assumptions adopted by the Committee. In addition, the Company may amend the Plan to restrict a Participant's right to change his or her election with respect to the timing and form of benefit, if and to the extent that the Company deems necessary to avoid the constructive receipt of benefits by Participants for tax purposes before actual distribution of benefits. Any amendment to the Plan must be made in writing; no oral amendment will be effective.

7.6 *Applicable Law.* To the extent not governed by Federal law, the laws of the State of California govern the Plan. If any provision of the Plan is held to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

7.7 *No Funding.* The Plan constitutes a mere promise by the Company to make payments in the future in accordance with the terms of the Plan. A Participant and his or her surviving spouse shall have the status of general unsecured creditors of the Company. Except to the extent provided below in Section 7.8, Plan benefits will be paid from the general assets of the Company and nothing in the Plan will be construed to give a Participant or any other person rights to any specific assets of the WellPoint Companies. In all events, it is the intention of the WellPoint Companies that the Plan be treated as unfunded for tax purposes and for purposes of Title I of ERISA.

7.8 *Trust.* Except to the extent the Committee determines otherwise before a benefit is credited under the Plan, Plan benefits will be paid from the assets of a grantor trust (the "Trust") established by the Company to assist it in meeting its obligations and, to the extent that such assets are not sufficient,

by the Company. The Trust shall conform to the terms of the Internal Revenue Service Model Trust as described in Internal Revenue Service Procedure 92−64.

7.9 *Plan Year*. The Plan Year of the Plan shall be the calendar year.

7.10 *Predecessor Employer Benefits.* Each Participant shall identify the amount and provide the Committee or its delegate with written materials from any predecessor employer showing the calculation of benefits payable to the Participant under the predecessor's defined benefit pension plan, if benefits from such plan are to be included in the Other Plan Offset Amount.

IN WITNESS WHEREOF, WellPoint Health Networks Inc. has caused this Plan to be executed by its duly authorized representative on the date indicated below.

WELLPOINT HEALTH NETWORKS INC.

By: /s/ LEONARD D. SCHAEFFER December 4, 2001

Date

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Exhibit 10.46

CALIFORNIA BLUE CROSS LICENSE ADDENDUM
AMENDED AND RESTATED AS OF JANUARY 31, 2002

This License Addendum ("this Addendum") has been amended and restated as of January , 2002 (the "date hereof") by the Blue Cross and Blue Shield Association ("BCBSA"), and WellPoint Health Networks Inc. ("WellPoint"). Capitalized terms not otherwise defined herein shall have the meanings given them in Article VII of WellPoint's Charter.

Whereas: It is fundamental to the integrity of the Blue Cross and Blue Shield names and marks that each primary licensee remain independent of any control or influence by any particular economic interest or other special interest which might impair its ability to (i) exercise independent judgment as to the programs which will best meet the needs of the communities in the state or area for which it is responsible or (ii) function as an integral part of the Blue Cross and Blue Shield national system of health benefits.

Whereas: WellPoint was incorporated in Delaware for the purpose of becoming the ultimate parent corporation in an organization (the "WellPoint Organization") which among other things provides health care plans and related services in California under the "Blue Cross" name and under various related marks.

Whereas: WellPoint has assumed its position as the ultimate parent in the WellPoint Organization as a result of a number of inter−related actions which are collectively called the "Reincorporation" in this Addendum. The Reincorporation occurred effective as of August 4, 1997.

Whereas: Prior to the Reincorporation, the WellPoint Organization was headed by a corporation incorporated in California which had the name "WellPoint Health Networks Inc." (and which is called "California Blue Cross" in this Addendum). As a result of the Reincorporation: (i) every share of common stock issued by California Blue Cross and outstanding immediately prior to the Reincorporation was converted into a share of common stock issued by WellPoint; (ii) California Blue Cross became an indirect wholly owned subsidiary of WellPoint; and (iii) the name of California Blue Cross was changed to "Blue Cross of California."

Whereas: Prior to May 1996, California Blue Cross was organized as a nonprofit public benefit corporation. In May 1996, California Blue Cross was converted into a for−profit business stock corporation as part of a series of interrelated actions which in this Addendum are collectively called the "1996 For−Profit Conversion." As part of the 1996 For−Profit Conversion, California Blue Cross issued shares of its common stock to a California nonprofit public benefit corporation which (i) then had the name "Western Health Partnerships," (ii) now has the name "California HealthCare Foundation," and (iii) is called the "California Foundation" in this Addendum. The common shares issued to the California Foundation (i) represented a substantial majority of California Blue Cross's common stock outstanding immediately after the 1996 For−Profit Conversion and (ii) carried voting power significantly in excess of the amount which BCBSA's licensing requirements allow to be concentrated in the hands of any single shareholder of a primary licensee.

Whereas: To mitigate the risks and disadvantages of the concentration of common stock in the hands of the California Foundation (i) certain mechanisms and covenants (the "Original Basic Protections") were incorporated in the Articles of Incorporation and Bylaws governing California Blue Cross and in agreements between California Blue Cross and the California Foundation and (ii) California Blue Cross entered into a License Addendum dated as of May 17, 1996 (the "Original Addendum") which provided among other things that the primary Blue Cross license for the WellPoint Organization would automatically terminate if there were any failure to comply with any of the Original Basic Protections specified in the Original Addendum.

Whereas: In the Reincorporation, the common stock previously held by the California Foundation in California Blue Cross was converted on a share for share basis to common stock issued by WellPoint

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in the Reincorporation. The California Foundation held the same percentage of WellPoint's common stock outstanding immediately after the Reincorporation as the percentage of the outstanding common stock which the California Foundation held in California Blue Cross immediately prior to the Reincorporation. The voting power attributable to the WellPoint common stock held by the California Foundation immediately after the Reincorporation was, and as of the date hereof continues to be, significantly higher than the percentage that BCBSA's licensing requirements allow to be concentrated in the hands of any single shareholder of a primary licensee. As of the date hereof, to the knowledge of WellPoint, the California Foundation no longer owns any shares of WellPoint common stock or any other outstanding securities of WellPoint.

Whereas: In connection with the Reincorporation, WellPoint requested that notwithstanding the concentration of its common stock in the hands of the California Foundation resulting from the Reincorporation, BCBSA issue the following licenses (the "New Licenses"): a Primary Blue Cross License to WellPoint to replace the primary license held prior to the Reincorporation by California Blue Cross; a Controlled Affiliate License to California Blue Cross to entitle it to conduct operations in California under the Blue Cross name; and various other affiliate licenses to other WellPoint subsidiaries to enable them to continue to conduct operations under the "Blue Cross" name and/or related names.

Whereas: To induce BCBSA to issue the New Licenses, WellPoint: (i) incorporated into its Certificate of Incorporation and Bylaws mechanisms designed to protect WellPoint from being controlled by the California Foundation (or any other large shareholder which might emerge in the future) which are analogous to the mechanisms previously incorporated into California Blue Cross' governing instruments; (ii) agreed with the California Foundation and California Blue Cross to amend and restate the agreements previously made by California Blue Cross with the California Foundation to obtain for WellPoint the benefit of the covenants in those agreements designed to protect WellPoint from 2 being controlled by the California Foundation; and (iii) entered into a new license addendum dated August 4, 1997 (the "Delaware Addendum") to take the place of the Original Addendum.

Whereas: The parties entered into an amendment and restatement of the Delaware Addendum (which is dated as of December 30, 1997 and is herein called the "12−30−97 Restatement") in order to, among other things, (i) implement revised restrictions on beneficial ownership of WellPoint securities embodied in Section 2.1(f) hereof, and (ii) modify the definition of the term "Ownership Limit."

Whereas: The parties entered into an amendment and restatement of the License Addendum (which is dated as of June 12, 1998 and is herein called the "6−12−98 Restatement") in order, among other things, to reflect an amendment dated as of June 12, 1998 to a voting trust agreement (which has since terminated) under which the California Foundation had the ability to effect certain changes in the composition of its Board in exchange for earlier contributions of its shares to the voting trust created thereunder.

Whereas: WellPoint has entered into that certain Agreement and Plan of Merger dated as of October 17, 2001 (the "Merger Agreement"), pursuant to which RightCHOICE Managed Care, Inc. will be merged with and into a wholly owned subsidiary of WellPoint (the "RightCHOICE Merger"). The RightCHOICE Merger is being consummated as of the date hereof.

Whereas: As part of the RightCHOICE Merger, the Missouri Foundation for Health is receiving 4,805,200 shares of WellPoint common stock (the "Foundation Shares"), representing approximately 6.7% of the outstanding voting securities of WellPoint. The Missouri Foundation for Health is called the "Missouri Foundation" in this addendum.

Whereas: It remains fundamental to the integrity of the Blue Cross and Blue Shield names and marks that each primary licensee remain independent of any control or influence by any particular economic interest or other special interest which might impair its ability to (i) exercise independent

judgment as to the programs which will best meet the needs of the communities in the state or area for which it is responsible or (ii) function as an integral part of the Blue Cross and Blue Shield national system of health benefits.

Whereas: In connection with the RightCHOICE Merger, WellPoint has requested that, notwithstanding the concentration of its common stock in the hands of the Missouri Foundation resulting from the RightCHOICE Merger, the BCBSA grant a waiver of the Ownership Limit in the Primary Blue Cross License.

The parties hereby amend and restate the License Addendum to read as follows:

1. *Waiver.* BCBSA hereby agrees that the ownership of WellPoint shares by the Missouri Foundation in excess of the number permitted by the Primary Blue Cross License will not be deemed to provide grounds for termination of the Primary Blue Cross License so long as the conditions specified in Part 2 of this Addendum are satisfied. In order to obtain the waiver in the preceding sentence, WellPoint agrees that its right to hold and utilize the Primary Blue Cross License will at all times be subject to the conditions in Part 2 of this Addendum and hereby covenants not to take or allow any action which could provide grounds for termination of the Primary Blue Cross License.

2. *Automatic Termination.*

2.1

Except as otherwise expressly provided in this Part 2, WellPoint's Primary Blue Cross License shall automatically terminate effective at the end of the Applicable Interval following the occurrence of any of the following events:

(a)

Any of the provisions in Article VII of WellPoint's Charter or any of the other Basic Protections identified in Section 3.5 shall expire or be amended (other than to extend its term), eliminated or otherwise impaired, the WellPoint board of directors takes any action that materially impairs or eliminates WellPoint's ability to eliminate any ownership of WellPoint shares in excess of the limits set forth in Sections 2.1(c), (e) and (f) of this Addendum, or any person shall be permitted, by the ruling of any court or otherwise, to take any action contrary to the terms of any of the Basic Protections without the written consent of BCBSA.

(b)

At any time before the date that the Missouri Foundation no longer Beneficially Owns WellPoint shares representing 5.0% or more of the voting power (the "Divestiture Completion Date"), the Missouri Foundation shall not be independent of all federal, state, local and other governmental authority over its affairs including any authority over the composition and membership of its Board of Directors, other than customary regulatory powers exercised by the Missouri Attorney General over similarly situated entities, provided that the nomination, selection and/or election of directors of the Missouri Foundation in accordance with the provisions of the Articles of Incorporation and Bylaws for the Missouri Foundation as constituted on the date hereof shall not be deemed to breach this Section 2.1(b) (other than the election or other appointment of any person to the Missouri Foundation Board who is an officer, agent, employee or independent contractor of any governmental authority, whether federal, state or local).

(c)

The Missouri Foundation Beneficially Owns WellPoint shares not on deposit in the Voting Trust identified in Section 3.5(b)(4) representing 5.0% or more of the voting power at any time on or after the date hereof.

(d)

At any time on or after the first anniversary of the date of this addendum (the "Divestiture Deadline"), the Missouri Foundation Beneficially Owns WellPoint shares representing 5.0% or more of the voting power.

(e)

The Missouri Foundation shall at any time before the Divestiture Completion Date become Beneficial Owner of any WellPoint shares except for (i) the common stock issued to the Missouri Foundation in the RightCHOICE Merger and (ii) common stock issued to the Missouri Foundation in connection with stock dividends, stock splits, recapitalizations and other events in which the Missouri Foundation receives the same consideration per common share owned prior to such event as every other holder of common stock and in which the voting power and percentage ownership interest represented by the Foundation Shares does not increase.

(f)

(i)

any Institutional Investor shall become the Beneficial Owner of WellPoint shares representing 10% or more of the voting power of WellPoint (an "Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(ii)

any Noninstitutional Investor other than the Missouri Foundation shall become the Beneficial Owner of WellPoint shares representing 5.0% or more of the voting power of WellPoint (an "Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(iii)

any person shall become the Beneficial Owner of 20% or more of WellPoint's then−outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 2.6 below (each, an "Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(iv)

WellPoint consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which WellPoint is the surviving entity and immediately after which merger no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

For the purposes hereof, a person shall be deemed to be an "Institutional Investor" if (but only if) (x) such person is an entity or group identified in Rule 13d−1(b)(1)(ii) of the rules and regulations promulgated under the Securities Exchange Act of 1934 (the "Exchange Act") as constituted on June 1, 1997, and (y) every filing made by such person with the Securities and Exchange Commission under Regulation 13D−G (or any successor Regulation) under the Exchange Act with respect to such person's Beneficial Ownership shall have contained a certification having substantially identical terms to the one required by Item 10 of Schedule 13G as constituted on June 1, 1997. For the purposes hereof, the term "Noninstitutional Investor" means any person who is not an Institutional Investor.

(g)

The Voting Trust Agreement identified in Section 3.5(b)(2) (the "Voting Trust Agreement") shall be amended, eliminated or otherwise impaired or any person shall take, or be permitted, by the ruling of any court or otherwise, to take any action contrary to any of the terms of the Voting Trust Agreement; the Missouri Foundation shall breach any of its covenants in Article V of the Voting Trust Agreement; the voting trust established by the Voting Trust Agreement (the "Voting Trust") shall expire or otherwise cease to exist other than as a result of the termination of the Voting Trust Agreement; except for the Undeposited Shares, any of the Foundation Shares shall be voted in any manner contrary to the express terms in the Voting Trust Agreement; except for the Undeposited Shares, any of the Foundation Shares shall not be held on deposit in the

Voting Trust and subject to all of the provisions in the Voting Trust Agreement from the time the Missouri Foundation acquires Beneficial Ownership of that Foundation Share until the sale of that Foundation Share in a manner that complies with the Voting Trust Agreement; or any of the Foundation Shares shall be withdrawn from the Voting Trust for any reason other than a sale consummating at the time of such withdrawal that causes the Missouri Foundation to cease to Beneficially Own that Foundation Share. The term "Undeposited Shares" means Foundation Shares which (i) have not been deposited in the voting trust established by the Voting Trust Agreement and (ii) in the aggregate are at all times less than 5.0% of the outstanding common stock of WellPoint and, if WellPoint shall issue any equity security other than common stock, are less than 5.0% of the outstanding common stock and less than levels of ownership of WellPoint equity securities that (but for this Addendum) could provide a basis for termination of the WellPoint Primary Licenses as then constituted.

(h)

Any shares known by WellPoint to be Excess Shares shall not be voted in accordance with the terms in Section 9 of Article VII of WellPoint's Charter as constituted on the date hereof.

(i)

At any time prior to the Divestiture Completion Date, less than 80% of the positions on the WellPoint Board shall be held by Independent Directors, and at any time thereafter, less than 50% of the positions on the WellPoint Board shall be held by Independent Directors.

(j)

WellPoint shall fail to comply with the requirements of Part 4 of this Addendum.

(k)

Any of WellPoint's representations and warranties contained in Section 6.4 of this Addendum shall be incorrect in any material respect at any time (whether or not true when made, and whether or not WellPoint or any other person knew or could have known that they were or are incorrect).

2.2 *Applicable Interval.*

(a)

The "Applicable Interval" with respect to any event specified in clause (b) or (j) of Section 2.1 shall begin upon the occurrence of that event and shall end on the 40th day after WellPoint shall first learn of such event.

(b)

The "Applicable Interval" with respect to any event specified in clause (f) (i), or (ii) or (iii) or clause (g) of Section 2.1 shall begin upon the occurrence of that event and shall end on the 30th day after the earlier of the time WellPoint shall first learn of such event or the occurrence of a public filing with the Securities and Exchange Commission disclosing such event.

(c)

The "Applicable Interval" with respect to any event specified in any other clause of Section 2.1 shall begin upon the occurrence of that event and shall end on the 10th day after WellPoint shall first learn of such event.

2.3 *Waiver.* WellPoint shall have the right to request any time prior to the expiration of the Applicable Interval that any termination which would otherwise be caused by the occurrence of any event listed in Section 2.1 be waived. Once such request has been made by WellPoint to BCBSA, the Primary Blue Cross License and any related controlled affiliate licenses shall be deemed to remain in full force and effect until a determination has been made by BCBSA. Such determination shall be made by BCBSA's disinterested member plans and any requested waiver shall be deemed to have been denied unless it shall be approved at the meeting called to consider such waiver by the affirmative vote of a majority of the disinterested BCBSA member plans and a majority of the then current weighted vote of the disinterested BCBSA member plans. Any such waiver may be conditioned upon such

additional requirements (including but not limited to requirements imposing new independent grounds for termination of the Primary Blue Cross License) as shall be approved by such vote by the disinterested BCBSA member plans.

2.4 *Notice.* WellPoint shall notify BCBSA in writing immediately after WellPoint learns of (i) the occurrence of any event specified in Section 2.1 or (ii) any development or state of facts which it is reasonably possible will lead to the occurrence of any event specified in Section 2.1.

2.5 *No Implied Exemption for Other Changes.* The references in the definitions of "WellPoint's Charter," "WellPoint's Bylaws" and "Voting Trust Agreement" to possible future amendments thereto or to instruments which may supersede such original instruments in the future shall not be deemed to exempt any amendment or replacement of any such instrument from the operation of Section 2.1 and any such amendment or replacement shall be deemed to cause an automatic termination at the end of the Applicable Interval if it changes or impacts any of the terms of the Basic Protections in a manner which causes such termination under the terms in Section 2.1.

2.6 *Restrictions on Issuance of Securities.* WellPoint shall not issue any class or series of securities other than (i) shares of common stock having identical terms or options or derivatives of common stock; (ii) non−voting, non−convertible debt securities; or (iii) such other securities as WellPoint may approve, provided that BCBSA shall receive notice at least 30 days prior to the issuance of such securities, including a description of the terms of such securities, and BCBSA shall have the authority to determine how such securities will be counted in determining whether any person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

3. *Definitions.* The following terms shall have the following meanings as used herein:

3.1 *Primary Blue Cross License.* The term "Primary Blue Cross License" means the license to use the Blue Cross name and all other rights granted under or by reason of the Blue Cross License Agreement dated as of August 4, 1997 between BCBSA and WellPoint and under any amendments or supplements to, or restatements or replacements of, that Agreement. The Primary Blue Cross License shall at all times be subject to this Addendum and in the event of any conflict between the Primary Blue Cross License and this Addendum, this Addendum shall control. In the event the Primary Blue Cross License shall terminate, such termination shall have the effect of terminating the right of any WellPoint subsidiary to use the Blue Cross name and all other names or rights licensed from BCBSA.

3.2 *Voting Power.* The WellPoint shares Beneficially Owned by any particular person shall be deemed to represent a percentage of the voting power equal to the percentage of all votes which could be cast in any election of any WellPoint director which could be accounted for by the shares Beneficially Owned by that particular person. If in connection with an election for any particular position on the WellPoint Board, shares in different classes or series are entitled to be voted together for purposes of such election, then in determining the number of "all votes which could be cast" in the election for that particular position for purposes of the preceding sentence, the number shall be equal to the number of votes which would be cast in the election for that particular position if all shares entitled to be voted in such election (regardless of series or class) were in fact voted in such election. If WellPoint shall issue any series or class of shares for which positions on the Board are reserved or shall otherwise issue shares which have voting rights which can arise or vary based upon terms governing that class or series, then the percentage of the voting power represented by the WellPoint shares Beneficially Owned by any particular person shall be the highest percentage of the total votes which could be accounted for by those shares in any election of any director.

3.3 *WellPoint Share.* The term "WellPoint share" designates and includes a share of common stock and a share (or other basic unit) of any class or series of any other equity security which WellPoint may at any time issue or be authorized to issue.

3.4 *Beneficial Ownership:*

(a)

Except as otherwise provided in Section 3.4(b), any particular person shall be deemed to Beneficially Own and to be the Beneficial Owner of:

(1)

Any WellPoint share in which such person shall then have a direct or indirect beneficial ownership interest;

(2)

Any WellPoint share in which such person shall have the right to acquire any direct or indirect beneficial ownership interest pursuant to any option or other agreement (either immediately or after the passage of time or the occurrence of any contingency);

(3)

Any WellPoint share which such person shall have the right to vote;

(4)

Any WellPoint share (i) which constitutes an "Excess Share" under Article VII of WellPoint's Charter or any successor to such provision and (ii) of which such person is the "Purported Owner" under such Article VII (or has an equivalent position under any such successor provision);

(5)

Any WellPoint share in which such person shall hold any other interest which would count in determining whether such person would be required to file a Schedule 13D; and

(6)

Any WellPoint share which shall be Beneficially Owned (under the concepts provided in the preceding clauses) by any affiliate or associate of the particular person or by any other person with whom the particular person or any such affiliate or associate has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities or other than that certain Registration Rights Agreement between WellPoint and the Missouri Foundation dated as of October 17, 2001) relating to the acquisition, holding, voting or disposing of any WellPoint shares. For purposes of this Addendum, the terms "affiliate" and "associate" have the same meanings they have under Rule 12b−2 under the Exchange Act as such Rule is constituted and interpreted on June 1, 1997.

(b)

Exceptions:

(1)

A person shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of any particular WellPoint shares by reason of possessing the right to vote if (i) such right arises solely from a revocable proxy or consent given to such person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act, and (ii) such person is not the Purported Owner of any Excess Shares (as those terms are used in Article VII of WellPoint's Charter), is not named as holding a beneficial ownership interest in any WellPoint shares in any filing on Schedule 13D, and is not an affiliate or associate of any such Purported Owner or named person.

(2)

A member of a national securities exchange or a registered depository shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of any particular WellPoint shares held directly or indirectly by it on behalf of another person (and not for its own account) solely because such member or depository is the record holder of such WellPoint shares, and (in the case of such member) pursuant to the rules of such exchange, such member may direct the vote of those WellPoint shares without instruction on matters which are uncontested and do not affect substantially the rights or the privileges of the holders of the shares to be voted, but is precluded by the rules of such exchange from voting those particular WellPoint shares without instruction on either

contested matters or matters that may affect substantially the rights or the privileges of the holders of the WellPoint shares to be voted.

(3)

A person who in the ordinary course of business is a pledgee of WellPoint shares under a written pledge agreement shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of those pledged WellPoint shares solely by reason of such pledge until the pledgee has taken all formal steps which are necessary to declare a default or has otherwise acquired the power to vote or to direct the vote of such pledged WellPoint shares, provided that:

(A)

The pledge agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of WellPoint, nor in connection with any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as constituted on June 1, 1997; and

(B)

The pledge agreement does not grant to the pledgee the right to vote or to direct the vote of such pledged WellPoint shares prior to the time the pledgee has taken all formal steps which are necessary to declare a default.

(4)

A person engaged in business as an underwriter or a placement agent for securities who enters into an agreement to acquire or acquires any particular WellPoint shares solely by reason of its participation in good faith and in the ordinary course of its business in the capacity of underwriter or placement agent in any underwriting or agent representation registered under the Securities Act of 1933, as amended and as constituted on the date hereof (the "Securities Act"), a bona fide private placement, a resale under Rule 144A promulgated under the Securities Act or in any foreign or other offering exempt from the registration requirements under the Securities Act shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of those particular WellPoint shares until the expiration of forty (40) days after the date of such acquisition so long as (i) such person does not vote such WellPoint shares during such period and (ii) such participation is not with the purpose or with the effect of changing or influencing control of WellPoint, nor in connection with or facilitating any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997.

(5)

If WellPoint shall sell shares in a transaction not involving any public offering, then each purchaser in such offering shall be deemed to obtain Beneficial Ownership in such offering of the shares purchased by such purchaser but no particular purchaser shall be deemed to have acquired Beneficial Ownership in such offering of shares purchased by any other purchaser solely by reason of the fact that all such purchasers are parties to customary agreements relating to the purchase of equity securities directly from WellPoint in a transaction not involving a public offering, provided that:

(A)

All the purchasers are persons specified in Rule 13d−1(b)(1)(ii) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997;

(B)

The purchase is in the ordinary course of each purchaser's business and not with the purpose nor with the effect of changing or influencing control of WellPoint, nor in connection with or as a participant in any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997;

(C)

There is no agreement among or between any purchasers to act together with respect to WellPoint or any WellPoint shares except for the purpose of facilitating the specific purchase involved; and

(D)

The only actions among or between any purchasers with respect to WellPoint or its securities subsequent to the closing date of the nonpublic offering are those which are necessary to conclude ministerial matters directly related to the completion of the offer or sale of the WellPoint shares sold in such offering.

3.5 *Basic Protections:*

(a)

The term "Basic Protections" designates and includes the following provisions in WellPoint's Charter: Section 1 of Article IV; all provisions in Article VII and Article IX; and the provision in Article XI which requires the affirmative vote of at least 75% of each class of WellPoint shares, represented and voting at a duly held meeting at which a quorum is present, voting by class to amend any of the provisions cited in this sentence or to amend Sections 2, 6, 8 or 10 in Article IV of WellPoint's Charter. (The term "WellPoint's Charter" as used in this Addendum means WellPoint's Restated Certificate of Incorporation as in effect from time to time after the date hereof. In the event WellPoint's Charter shall be replaced by another governing instrument as a result of a merger, a reorganization or other similar event, if any, then the term "WellPoint's Charter" shall thereafter refer to such other governing instrument and the citations and terms used in this agreement shall be deemed adjusted to refer to the appropriate provisions in such subsequent instrument.)

(b)

Until the Diversity Goal (identified in Section 3.6) is achieved, the term "Basic Protections" also means:

(1)

Sections 2, 6, 8, and 10 in Article IV in WellPoint's Charter.

(2)

The Voting Trust Agreement. (The term "Voting Trust Agreement" whenever it is used in this Addendum means the Voting Trust Agreement dated as of the date hereof between the Missouri Foundation and Wilmington Trust Company. In the event the agreement in the preceding sentence shall be amended after the dated hereof, then the term "Voting Trust Agreement" shall thereafter mean that agreement as so amended. In the event the Voting Trust Agreement shall be replaced by another agreement as a result of a merger, a reorganization or other similar event, if any, then the term "Voting Trust Agreement" shall thereafter refer to that replacement agreement and the citations and terms used in this agreement shall be deemed adjusted to refer to the appropriate provisions in that replacement agreement. The term "Voting Trust" whenever it is used in this Addendum means the voting trust governed by the Voting Trust Agreement.)

3.6

Diversity Goal. The Missouri Foundation's Diversity Goal shall be deemed to be achieved when the Missouri Foundation shall Beneficially Own WellPoint shares representing less than 5% of the voting power and shall not be an Excess Owner.

3.7

Independent Director. Any particular individual shall be deemed to be a "Independent Director" if (but not unless) such individual

(a)

either (i) is W. Toliver Besson, Roger E. Birk, Sheila P. Burke, Stephen L. Davenport, Julie A. Hill, Warren Y. Jobe, Elizabeth A. Sanders or Leonard D. Schaeffer or (ii) was elected to the Board after the date hereof with the approval of two thirds of the directors then in office who then constituted Independent Directors, and

(b)

does not Beneficially Own WellPoint shares which represent more than 5% of the voting power, and

(c)

was not nominated or promoted by a person who Beneficially Owns WellPoint shares representing more than 5% of the voting power or who is an "Excess Owner" and, prior to such individual's election, did not have any agreement, arrangement or understanding with any such Beneficial Owner with respect to any action to be taken by such individual as a director.

3.8 *Exchange Act.* The term "Exchange Act" means the Securities Exchange Act of 1934 as amended or supplemented at the time as of which the term shall be applied and any other federal law which BCBSA shall reasonably judge to have replaced or supplemented the coverage of the Securities Exchange Act of 1934 as in effect on the date hereof.

3.9 *Schedule 13D.* The term "Schedule 13D" means a report on Schedule 13D under Regulation 13D under the Exchange Act as constituted on the date hereof and any report which may be required in the future under any requirement which BCBSA shall reasonably judge to have any of the purposes served by Schedule 13D on the date hereof.

3.10

Ownership Limit.

(a)

From and after June 12, 1998, the term "Ownership Limit" defined in Article VII of WellPoint's Restated Certificate of Incorporation shall for all purposes mean the following:

(1)

For all stockholders that are Noninstitutional Investors (as defined herein), that number of shares of Capital Stock one share lower than the number of shares of Capital Stock which would represent 5% of the Voting Power (as defined in the Restated Certificate of Incorporation); and

(2)

For all stockholders that are Institutional Investors (as defined herein), that number of shares of Capital Stock one share lower than the number of shares of Capital Stock which would represent 10% of the Voting Power.

(b)

The parties hereto intend that the revisions contained herein to the definition of the term "Ownership Limit" shall constitute an agreement in writing between the parties hereto within the meaning of Section 14(f)(2) of Article VII of WellPoint's Restated Certificate of Incorporation and as such shall apply to the interpretation of such term for all purposes under WellPoint's Restated Certificate of Incorporation.

4.

Commitment to Use Blue Cross Marks.

4.1 WellPoint covenants that all Relevant Businesses conducted in the State of California by WellPoint or any of its affiliates will be conducted after the date hereof under the name "Blue Cross of California" and will be conducted utilizing the Blue Cross name and marks in identifying such business. The term "Relevant Businesses" means all health care benefits businesses which were conducted on February 13, 1996 by California Blue Cross or its subsidiary which then had the name "CaliforniaCare Health Plans" and the businesses in California which may develop or evolve from those businesses after February 13, 1996. The term "Relevant Businesses" shall not include (except as provided in Section 4.2) the business acquired by California Blue Cross from Massachusetts Mutual Life Insurance Company on March 31, 1996 (the "MassMutual Business") and shall not include WellPoint's workers' compensation managed care services business.

4.2 On or prior to May 17, 2001, the MassMutual Business composed of accounts with California headquarters ("California Accounts") were transitioned to being offered by WellPoint, California Blue Cross, or BC Life & Health Insurance Company and after such transition have used and shall continue to use the Blue Cross name and marks to the extent required by this Part 4 for businesses operated by those companies. No new California Accounts shall become part of the MassMutual Business after May 17, 1996, but rather all new accounts with California headquarters arising after May 17, 1996 shall be offered by WellPoint, California Blue Cross, or BC Life & Health Insurance Company and shall use

the Blue Cross name and marks to the extent required by this Part 4 for businesses operated by those companies.

4.3 BC Life & Health Insurance Company and WellPoint shall take the actions necessary so that BC Life & Health Insurance Company (i) continuously meets all qualifications necessary to hold a controlled affiliate license from BCBSA, (ii) utilizes the Blue Cross of California name and Blue Cross marks in marketing materials, (iii) identifies its products in marketing materials as being brought to its subscribers by "Blue Cross of California," and (iv) shall identify itself in marketing materials as an affiliate of Blue Cross of California.

4.4 The covenants in this Part 4 are in addition to and distinct from WellPoint's obligations under the Primary Blue Cross License. For purposes of this Part 4 only, the term "affiliate" does not include the California Foundation or the Missouri Foundation.

5. *No Other Waiver.* Nothing herein shall constitute a waiver of BCBSA's rights to terminate the Primary Blue Cross License for any reason allowed under the Primary Blue Cross License other than the reason expressly waived in Part 1 of this Addendum. All agreements, understandings or other circumstances which were made or arose prior to the issuance of the Primary Blue Cross License granting WellPoint, California Blue Cross or any of their respective subsidiaries or predecessors licenses or rights in the Blue Cross name or other rights licensed by BCBSA are hereby terminated effective as of the issuance of the Primary Blue Cross License, and neither WellPoint nor California Blue Cross nor any of their respective affiliates shall have any rights under or by reason of such earlier agreements, understandings or other circumstances. The rights of WellPoint, California Blue Cross and their respective subsidiaries to use the Blue Cross name and other rights licensed by BCBSA shall instead be derived from the date of issuance of the Primary Blue Cross License exclusively from the Primary Blue Cross License and related written agreements granted on or after the time of the issuance of the Primary Blue Cross License. The Delaware Addendum shall govern during the period from the issuance of the Primary Blue Cross License to but not including December 30, 1997; the terms of the 12−30−97 Restatement shall govern from and including December 30,1997 to but not June 12, 1998; the terms of 6−12−98 Restatement shall govern from and including June 12, 1998 to but not including the date hereof; and the terms of this amendment and restatement of the License Addendum shall govern from and after the date hereof.

6. *Miscellaneous*

6.1 WellPoint shall not assign its rights or obligations under this Addendum to any other person without the prior written consent of BCBSA. BCBSA shall have the right to assign its rights under this Addendum to any corporation or other entity which shall assume any of its responsibility for the Blue Cross name or other rights licensed under the Primary Blue Cross License Agreement. This Addendum and the provisions hereof shall be binding upon each of the parties, and their successors and assigns, and shall inure to the benefit of each party's successors and permitted assignees.

6.2 Any term or provision of this Addendum may be amended, and the observance of any term of this Addendum may be waived (either generally or in a particular instance and either retroactively or prospectively) only by a writing signed by the party to be bound thereby. Without limiting by implication the generality of the preceding sentence, every time any event listed in Section 2.1 shall occur, it shall constitute a separate and self−sufficient cause for automatic termination of the Primary Blue Cross License regardless of whether any prior occurrence of such event or any other event shall have been waived absolutely or conditionally. The failure of any party to enforce any of the provisions hereof shall not be construed to be a waiver of the right of such party thereafter to enforce such provisions.

6.3 Each of the parties acknowledges that the other party will be irreparably harmed and that there will be no adequate remedy at law for a violation of any of the covenants of the other party set

forth herein. Therefore, it is agreed that, in addition to any other remedies that may be available to either party to this Addendum in connection with any such violation or prospective violation, such party shall have the right to enforce such covenant by specific performance, by injunctive relief or by any other means available to such party at law or in equity.

6.4 WellPoint warrants to BCBSA that: (i) the RightCHOICE Merger identified in the proxy statement/prospectus dated December 12, 2001 by WellPoint and RightCHOICE has become effective in Delaware on the terms and with the effect described in that proxy statement / prospectus; (ii) WellPoint provided BCBSA prior to the date hereof with complete and accurate copies of WellPoint's Charter, WellPoint's Bylaws, the Voting Trust Agreement and the Registration Rights Agreement as constituted on the date hereof; (iii) there has been no change to any of the things cited in clause (ii); (iv) the Missouri Foundation has executed and delivered the Voting Trust Agreement and the Registration Rights Agreement; (v) there are no agreements or understandings that govern the rights or obligations of WellPoint or the Missouri Foundation with respect to each other except those cited in clause (iv); (vi) on the date hereof, the Missouri Foundation Beneficially Owns approximately 6.7% of WellPoint's common stock outstanding; (vii) no person other than the Missouri Foundation and T. Rowe Price Associatess Beneficially Owns WellPoint shares representing more than 5.0% of the voting power; (viii) on the date hereof and after giving effect to the consummation of the RightCHOICE Merger, there are no WellPoint shares outstanding other than Common Stock and WellPoint has no obligation to issue any equity securities other than Common Stock; and (ix) the Board of Directors of WellPoint is on the date hereof composed exclusively of the individuals previously identified to the BCBSA as the individuals who will serve on such Board immediately after completion of the RightCHOICE Merger. For purposes of the foregoing sentence, the terms "WellPoint shares" and "equity securities" shall not include options to purchase WellPoint Common Stock under WellPoint's employee benefit plans or WellPoint's Zero Coupon Convertible Subordinated Debentures due 2019.

6.5 The internal laws of the State of Illinois (irrespective of its choice of law principles) shall govern all issues concerning the validity of this Addendum, the construction of its terms, and the interpretation and enforcement of the rights and duties of the parties.

Each of the parties has executed this amendment and restatement of the New Addendum to evidence its agreement to be bound by all of its terms.

Blue Cross and Blue Shield Association

By: /s/ SCOTT P. SEROTA

Name: Scott P. Serota
Title: *President*

WellPoint Health Networks Inc.
(a Delaware corporation identified herein as "WellPoint")

By: /s/ LEONARD D. SCHAEFFER

Name: Leonard D. Schaeffer
Title: *Chairman and Chief Executive Officer*

QuickLinks

CALIFORNIA BLUE CROSS LICENSE ADDENDUM AMENDED AND RESTATED AS OF JANUARY 31, 2002

QuickLinks −− Click here to rapidly navigate through this document

Exhibit 10.47

CALIFORNIA BLUE SHIELD LICENSE ADDENDUM
AMENDED AND RESTATED AS OF JANUARY 31, 2002

This License Addendum ("this Addendum") has been amended and restated as of January , 2002 (the "date hereof") by the Blue Cross and Blue Shield Association ("BCBSA"), and WellPoint Health Networks Inc. ("WellPoint"). Capitalized terms not otherwise defined herein shall have the meanings given them in Article VII of WellPoint's Charter.

Whereas: It is fundamental to the integrity of the Blue Cross and Blue Shield names and marks that each primary licensee remain independent of any control or influence by any particular economic interest or other special interest which might impair its ability to (i) exercise independent judgment as to the programs which will best meet the needs of the communities in the state or area for which it is responsible or (ii) function as an integral part of the Blue Cross and Blue Shield national system of health benefits.

Whereas: WellPoint was incorporated in Delaware for the purpose of becoming the ultimate parent corporation in an organization (the "WellPoint Organization") which among other things provides health care plans and related services in California under the "Blue Cross" name and under various related marks.

Whereas: WellPoint has assumed its position as the ultimate parent in the WellPoint Organization as a result of a number of inter−related actions which are collectively called the "Reincorporation" in this Addendum. The Reincorporation occurred effective as of August 4, 1997.

Whereas: Prior to the Reincorporation, the WellPoint Organization was headed by a corporation incorporated in California which had the name "WellPoint Health Networks Inc." (and which is called "California Blue Cross" in this Addendum). As a result of the Reincorporation: (i) every share of common stock issued by California Blue Cross and outstanding immediately prior to the Reincorporation was converted into a share of common stock issued by WellPoint; (ii) California Blue Cross became an indirect wholly owned subsidiary of WellPoint; and (iii) the name of California Blue Cross was changed to "Blue Cross of California."

Whereas: Prior to May 1996, California Blue Cross was organized as a nonprofit public benefit corporation. In May 1996, California Blue Cross was converted into a for−profit business stock corporation as part of a series of interrelated actions which in this Addendum are collectively called the "1996 For−Profit Conversion." As part of the 1996 For−Profit Conversion, California Blue Cross issued shares of its common stock to a California nonprofit public benefit corporation which (i) then had the name "Western Health Partnerships," (ii) now has the name "California HealthCare Foundation," and (iii) is called the "California Foundation" in this Addendum. The common shares issued to the California Foundation (i) represented a substantial majority of California Blue Cross's common stock outstanding immediately after the 1996 For−Profit Conversion and (ii) carried voting power significantly in excess of the amount which BCBSA's licensing requirements allow to be concentrated in the hands of any single shareholder of a primary licensee.

Whereas: To mitigate the risks and disadvantages of the concentration of common stock in the hands of the California Foundation (i) certain mechanisms and covenants (the "Original Basic Protections") were incorporated in the Articles of Incorporation and Bylaws governing California Blue Cross and in agreements between California Blue Cross and the California Foundation and (ii) California Blue Cross entered into a License Addendum dated as of May 17, 1996 (the "Original Addendum") which provided among other things that the primary Blue Cross license for the WellPoint Organization would automatically terminate if there were any failure to comply with any of the Original Basic Protections specified in the Original Addendum.

Whereas: In the Reincorporation, the common stock previously held by the California Foundation in California Blue Cross was converted on a share for share basis to common stock issued by WellPoint

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in the Reincorporation. The California Foundation held the same percentage of WellPoint's common stock outstanding immediately after the Reincorporation as the percentage of the outstanding common stock which the California Foundation held in California Blue Cross immediately prior to the Reincorporation. The voting power attributable to the WellPoint common stock held by the California Foundation immediately after the Reincorporation was, and as of the date hereof continues to be, significantly higher than the percentage that BCBSA's licensing requirements allow to be concentrated in the hands of any single shareholder of a primary licensee. As of the date hereof, to the knowledge of WellPoint, the California Foundation no longer owns any shares of WellPoint common stock or any other outstanding securities of WellPoint.

Whereas: In connection with the Reincorporation, WellPoint requested that notwithstanding the concentration of its common stock in the hands of the California Foundation resulting from the Reincorporation, BCBSA issue the following licenses (the "New Licenses"): a Primary Blue Cross License to WellPoint to replace the primary license held prior to the Reincorporation by California Blue Cross; a Controlled Affiliate License to California Blue Cross to entitle it to conduct operations in California under the Blue Cross name; and various other affiliate licenses to other WellPoint subsidiaries to enable them to continue to conduct operations under the "Blue Cross" name and/or related names.

Whereas: To induce BCBSA to issue the New Licenses, WellPoint: (i) incorporated into its Certificate of Incorporation and Bylaws mechanisms designed to protect WellPoint from being controlled by the California Foundation (or any other large shareholder which might emerge in the future) which are analogous to the mechanisms previously incorporated into California Blue Cross' governing instruments; (ii) agreed with the California Foundation and California Blue Cross to amend and restate the agreements previously made by California Blue Cross with the California Foundation to obtain for WellPoint the benefit of the covenants in those agreements designed to protect WellPoint from 2 being controlled by the California Foundation; and (iii) entered into a new license addendum dated August 4, 1997 (the "Delaware Addendum") to take the place of the Original Addendum.

Whereas: The parties entered into an amendment and restatement of the Delaware Addendum (which is dated as of December 30, 1997 and is herein called the "12−30−97 Restatement") in order to, among other things, (i) implement revised restrictions on beneficial ownership of WellPoint securities embodied in Section 2.1(f) hereof, and (ii) modify the definition of the term "Ownership Limit."

Whereas: The parties entered into an amendment and restatement of the License Addendum (which is dated as of June 12, 1998 and is herein called the "6−12−98 Restatement") in order, among other things, to reflect an amendment dated as of June 12, 1998 to a voting trust agreement (which has since terminated) under which the California Foundation had the ability to effect certain changes in the composition of its Board in exchange for earlier contributions of its shares to the voting trust created thereunder.

Whereas: WellPoint has entered into that certain Agreement and Plan of Merger dated as of October 17, 2001 (the "Merger Agreement"), pursuant to which RightCHOICE Managed Care, Inc. will be merged with and into a wholly owned subsidiary of WellPoint (the "RightCHOICE Merger"). The RightCHOICE Merger is being consummated as of the date hereof.

Whereas: As part of the RightCHOICE Merger, the Missouri Foundation for Health is receiving 4,805,200 shares of WellPoint common stock (the "Foundation Shares"), representing approximately 6.7% of the outstanding voting securities of WellPoint. The Missouri Foundation for Health is called the "Missouri Foundation" in this addendum.

Whereas: It remains fundamental to the integrity of the Blue Cross and Blue Shield names and marks that each primary licensee remain independent of any control or influence by any particular economic interest or other special interest which might impair its ability to (i) exercise independent

judgment as to the programs which will best meet the needs of the communities in the state or area for which it is responsible or (ii) function as an integral part of the Blue Cross and Blue Shield national system of health benefits.

Whereas: In connection with the RightCHOICE Merger, WellPoint has requested that, notwithstanding the concentration of its common stock in the hands of the Missouri Foundation resulting from the RightCHOICE Merger, the BCBSA grant a waiver of the Ownership Limit in the Primary Blue Shield License.

The parties hereby amend and restate the License Addendum to read as follows:

1.

Waiver. BCBSA hereby agrees that the ownership of WellPoint shares by the Missouri Foundation in excess of the number permitted by the Primary Blue Shield License will not be deemed to provide grounds for termination of the Primary Blue Shield License so long as the conditions specified in Part 2 of this Addendum are satisfied. In order to obtain the waiver in the preceding sentence, WellPoint agrees that its right to hold and utilize the Primary Blue Shield License will at all times be subject to the conditions in Part 2 of this Addendum and hereby covenants not to take or allow any action which could provide grounds for termination of the Primary Blue Shield License.

2.

Automatic Termination.

2.1 Except as otherwise expressly provided in this Part 2, WellPoint's Primary Blue Shield License shall automatically terminate effective at the end of the Applicable Interval following the occurrence of any of the following events:

(a)

Any of the provisions in Article VII of WellPoint's Charter or any of the other Basic Protections identified in Section 3.5 shall expire or be amended (other than to extend its term), eliminated or otherwise impaired, the WellPoint board of directors takes any action that materially impairs or eliminates WellPoint's ability to eliminate any ownership of WellPoint shares in excess of the limits set forth in Sections 2.1(c), (e) and (f) of this Addendum, or any person shall be permitted, by the ruling of any court or otherwise, to take any action contrary to the terms of any of the Basic Protections without the written consent of BCBSA.

(b)

At any time before the date that the Missouri Foundation no longer Beneficially Owns WellPoint shares representing 5.0% or more of the voting power (the "Divestiture Completion Date"), the Missouri Foundation shall not be independent of all federal, state, local and other governmental authority over its affairs including any authority over the composition and membership of its Board of Directors, other than customary regulatory powers exercised by the Missouri Attorney General over similarly situated entities, provided that the nomination, selection and/or election of directors of the Missouri Foundation in accordance with the provisions of the Articles of Incorporation and Bylaws for the Missouri Foundation as constituted on the date hereof shall not be deemed to breach this Section 2.1(b) (other than the election or other appointment of any person to the Missouri Foundation Board who is an officer, agent, employee or independent contractor of any governmental authority, whether federal, state or local).

(c)

The Missouri Foundation Beneficially Owns WellPoint shares not on deposit in the Voting Trust identified in Section 3.5(b)(4) representing 5.0% or more of the voting power at any time on or after the date hereof.

(d)

At any time on or after the first anniversary of the date of this addendum (the "Divestiture Deadline"), the Missouri Foundation Beneficially Owns WellPoint shares representing 5.0% or more of the voting power.

(e)

The Missouri Foundation shall at any time before the Divestiture Completion Date become Beneficial Owner of any WellPoint shares except for (i) the common stock issued to the Missouri Foundation in the RightCHOICE Merger and (ii) common stock issued to the Missouri Foundation in connection with stock dividends, stock splits, recapitalizations and other events in which the Missouri Foundation receives the same consideration per common share owned prior to such event as every other holder of common stock and in which the voting power and percentage ownership interest represented by the Foundation Shares does not increase.

(f)

(i)

any Institutional Investor shall become the Beneficial Owner of WellPoint shares representing 10% or more of the voting power of WellPoint (an "Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(ii)

any Noninstitutional Investor other than the Missouri Foundation shall become the Beneficial Owner of WellPoint shares representing 5.0% or more of the voting power of WellPoint (an "Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(iii)

any person shall become the Beneficial Owner of 20% or more of WellPoint's then−outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 2.6 below (each, an "Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to the end of the Applicable Interval arising from such Beneficial Ownership; or

(iv)

WellPoint consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which WellPoint is the surviving entity and immediately after which merger no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

For the purposes hereof, a person shall be deemed to be an "Institutional Investor" if (but only if) (x) such person is an entity or group identified in Rule 13d−1(b)(1)(ii) of the rules and regulations promulgated under the Securities Exchange Act of 1934 (the "Exchange Act") as constituted on June 1, 1997, and (y) every filing made by such person with the Securities and Exchange Commission under Regulation 13D−G (or any successor Regulation) under the Exchange Act with respect to such person's Beneficial Ownership shall have contained a certification having substantially identical terms to the one required by Item 10 of Schedule 13G as constituted on June 1, 1997. For the purposes hereof, the term "Noninstitutional Investor" means any person who is not an Institutional Investor.

(g)

The Voting Trust Agreement identified in Section 3.5(b)(2) (the "Voting Trust Agreement") shall be amended, eliminated or otherwise impaired or any person shall take, or be permitted, by the ruling of any court or otherwise, to take any action contrary to any of the terms of the Voting Trust Agreement; the Missouri Foundation shall breach any of its covenants in Article V of the Voting Trust Agreement; the voting trust established by the Voting Trust Agreement (the "Voting Trust") shall expire or otherwise cease to exist other than as a result of the termination of the Voting Trust Agreement; except for the Undeposited Shares, any of the Foundation Shares shall be voted in any manner contrary to the express terms in the Voting Trust Agreement; except for the Undeposited Shares, any of the Foundation Shares shall not be held on deposit in the Voting Trust and subject to all of the provisions in the Voting Trust Agreement from the time the Missouri Foundation acquires Beneficial

Ownership of that Foundation Share until the sale of that Foundation Share in a manner that complies with the Voting Trust Agreement; or any of the Foundation Shares shall be withdrawn from the Voting Trust for any reason other than a sale consummating at the time of such withdrawal that causes the Missouri Foundation to cease to Beneficially Own that Foundation Share. The term "Undeposited Shares" means Foundation Shares which (i) have not been deposited in the voting trust established by the Voting Trust Agreement and (ii) in the aggregate are at all times less than 5.0% of the outstanding common stock of WellPoint and, if WellPoint shall issue any equity security other than common stock, are less than 5.0% of the outstanding common stock and less than levels of ownership of WellPoint equity securities that (but for this Addendum) could provide a basis for termination of the WellPoint Primary Licenses as then constituted.

(h)

Any shares known by WellPoint to be Excess Shares shall not be voted in accordance with the terms in Section 9 of Article VII of WellPoint's Charter as constituted on the date hereof.

(i)

At any time prior to the Divestiture Completion Date, less than 80% of the positions on the WellPoint Board shall be held by Independent Directors, and at any time thereafter, less than 50% of the positions on the WellPoint Board shall be held by Independent Directors.

(j)

WellPoint shall fail to comply with the requirements of Part 4 of this Addendum.

(k)

Any of WellPoint's representations and warranties contained in Section 6.4 of this Addendum shall be incorrect in any material respect at any time (whether or not true when made, and whether or not WellPoint or any other person knew or could have known that they were or are incorrect).

2.2 *Applicable Interval.*

(a)

The "Applicable Interval" with respect to any event specified in clause (b) or (j) of Section 2.1 shall begin upon the occurrence of that event and shall end on the 40th day after WellPoint shall first learn of such event.

(b)

The "Applicable Interval" with respect to any event specified in clause (f) (i), or (ii) or (iii) or clause (g) of Section 2.1 shall begin upon the occurrence of that event and shall end on the 30th day after the earlier of the time WellPoint shall first learn of such event or the occurrence of a public filing with the Securities and Exchange Commission disclosing such event.

(c)

The "Applicable Interval" with respect to any event specified in any other clause of Section 2.1 shall begin upon the occurrence of that event and shall end on the 10th day after WellPoint shall first learn of such event.

2.3 *Waiver.* WellPoint shall have the right to request any time prior to the expiration of the Applicable Interval that any termination which would otherwise be caused by the occurrence of any event listed in Section 2.1 be waived. Once such request has been made by WellPoint to BCBSA, the Primary Blue Shield License and any related controlled affiliate licenses shall be deemed to remain in full force and effect until a determination has been made by BCBSA. Such determination shall be made by BCBSA's disinterested member plans and any requested waiver shall be deemed to have been denied unless it shall be approved at the meeting called to consider such waiver by the affirmative vote of a majority of the disinterested BCBSA member plans and a majority of the then current weighted vote of the disinterested BCBSA member plans. Any such waiver may be conditioned upon such additional requirements (including but not limited to requirements imposing new independent grounds for termination of the Primary Blue Shield License) as shall be approved by such vote by the disinterested BCBSA member plans.

2.4 *Notice.* WellPoint shall notify BCBSA in writing immediately after WellPoint learns of (i) the occurrence of any event specified in Section 2.1 or (ii) any development or state of facts which it is reasonably possible will lead to the occurrence of any event specified in Section 2.1.

2.5 *No Implied Exemption for Other Changes.* The references in the definitions of "WellPoint's Charter," "WellPoint's Bylaws" and "Voting Trust Agreement" to possible future amendments thereto or to instruments which may supersede such original instruments in the future shall not be deemed to exempt any amendment or replacement of any such instrument from the operation of Section 2.1 and any such amendment or replacement shall be deemed to cause an automatic termination at the end of the Applicable Interval if it changes or impacts any of the terms of the Basic Protections in a manner which causes such termination under the terms in Section 2.1.

2.6 *Restrictions on Issuance of Securities.* WellPoint shall not issue any class or series of securities other than (i) shares of common stock having identical terms or options or derivatives of common stock; (ii) non−voting, non−convertible debt securities; or (iii) such other securities as WellPoint may approve, provided that BCBSA shall receive notice at least 30 days prior to the issuance of such securities, including a description of the terms of such securities, and BCBSA shall have the authority to determine how such securities will be counted in determining whether any person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

3.

Definitions. The following terms shall have the following meanings as used herein:

3.1 *Primary Blue Shield License.* The term "Primary Blue Shield License" means the license to use the Blue Shield name and all other rights granted under or by reason of the Blue Shield License Agreementbetween BCBSA and WellPoint and under any amendments or supplements to, or restatements or replacements of, that Agreement. The Primary Blue Shield License shall at all times be subject to this Addendum and in the event of any conflict between the Primary Blue Shield License and this Addendum, this Addendum shall control. In the event the Primary Blue Shield License shall terminate, such termination shall have the effect of terminating the right of any WellPoint subsidiary to use the Blue Shield name and all other names or rights licensed from BCBSA.

3.2 *Voting Power.* The WellPoint shares Beneficially Owned by any particular person shall be deemed to represent a percentage of the voting power equal to the percentage of all votes which could be cast in any election of any WellPoint director which could be accounted for by the shares Beneficially Owned by that particular person. If in connection with an election for any particular position on the WellPoint Board, shares in different classes or series are entitled to be voted together for purposes of such election, then in determining the number of "all votes which could be cast" in the election for that particular position for purposes of the preceding sentence, the number shall be equal to the number of votes which would be cast in the election for that particular position if all shares entitled to be voted in such election (regardless of series or class) were in fact voted in such election. If WellPoint shall issue any series or class of shares for which positions on the Board are reserved or shall otherwise issue shares which have voting rights which can arise or vary based upon terms governing that class or series, then the percentage of the voting power represented by the WellPoint shares Beneficially Owned by any particular person shall be the highest percentage of the total votes which could be accounted for by those shares in any election of any director.

3.3 *WellPoint Share.* The term "WellPoint share" designates and includes a share of common stock and a share (or other basic unit) of any class or series of any other equity security which WellPoint may at any time issue or be authorized to issue.

3.4 *Beneficial Ownership:*

(a)

Except as otherwise provided in Section 3.4(b), any particular person shall be deemed to Beneficially Own and to be the Beneficial Owner of:

(1)

Any WellPoint share in which such person shall then have a direct or indirect beneficial ownership interest;

(2)

Any WellPoint share in which such person shall have the right to acquire any direct or indirect beneficial ownership interest pursuant to any option or other agreement (either immediately or after the passage of time or the occurrence of any contingency);

(3)

Any WellPoint share which such person shall have the right to vote;

(4)

Any WellPoint share (i) which constitutes an "Excess Share" under Article VII of WellPoint's Charter or any successor to such provision and (ii) of which such person is the "Purported Owner" under such Article VII (or has an equivalent position under any such successor provision);

(5)

Any WellPoint share in which such person shall hold any other interest which would count in determining whether such person would be required to file a Schedule 13D; and

(6)

Any WellPoint share which shall be Beneficially Owned (under the concepts provided in the preceding clauses) by any affiliate or associate of the particular person or by any other person with whom the particular person or any such affiliate or associate has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities or other than that certain Registration Rights Agreement between WellPoint and the Missouri Foundation dated as of October 17, 2001) relating to the acquisition, holding, voting or disposing of any WellPoint shares. For purposes of this Addendum, the terms "affiliate" and "associate" have the same meanings they have under Rule 12b−2 under the Exchange Act as such Rule is constituted and interpreted on June 1, 1997.

(b)

Exceptions:

(1)

A person shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of any particular WellPoint shares by reason of possessing the right to vote if (i) such right arises solely from a revocable proxy or consent given to such person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act, and (ii) such person is not the Purported Owner of any Excess Shares (as those terms are used in Article VII of WellPoint's Charter), is not named as holding a beneficial ownership interest in any WellPoint shares in any filing on Schedule 13D, and is not an affiliate or associate of any such Purported Owner or named person.

(2)

A member of a national securities exchange or a registered depository shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of any particular WellPoint shares held directly or indirectly by it on behalf of another person (and not for its own account) solely because such member or depository is the record holder of such WellPoint shares, and (in the case of such member) pursuant to the rules of such exchange, such member may direct the vote of those WellPoint shares without instruction on matters which are uncontested and do not affect substantially the rights or the privileges of the holders of the shares to be voted, but is precluded by the rules of such exchange from voting those particular WellPoint shares without instruction on either

contested matters or matters that may affect substantially the rights or the privileges of the holders of the WellPoint shares to be voted.

(3)

A person who in the ordinary course of business is a pledgee of WellPoint shares under a written pledge agreement shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of those pledged WellPoint shares solely by reason of such pledge until the pledgee has taken all formal steps which are necessary to declare a default or has otherwise acquired the power to vote or to direct the vote of such pledged WellPoint shares, provided that:

(A)

The pledge agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of WellPoint, nor in connection with any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as constituted on June 1, 1997; and

(B)

The pledge agreement does not grant to the pledgee the right to vote or to direct the vote of such pledged WellPoint shares prior to the time the pledgee has taken all formal steps which are necessary to declare a default.

(4)

A person engaged in business as an underwriter or a placement agent for securities who enters into an agreement to acquire or acquires any particular WellPoint shares solely by reason of its participation in good faith and in the ordinary course of its business in the capacity of underwriter or placement agent in any underwriting or agent representation registered under the Securities Act of 1933, as amended and as constituted on the date hereof (the "Securities Act"), a bona fide private placement, a resale under Rule 144A promulgated under the Securities Act or in any foreign or other offering exempt from the registration requirements under the Securities Act shall not be deemed to "Beneficially Own" or have "Beneficial Ownership" of those particular WellPoint shares until the expiration of forty (40) days after the date of such acquisition so long as (i) such person does not vote such WellPoint shares during such period and (ii) such participation is not with the purpose or with the effect of changing or influencing control of WellPoint, nor in connection with or facilitating any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997.

(5)

If WellPoint shall sell shares in a transaction not involving any public offering, then each purchaser in such offering shall be deemed to obtain Beneficial Ownership in such offering of the shares purchased by such purchaser but no particular purchaser shall be deemed to have acquired Beneficial Ownership in such offering of shares purchased by any other purchaser solely by reason of the fact that all such purchasers are parties to customary agreements relating to the purchase of equity securities directly from WellPoint in a transaction not involving a public offering, provided that:

(A)

All the purchasers are persons specified in Rule 13d−1(b)(1)(ii) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997;

(B)

The purchase is in the ordinary course of each purchaser's business and not with the purpose nor with the effect of changing or influencing control of WellPoint, nor in connection with or as a participant in any transaction having such purpose or effect, including any transaction subject to Rule 13d−3(b) promulgated under the Exchange Act as such Rule is constituted on June 1, 1997;

(C)

There is no agreement among or between any purchasers to act together with respect to WellPoint or any WellPoint shares except for the purpose of facilitating the specific purchase involved; and

(D)

The only actions among or between any purchasers with respect to WellPoint or its securities subsequent to the closing date of the nonpublic offering are those which are necessary to conclude ministerial matters directly related to the completion of the offer or sale of the WellPoint shares sold in such offering.

3.5

Basic Protections:

(a)

The term "Basic Protections" designates and includes the following provisions in WellPoint's Charter: Section 1 of Article IV; all provisions in Article VII and Article IX; and the provision in Article XI which requires the affirmative vote of at least 75% of each class of WellPoint shares, represented and voting at a duly held meeting at which a quorum is present, voting by class to amend any of the provisions cited in this sentence or to amend Sections 2, 6, 8 or 10 in Article IV of WellPoint's Charter. (The term "WellPoint's Charter" as used in this Addendum means WellPoint's Restated Certificate of Incorporation as in effect from time to time after the date hereof. In the event WellPoint's Charter shall be replaced by another governing instrument as a result of a merger, a reorganization or other similar event, if any, then the term "WellPoint's Charter" shall thereafter refer to such other governing instrument and the citations and terms used in this agreement shall be deemed adjusted to refer to the appropriate provisions in such subsequent instrument.)

(b)

Until the Diversity Goal (identified in Section 3.6) is achieved, the term "Basic Protections" also means:

(1)

Sections 2, 6, 8, and 10 in Article IV in WellPoint's Charter.

(2)

The Voting Trust Agreement. (The term "Voting Trust Agreement" whenever it is used in this Addendum means the Voting Trust Agreement dated as of the date hereof between the Missouri Foundation and Wilmington Trust Company. In the event the agreement in the preceding sentence shall be amended after the dated hereof, then the term "Voting Trust Agreement" shall thereafter mean that agreement as so amended. In the event the Voting Trust Agreement shall be replaced by another agreement as a result of a merger, a reorganization or other similar event, if any, then the term "Voting Trust Agreement" shall thereafter refer to that replacement agreement and the citations and terms used in this agreement shall be deemed adjusted to refer to the appropriate provisions in that replacement agreement. The term "Voting Trust" whenever it is used in this Addendum means the voting trust governed by the Voting Trust Agreement.)

3.6 *Diversity Goal.* The Missouri Foundation's Diversity Goal shall be deemed to be achieved when the Missouri Foundation shall Beneficially Own WellPoint shares representing less than 5% of the voting power and shall not be an Excess Owner.

3.7 *Independent Director.* Any particular individual shall be deemed to be a "Independent Director" if (but not unless) such individual

(a)

either (i) is W. Toliver Besson, Roger E. Birk, Sheila P. Burke, Stephen L. Davenport, Julie A. Hill, Warren Y. Jobe, Elizabeth A. Sanders or Leonard D. Schaeffer or (ii) was elected to the Board after the date hereof with the approval of two thirds of the directors then in office who then constituted Independent Directors, and

(b)

does not Beneficially Own WellPoint shares which represent more than 5% of the voting power, and

(c)

was not nominated or promoted by a person who Beneficially Owns WellPoint shares representing more than 5% of the voting power or who is an "Excess Owner" and, prior to such individual's election, did not have any agreement, arrangement or understanding with any such Beneficial Owner with respect to any action to be taken by such individual as a director.

3.8 *Exchange Act.* The term "Exchange Act" means the Securities Exchange Act of 1934 as amended or supplemented at the time as of which the term shall be applied and any other federal law which BCBSA shall reasonably judge to have replaced or supplemented the coverage of the Securities Exchange Act of 1934 as in effect on the date hereof.

3.9 *Schedule 13D.* The term "Schedule 13D" means a report on Schedule 13D under Regulation 13D under the Exchange Act as constituted on the date hereof and any report which may be required in the future under any requirement which BCBSA shall reasonably judge to have any of the purposes served by Schedule 13D on the date hereof.

3.10 *Ownership Limit.*

(a)

From and after June 12, 1998, the term "Ownership Limit" defined in Article VII of WellPoint's Restated Certificate of Incorporation shall for all purposes mean the following:

(1)

For all stockholders that are Noninstitutional Investors (as defined herein), that number of shares of Capital Stock one share lower than the number of shares of Capital Stock which would represent 5% of the Voting Power (as defined in the Restated Certificate of Incorporation); and

(2)

For all stockholders that are Institutional Investors (as defined herein), that number of shares of Capital Stock one share lower than the number of shares of Capital Stock which would represent 10% of the Voting Power.

(b)

The parties hereto intend that the revisions contained herein to the definition of the term "Ownership Limit" shall constitute an agreement in writing between the parties hereto within the meaning of Section 14(f)(2) of Article VII of WellPoint's Restated Certificate of Incorporation and as such shall apply to the interpretation of such term for all purposes under WellPoint's Restated Certificate of Incorporation.

4.

Commitment to Use Blue Cross Marks.

4.1 WellPoint covenants that all Relevant Businesses conducted in the State of California by WellPoint or any of its affiliates will be conducted after the date hereof under the name "Blue Cross of California" and will be conducted utilizing the Blue Cross name and marks in identifying such business. The term "Relevant Businesses" means all health care benefits businesses which were conducted on February 13, 1996 by California Blue Cross or its subsidiary which then had the name "CaliforniaCare Health Plans" and the businesses in California which may develop or evolve from those businesses after February 13, 1996. The term "Relevant Businesses" shall not include (except as provided in Section 4.2) the business acquired by California Blue Cross from Massachusetts Mutual Life Insurance Company on March 31, 1996 (the "MassMutual Business") and shall not include WellPoint's workers' compensation managed care services business.

4.2 On or prior to May 17, 2001, the MassMutual Business composed of accounts with California headquarters ("California Accounts") were transitioned to being offered by WellPoint, California Blue Cross, or BC Life & Health Insurance Company and after such transition have used and shall continue to use the Blue Cross name and marks to the extent required by this Part 4 for businesses operated by those companies. No new California Accounts shall become part of the MassMutual Business after May 17, 1996, but rather all new accounts with California headquarters arising after May 17, 1996 shall be offered by WellPoint, California Blue Cross, or BC Life & Health Insurance Company and shall use

the Blue Cross name and marks to the extent required by this Part 4 for businesses operated by those companies.

4.3 BC Life & Health Insurance Company and WellPoint shall take the actions necessary so that BC Life & Health Insurance Company (i) continuously meets all qualifications necessary to hold a controlled affiliate license from BCBSA, (ii) utilizes the Blue Cross of California name and Blue Cross marks in marketing materials, (iii) identifies its products in marketing materials as being brought to its subscribers by "Blue Cross of California," and (iv) shall identify itself in marketing materials as an affiliate of Blue Cross of California.

4.4 The covenants in this Part 4 are in addition to and distinct from WellPoint's obligations under the Primary Blue Shield License. For purposes of this Part 4 only, the term "affiliate" does not include the California Foundation or the Missouri Foundation.

5.

No Other Waiver. Nothing herein shall constitute a waiver of BCBSA's rights to terminate the Primary Blue Shield License for any reason allowed under the Primary Blue Shield License other than the reason expressly waived in Part 1 of this Addendum. All agreements, understandings or other circumstances which were made or arose prior to the issuance of the Primary Blue Shield License granting WellPoint, or any of their respective subsidiaries or predecessors licenses or rights in the Blue Shield name or other rights licensed by BCBSA are hereby terminated effective as of the issuance of the Primary Blue Shield License, and neither WellPoint nor any of its affiliates shall have any rights under or by reason of such earlier agreements, understandings or other circumstances. The rights of WellPointand its subsidiaries to use the Blue Shield name and other rights licensed by BCBSA shall instead be derived from the date of issuance of the Primary Blue Shield License exclusively from the Primary Blue Shield License and related written agreements granted on or after the time of the issuance of the Primary Blue Shield License.

6.

Miscellaneous

6.1 WellPoint shall not assign its rights or obligations under this Addendum to any other person without the prior written consent of BCBSA. BCBSA shall have the right to assign its rights under this Addendum to any corporation or other entity which shall assume any of its responsibility for the Blue Shield name or other rights licensed under the Primary Blue Shield License Agreement. This Addendum and the provisions hereof shall be binding upon each of the parties, and their successors and assigns, and shall inure to the benefit of each party's successors and permitted assignees.

6.2 Any term or provision of this Addendum may be amended, and the observance of any term of this Addendum may be waived (either generally or in a particular instance and either retroactively or prospectively) only by a writing signed by the party to be bound thereby. Without limiting by implication the generality of the preceding sentence, every time any event listed in Section 2.1 shall occur, it shall constitute a separate and self−sufficient cause for automatic termination of the Primary Blue Shield License regardless of whether any prior occurrence of such event or any other event shall have been waived absolutely or conditionally. The failure of any party to enforce any of the provisions hereof shall not be construed to be a waiver of the right of such party thereafter to enforce such provisions.

6.3 Each of the parties acknowledges that the other party will be irreparably harmed and that there will be no adequate remedy at law for a violation of any of the covenants of the other party set forth herein. Therefore, it is agreed that, in addition to any other remedies that may be available to either party to this Addendum in connection with any such violation or prospective violation, such party shall have the right to enforce such covenant by specific performance, by injunctive relief or by any other means available to such party at law or in equity.

6.4 WellPoint warrants to BCBSA that: (i) the RightCHOICE Merger identified in the proxy statement/prospectus dated December 12, 2001 by WellPoint and RightCHOICE has become effective

in Delaware on the terms and with the effect described in that proxy statement / prospectus; (ii) WellPoint provided BCBSA prior to the date hereof with complete and accurate copies of WellPoint's Charter, WellPoint's Bylaws, the Voting Trust Agreement and the Registration Rights Agreement as constituted on the date hereof; (iii) there has been no change to any of the things cited in clause (ii); (iv) the Missouri Foundation has executed and delivered the Voting Trust Agreement and the Registration Rights Agreement; (v) there are no agreements or understandings that govern the rights or obligations of WellPoint or the Missouri Foundation with respect to each other except those cited in clause (iv); (vi) on the date hereof, the Missouri Foundation Beneficially Owns approximately 6.7% of WellPoint's common stock outstanding; (vii) no person other than the Missouri Foundation and T. Rowe Price Associates Beneficially Owns WellPoint shares representing more than 5.0% of the voting power; (viii) on the date hereof and after giving effect to the consummation of the RightCHOICE Merger, there are no WellPoint shares outstanding other than Common Stock and WellPoint has no obligation to issue any equity securities other than Common Stock; and (ix) the Board of Directors of WellPoint is on the date hereof composed exclusively of the individuals previously identified to the BCBSA as the individuals who will serve on such Board immediately after completion of the RightCHOICE Merger. For purposes of the foregoing sentence, the terms "WellPoint shares" and "equity securities" shall not include options to purchase WellPoint Common Stock under WellPoint's employee benefit plans or WellPoint's Zero Coupon Convertible Subordinated Debentures due 2019.

6.5 The internal laws of the State of Illinois (irrespective of its choice of law principles) shall govern all issues concerning the validity of this Addendum, the construction of its terms, and the interpretation and enforcement of the rights and duties of the parties.

Each of the parties has executed this amendment and restatement of the New Addendum to evidence its agreement to be bound by all of its terms.

Blue Cross and Blue Shield Association

By: /s/ SCOTT P. SEROTA

Name: Scott P. Serota
Title: *President*

WellPoint Health Networks Inc.
(a Delaware corporation identified herein as "WellPoint")

By: /s/ LEONARD D. SCHAEFFER

Name: Leonard D. Schaeffer
Title: *Chairman and Chief Executive Officer*

QuickLinks

CALIFORNIA BLUE SHIELD LICENSE ADDENDUM AMENDED AND RESTATED AS OF JANUARY 31, 2002

BLUE CROSS

CONTROLLED AFFILIATE LICENSE AGREEMENT

(**Includes revisions adopted by Member Plans through their November 15, 2001 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and RightCHOICE Managed Care, Inc. ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

RightCHOICE Managed Care, Inc.:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Scott P. Serota

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%

Standard 1A, 4

50%

Standard 1B, 4

100% and Primary Business is Government Non−Risk

Standard 4*,10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance

Standards **7A−7E**

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 2 (Guidelines 1.1,1.2) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 6H

No

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates

Standard 2 (Guidelines 1.1,1.3) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates

Standard 6H

Controlled Affiliate's Primary Business is Government Non−Risk

Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes

Standard 3A

No

Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes

Standards 6A−6I

No

Controlled Affiliate is a former primary licensee

Standards 5,8,9,11

Controlled Affiliate is not a former primary licensee

Standards 5,8

Controlled Affiliate's Primary Business is Government Non−Risk

Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter−Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report"as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Captial (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE

CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

BLUE SHIELD

CONTROLLED AFFILIATE LICENSE AGREEMENT

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and RightCHOICE Managed Care, Inc. ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

RightCHOICE Managed Care, Inc.:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

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* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%

Standard 1A, 4

50%

Standard 1B, 4

100% and Primary Business is Government Non−Risk

Standard 4*,10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance

Standards 7A−7E

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 2 (Guidelines 1.1,1.2) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 6H

No

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates

Standard 2 (Guidelines 1.1,1.3) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates

Standard 6H

Controlled Affiliate's Primary Business is Government Non−Risk

Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes

Standard 3A

No

Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes

Standards 6A−6I

No

Controlled Affiliate is a former primary licensee

Controlled Affiliate is not a former primary licensee

Controlled Affiliate's Primary Business is Government Non−Risk

Standards 5,8

Standards 8, 10(C)

Standards 5,8,9,11

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter−Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Capital (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15, 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE

CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

EXHIBIT B (continued)

FOR NON RISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater of less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 10.50

BLUE CROSS

CONTROLLED AFFILIATE LICENSE AGREEMENT

(**Includes revisions adopted by Member Plans through their November 15, 2001 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and Healthy Alliance Life Insurance Company: ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

Amended as of November 16, 2000

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Healthy Alliance Life Insurance Company:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Scott P. Serota

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%

Standard 1A, 4

50%

Standard 1B, 4

100% and Primary Business is Government Non−Risk

Standard 4*,10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance

Standards 7A−7E

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 2 (Guidelines 1.1,1.2) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 6H

No

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates

Standard 2 (Guidelines 1.1,1.3) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates

Standard 6H

Controlled Affiliate's Primary Business is Government Non−Risk

Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes

Standard 3A

No

Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes

Standards 6A−6I

No

Controlled Affiliate is a former primary licensee

Standards 5,8,9,11

Controlled Affiliate is not a former primary licensee

Standards 5,8

Controlled Affiliate's Primary Business is Government Non−Risk

Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter−Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in

Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report"as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Captial (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE

CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 10.51

BLUE SHIELD

CONTROLLED AFFILIATE LICENSE AGREEMENT

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and Healthy Alliance Life Insurance Company. ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Healthy Alliance Life Insurance Company:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Scott P. Serota

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

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* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50% → Standard 1A, 4

50% → Standard 1B, 4

100% and Primary Business is Government Non−Risk → Standard 4*,10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

- Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance → Standards 7A−7E
- Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance → Standard 2 (Guidelines 1.1,1.2) and Standard 11
- Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance → Standard 6H

No

- Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates → Standard 2 (Guidelines 1.1,1.3) and Standard 11
- Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates → Standard 6H
- Controlled Affiliate's Primary Business is Government Non−Risk → Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes → Standard 3A

No → Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes → Standards 6A−6I

No

- Controlled Affiliate is a former primary
- Controlled Affiliate is not a
- Controlled Affiliate's Primary Business is

licensee	former primary licensee	Government Non−Risk
Standards 5,8,9,11	Standards 5,8	Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter–Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Capital (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15, 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

BLUE CROSS

CONTROLLED AFFILIATE LICENSE AGREEMENT

(**Includes revisions adopted by Member Plans through their November 15, 2001 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and HMO Missouri, Inc. ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

Amended as of November 16, 2000

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

HMO Missouri, Inc.:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Scott P. Serota

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001.

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%	50%	100% and Primary Business is Government Non−Risk
Standard 1A, 4	Standard 1B, 4	Standard 4*,10A

* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

	Yes			No	
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance Standards 7A−7E	Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance Standard 6H	Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates Standard 6H	Controlled Affiliate's Primary Business is Government Non−Risk Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes	No
Standard 3A	Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes		No	
Standards 6A−6I	Controlled Affiliate is a former primary licensee	Controlled Affiliate is not a former primary licensee	Controlled Affiliate's Primary Business is Government Non−Risk

		Standards 5,8,9,11		Standards 5,8		Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter−Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report"as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Captial (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

BLUE SHIELD

CONTROLLED AFFILIATE LICENSE AGREEMENT

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and HMO Missouri, Inc. ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as WellPoint Health Networks Inc. ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

HMO Missouri, Inc.:

By: /s/ John A. O'Rourke

Date: January 31, 2002

WellPoint Health Networks Inc.:

By: /s/ Leonard D. Schaeffer

Date: January 31, 2002

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: /s/ Scott P. Serota

Date: January 31, 2002

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50% → Standard 1A, 4

50% → Standard 1B, 4

100% and Primary Business is Government Non−Risk → Standard 4*, 10A

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

- Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance → Standards 7A−7E
- Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance → Standard 2 (Guidelines 1.1,1.2) and Standard 11
- Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance → Standard 6H

No

- Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates → Standard 2 (Guidelines 1.1,1.3) and Standard 11
- Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates → Standard 6H
- Controlled Affiliate's Primary Business is Government Non−Risk → Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes → Standard 3A

No → Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes → Standards 6A−6I

No

- Controlled Affiliate is a former primary licensee
- Controlled Affiliate is not a former primary licensee
- Controlled Affiliate's Primary Business is Government Non−Risk

Standards 5,8,9,11

Standards 5,8

Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter–Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Capital (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15, 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE

CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

QuickLinks −− Click here to rapidly navigate through this document

Exhibit 10.55

AMENDMENT NO. 2
TO THE
WELLPOINT 401(k) RETIREMENT SAVINGS PLAN
(As Amended Through January 1, 2001)

The WellPoint 401(k) Retirement Savings Plan, as amended through January 1, 2001 is further amended effective as of January 1, 2001, unless a different date is specifically provided as follows:

1. Section 2.09(c) is amended effective February 28, 2001 to clarify the treatment of different categories of paid time off:

(c) *Exceptions.* Compensation shall not include pay in lieu of vacation days or pay in lieu of any category of paid time off that is unused at terminations of employment.

2. Section 2.16 defining "Highly Compensated Employee" is amended to clarify the use of the top paid group election effective January 1, 1997:

"Highly Compensated Employee" means (i) any 5% owner during the current Plan Year or the preceding Plan Year (the "lookback year") and (ii) any Employee receiving Remuneration from a Participating Company in the lookback year in excess of $80,000 (indexed consistent with Code Section 414(q)) without regard to whether the Employee is in the top 20% of Employees ranked by Remuneration.

3. Section 2.25 defining "Remuneration" is amended to incorporate amounts excluded under the qualified transportation fringe benefit provisions of Code Section 132(f):

"Remuneration" means compensation as defined in Code Section 415(c)(3) and in accordance with Treasury Regulation sections 1.415−2(d)(2) and 1.415−2(d)(3). This alternate definition of compensation is used for purposes of the Highly Compensated Employee definition in Section 2.16 and the Testing Salary Deferral and Matching Contributions Appendix, the Limitations on Allocations Appendix and the Top Heavy Appendix to this Plan. Remuneration also includes an Employee's elective deferrals under a qualified cash or deferred arrangement described in Code Sections 401(k) and 402(e)(3), a simplified employee pension plan described in Code Section 408(k)(6) and a cafeteria plan described in Code Section 125 and elective salary reductions not includible in gross income as a qualified transportation fringe under Code Section 132(f)(4).

4. Section 3.06 is amended to confirm the effective date of the Uniformed Services Employment and Reemployment Rights Act of 1994.

Notwithstanding any provision of this Plan to the contrary, contributions and benefits with respect to qualified military service will be provided to the extent required by Code Section 414(u) effective December 12, 1994.

5. The introduction to Section 9.04 governing hardship withdrawals is amended effective July 1, 2002 to provide for a minimum amount.

If a Participant has an immediate and heavy financial need (as defined below), and has no other resources reasonably available to meet this need (as defined below), the Participant may request a hardship withdrawal from his or her Salary Deferral Contributions Account and Rollover Account. The amount available from the Participant's Salary Deferral Contributions Account does not include earnings after December 31, 1988. For hardship withdrawals made on and after July 1, 2002, the amount of a hardship withdrawal may not be less the lesser of (i) $1,000 and (ii) the sum of the balances in the Participant's Salary Deferral Contributions Account (excluding earnings after December 31, 1988) and Rollover Account.

6. The suspension period applicable to hardship withdrawals is reduced, effective January 1, 2002 to six months by amending Section 9.04(c) as follows

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Effective July 1, 2001, any withdrawal from a Participant's Salary Deferral Contributions Account will result in a suspension of the Participant's right to direct Salary Deferral Contributions under the Plan and to make pre−tax and post−tax elective contributions under all other qualified and nonqualified plans maintained by an Affiliated Company ("Other Elective Contributions"). The suspension will continue for a period of 12 months (6 months effective January 1, 2002) following the effective date of the withdrawal and expire on the first day of the first payroll period beginning 365 days (183 days effective January 1, 2002) after the effective date of the withdrawal. If, as of January 1, 2002, a Participant's ability to make pre−tax and post−tax contributions is suspended as described in this subsection (c), his or her period of suspension will end on the last day of the six−month period beginning on the effective date of the withdrawal or January 1, 2002, whichever is later. The aggregate amount of a Participant's Salary Deferral Contributions to this Plan and the Participant's Other Elective Contributions in the Plan Year immediately following the Plan Year in which the hardship withdrawal is made will not exceed the Code Section 402(g) limit described in Section 5.01 reduced by the amount of his or her Salary Deferral Contributions made to this Plan and Other Elective Contributions made in the Plan Year in which the hardship withdrawal is made..

7. Section 11.07 is amended to eliminate the lookback rule formerly applicable to the mandatory cashout provisions.

Notwithstanding any provision of this Plan, if the vested portion of a Participant's Account on the date the Participant ceases to be an Employee is $5,000 ($3,500 prior to January 1, 1998) or less, the Participant's Account will be distributed to the Participant, or Beneficiary, as the case may be, as soon as practicable, without the consent of the Participant or the Participant's Beneficiary. For distributions made prior to January 1, 2001, if the vested portion of the Participant's Account on the date the Participant ceased to be an Employee, or at the time of any earlier distribution or withdrawal, exceeded $5,000 ($3,500 prior to January 1, 1998), no distribution will be made without the consent of the Participant or the Participant's Beneficiary, as applicable.

8. Section 1.03 of Appendix I: Testing Salary Deferral and Matching Contributions is amended effective January 1, 1997 to incorporate the multiple use limitation.

Limit on Matching Contributions.

(a) *Contribution Percentage Test*. Matching Contributions are tested and distributed similarly to Salary Deferral Contributions under Section 1.02 above except (i) the contribution percentage test described in Code Section 401(m)(2) is substituted for the Deferral Percentage test and (ii) Excess Contribution Amounts are substituted for Excess Deferral Contributions. Excess Contribution Amounts are equal to the excess of (i) over (ii) where (i) is the amount of Matching Contributions made on behalf of all Highly Compensated Employees for the Plan Year in which the excess arose and (ii) is the maximum amount of such contributions that could be made on behalf of Highly Compensated Employees for the Plan Year, determined by hypothetically reducing each Highly Compensated Employee's Matching Contributions to the extent necessary to satisfy the contribution percentage test, starting with the Highly Compensated Employee with the highest individual contribution rate. The determination is made after returning any excess Elective Deferrals as described in Section 1.01 and any Excess Deferral Contributions as described in Section 1.02.

(b) *Multiple Use Limitation*. If testing under Sections 1.02 and 1.03 results in the multiple use of the alternative limitation (e.g., the percentage for Highly Compensated Employees is not greater than the Non−highly Compensated Employee percentage for the prior Plan Year plus 2 points or 200% of the Non−highly Compensated Employee percentage for the prior Plan Year for both tests), the amount over the aggregate limit described in Treasury Regulation

section 1.401(m)−2(b)(3) will be treated as an Excess Deferral Contribution described in Section 1.02 and returned to Highly Compensated Employees as described therein.

9. Section 1.01 of Appendix II: Limitations on Allocations is amended to confirm the basic limitation applicable to Annual Additions for Limitation Years after 1994.

Basic Limitation. The total Annual Addition to Participants' Accounts under this Plan and under any other defined contribution plan maintained by an Affiliated Company may not, for any Limitation Year beginning after 1994, exceed the lesser of (i) the dollar limit which is $30,000 indexed for cost of living changes consistent with Code Section 415(d) or (ii) 25% of the Participant's Remuneration for that Limitation Year.

10. Section 1.03(b)(iii) of Appendix III: Top Heavy Provisions is amended to confirm that 5% of Remuneration will be contributed if a Participant participates in a defined benefit plan of an Affiliated Company in addition to participating in the Plan, and both plans are Top Heavy.

(iii) *Adjustment.* If a Participant also participates in a defined benefit plan of an Affiliated Company, and the Plan and the defined benefit plan are Top Heavy in a Plan Year, then the minimum contribution requirement of this Section for that Participant will be fulfilled in accordance with this subsection, except that "5%" will be substituted for "3%."

11. A new Section 1.13 is added at the end of Appendix IX: Merger of National Capital Preferred Provider Organization, Inc. 401(k) Plan to confirm the effective dates of provisions affected by the Uniformed Services Employment and Reemployment Rights Act of 1994 and the Small Business Job Protection Act of 1996:

(a) Effective December 12, 1994, contributions and benefits with respect to qualified military service are provided to the extent required by Code Section 414(u) consistent with the Uniformed Services Employment and Reemployment Rights Act of 1994.

(b) Effective January 1, 1998, the definition of "Compensation" for Code Section 415 testing is expanded to include elective contributions that are not includible in gross income under Code Sections 125, 402(e)(3), 402(h) and 403(b) for all purposes, including Code Section 415 testing, consistent with the Small Business Job Protection Act of 1996.

(c) Effective January 1, 1997, the return of excess contributions and excess aggregate contributions to a Highly Compensated Employee is based on the amount of the Employee's contributions rather than his or her deferral or contribution percentage consistent with the Small Business Job Protection Act of 1996.

(d) Effective January 1, 1997, the definitions of "Highly Compensated Employee" and leased employee are amended consistent with the Small Business Job Protection Act of 1996.

12. A new Section 1.08 is added at the end of Appendix XI: Merger of Blue Cross and Blue Shield of Georgia, Inc. Tax−Favored Savings Program to confirm the effective dates of provisions under various tax acts to the Blue Cross and Blue Shield of Georgia, Inc. Tax−Favored Savings Program:

1.08 *Special Effective Dates.* The following special effective dates apply to the provisions of the Georgia Savings Program as in effect prior to the merger:

(a) Effective December 12, 1994, contributions and benefits with respect to qualified military service are provided to the extent required by Code Section 414(u) consistent with the Uniformed Services Employment and Reemployment Rights Act of 1994.

(b) Effective January 1, 1998, the definition of "Section 415 Compensation" is expanded to include elective contributions that are not includible in gross income under Code Sections 125, 402(e)(3), 402(h) and 403(b) for all purposes, including Code Section 415 testing, consistent with

the Small Business Job Protection Act of 1996. Effective January 1, 2001, Section 415 Compensation is further expanded to include elective salary reductions not included in gross income under Code Section 132(f)(4) consistent with the Community Renewal Tax Relief Act of 2000.

(c) Effective for Limitation Years beginning on and after January 1, 2000, the combined limit under Code Section 415(e) is eliminated consistent with the Small Business Job Protection Act of 1996.

(d) Effective January 1, 1997, the return of excess contributions and excess aggregate contributions to a Highly Compensated Employee is based on the amount of the Employee's contributions rather than his or her deferral or contribution percentage consistent with the Small Business Job Protection Act of 1996.

(e) Effective January 1, 2000, an "eligible rollover distribution" does not include salary deferral contributions distributed in a hardship distribution consistent with the Restructuring and Reform Act of 1998.

(f) Notwithstanding anything contrary in the Plan, including Appendix VIII, a Georgia Participant may not defer payment of Plan benefits past his or her required beginning date as modified by this subsection (f). If a Georgia Participant attains age 70 $^{1}/_{2}$ before January 1, 2002, or if the Participant is a 5% owner (within the meaning of Code Section 416(i)), his or her required beginning date is April 1 following the close of the calendar year in which the Participant attains age 70$^{1}/_{2}$. If a Participant who is not a 5% owner attains age 70$^{1}/_{2}$ on or after January 1, 2002, his or her required beginning date is April 1 of the later of (i) the calendar year following the calendar year in which the Participant attains age 70 $^{1}/_{2}$, or (ii) the calendar year following the calendar year in which the Participant terminates employment.

IN WITNESS WHEREOF, WellPoint Health Networks Inc. caused this Amendment to be executed this 26th day of February, 2002.

WELLPOINT HEALTH NETWORKS INC.

By: /s/ J. THOMAS VAN BERKEM Date: February 26, 2002

QuickLinks

AMENDMENT NO. 2 TO THE WELLPOINT 401(k) RETIREMENT SAVINGS PLAN (As Amended Through January 1, 2001)

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Exhibit 10.56

AMENDMENT NO. 3
TO THE
WELLPOINT 401(k) RETIREMENT SAVINGS PLAN
(As Amended through January 1, 2001)

The WellPoint 401(k) Retirement Savings Plan, as amended to January 1, 2001, is further amended effective as of February 28, 2002 to revise the Bonus Contribution provisions.

1. Section 2.20 defining "Participant" is expanded to include an Employee who is not employed by a Participating Company (and thus an "Eligible Employee"), but receives an allocation of the Bonus Contribution described in Section 5.10.

> 2.20 *"Participant"* means (i) an Eligible Employee who becomes a Participant under Article IV or Article V, (ii) an individual not described in clause (i) who had an Account balance in another tax−qualified retirement plan as of the date such plan is merged with the Plan, and (iii) an Employee of an Affiliated Company that is not a Participating Company who receives an allocation of a Bonus Contribution as described in Section 5.10. An individual described in clauses (i) through (iii) will be a Participant only for the period an Account is maintained under the Plan for such individual.

2. Section 5.10(b)(2) is amended to expand the potential categories of Employees eligible to receive an allocation of the Bonus Contribution.

> (2) A "Bonus Eligible Employee" refers to each Employee of a Participating Company employed on the effective date of the Bonus Contribution (including any such Employee on an authorized leave of absence as of such effective date who returns to employment at the end of the leave), other than a Temporary Employee, a non−resident alien who receives no earned income from sources within the United States, an Employee who has not attained age 18 or an Employee whose terms of employment are governed by a collective bargaining agreement except to the extent such agreement expressly provides for an allocation of any Bonus Contribution. Notwithstanding the prior sentence, an individual employed by RightCHOICE Managed Care, Inc. or any of its subsidiaries (collectively, "RightCHOICE") on February 28, 2002 will be eligible to receive an allocation of the Bonus Contribution made as of such date provided the individual (i) is not categorized as a temporary employee by RightCHOICE and has not performed 1,000 Hours of Service during any consecutive 12−month period, (ii) is not a non−resident alien who receives no earned income from sources within the United States, and (iii) is not less than 18 years of age. An individual employed by RightCHOICE who would otherwise be eligible for an allocation of the Bonus Contribution, but is on a leave of absence on February 28, 2002, will be eligible for such an allocation if, and at such time as, he or she returns to employment with RightCHOICE at the end of the leave.

IN WITNESS WHEREOF, WellPoint Health Networks Inc. caused this Amendment to be executed this 26th day of February, 2002.

WELLPOINT HEALTH NETWORKS INC.

By: /s/ J. THOMAS VAN BERKEM Date: February 26, 2002

QuickLinks

AMENDMENT NO. 3 TO THE WELLPOINT 401(k) RETIREMENT SAVINGS PLAN (As Amended through January 1, 2001)

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Exhibit 10.57

AMENDMENT NO. 4
TO THE
WELLPOINT 401(k) RETIREMENT SAVINGS PLAN
(As Amended through January 1, 2001)

The WellPoint 401(k) Retirement Savings Plan, as amended to January 1, 2001, is further amended effective as of March 1, 2002 to eliminate the liquidation restriction on units of the WellPoint Common Stock Fund.

1. Section 5.10(a) is amended, effective March 1, 2002, to eliminate the liquidation restriction on the Bonus Contribution as follows:

(a) *Liquidation Restriction.* The provisions of this subsection (a) are repealed effective March 1, 2002. As of that date, a Participant may liquidate any units of the WellPoint Common Stock Fund in his or her Account that are attributable to a Bonus Contribution at any time, consistent with the Plan's standard investment procedures, and reinvest the funds in another investment fund under the Plan.

Prior to March 1, 2002, the following provisions apply: To the extent that the Bonus Contribution is made in the form of shares of the common stock of the Company, any units of the WellPoint Common Stock Fund in a Participant's Account that are attributable to such contribution may not be liquidated and invested in another investment fund under the Plan before the earliest to occur of (1), (2), or (3) below:

(1) The date that the Participant attains age 55.

(2) The date that the Participant ceases to be a common law Employee of all Affiliated Companies.

(3) Any date after the last day of the Plan Year in which the Bonus Contribution is made.

Any units acquired due to a stock dividend or a stock split will be subject to the liquidation restrictions outlined in this subsection (a). Any units acquired due to a stock dividend or a stock split will be considered to have been credited to a Participant's Account as of the date that units representing the original shares were credited to that Participant's Account. Cash dividends on WellPoint Common Stock will not be subject to the liquidation restrictions outlined in this subsection (a).

2. Section 6.05 is amended, effective March 1, 2002, to eliminate the liquidation restriction on units of the WellPoint Common Stock Fund made as Matching Contributions as follows:

6.05 *Restriction on Liquidation of Units in a WellPoint Common Stock Fund.* The provisions of this Section 6.05 are repealed effective March 1, 2002. As of that date, a Participant may liquidate any units of the WellPoint Common Stock Fund in his or her Account that are attributable to a Matching Contribution at any time, consistent with the Plan's standard investment procedures, and reinvest the funds in another investment fund under the Plan.

Prior to March 1, 2002, the following provisions apply: Once each Plan Year, a Participant may liquidate any units in a WellPoint Common Stock Fund that were required to be credited to his or her Account as a Matching Contribution ("Required Units") during any prior Plan Year. In addition, a Participant may liquidate any or all Required Units upon attaining age 55 or ceasing to be a common law employee with any Affiliated Company. Prior to 1999, a Participant may not

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direct that Required Units be liquidated and invested in another investment fund under the Plan until the earliest to occur of (a), (b), or (c) below:

(a) *Two Years.* The date that is 730 days after the date that the units to be liquidated were credited to the Participant's Account.

(b) *Age 55.* The date that the Participant attains age 55.

(c) *No Longer an Employee.* The date that the Participant ceases to be a common law Employee of all Affiliated Companies.

Cash dividends on WellPoint Common Stock will not be subject to the liquidation restrictions outlined in this Section. Units acquired due to a stock dividend or a stock split will be subject to the liquidation restrictions outlined in this Section to the extent that the original shares were subject to these restrictions. For these purposes, units acquired due to a stock dividend or a stock split will be considered to have been credited to a Participant's Account as of the date that units representing the original shares were credited to that Participant's Account.

IN WITNESS WHEREOF, WellPoint Health Networks Inc. caused this Amendment to be executed this 26th day of February, 2002.

WELLPOINT HEALTH NETWORKS INC.

By: /s/ J. THOMAS VAN BERKEM Date: February 26, 2002

QuickLinks

AMENDMENT NO. 4 TO THE WELLPOINT 401(k) RETIREMENT SAVINGS PLAN (As Amended through January 1, 2001)

EXHIBIT 10.58

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their November 15, 2001 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as WellPoint Health Networks Inc. (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement, the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for−profit health care plan, or mutual health insurer operating on a not–for–profit or for−profit basis, under state law; financing access to health care services; providing health care management and administration; administering, but not underwriting, non−health portions of Worker's Compensation insurance; and delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: a) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and: b) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and c) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of subparagraph B but not subparagraph A of this paragraph, the entity, its owners, and persons with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean that a Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have:

A. The legal authority, directly or indirectly through wholly–owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for–profit Controlled Affiliate; or

B. The legal authority directly or indirectly through wholly−owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s). Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

6. Make any loans or advances except in the ordinary course of business;

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Amended as of June 11, 1998

3. The Plan may engage in activities not required by BCBSA to be directly licensed through Controlled Affiliates and may indicate its relationship thereto by use of the Licensed Name as a tag line, provided that the engaging in such activities does not and will not dilute or tarnish the unique value of the Licensed Marks and Name and further provided that such tag line use is not in a manner likely to cause confusion or mistake. Consistent with the avoidance of confusion or mistake, each tag line use of the Plan's Licensed Name: (a) shall be in the style and manner specified by BCBSA from time–to–time; (b) shall not include the design service marks; (c) shall not be in a manner to import more than the Plan's mere ownership of the Controlled Affiliate; and (d) shall be restricted to the Service Area. No rights are hereby created in any Controlled Affiliate to use the Licensed Name in its own name or otherwise. At least annually, the Plan shall provide BCBSA with representative samples of each such use of its Licensed Name pursuant to the foregoing conditions.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of November 20, 1997

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time–to–time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended November 18, 1999

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2–4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii) and 15(a)(i)–(viii) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three–fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three–fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing National Accounts, Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three–fourths of the Plans and of three–fourths of the total then current weighted vote of all the Plans.

Amended as of March 11, 1999

9. (d). The Plan may operate as a for−profit company on the following conditions:

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)−(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non−voting, non−convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b−2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

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(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d−1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D−G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

Amended as of September 17, 1997

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three–fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon six (6) months written notice to BCBSA.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three–fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of the Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended March 12, 1998

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of September 19, 1996

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the capital benchmark formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

Amended as of November 19, 1998

(iv) BCBSA shall have the right to audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with this paragraph 15(d).

(v) As to a breach of 15 (d) (i), (ii), (iii) or (iv), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii) or (iv) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three–fourths of the Plans and three–fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

Amended as of November 20, 1997

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By /s/ Scott P. Serota

Title President

Date January 31, 2002

WellPoint Health Networks Inc.

By /s/ Leonard D. Schaeffer

Title Chairman and Chief Executive Officer

Date January 31, 2002

EXHIBIT 1

BLUE SHIELD

CONTROLLED AFFILIATE LICENSE AGREEMENT

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as ("Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non−health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the sponsoring Plan's net subscription revenue.

This grant of rights is non−exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time−to−time.

Amended as of November 15, 2001

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time−to−time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), must have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s); and

Notwithstanding anything to the contrary in (a) through (b) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Or

(2) A Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority directly or indirectly through wholly−owned subsidiaries to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(a) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur;

(b) exercise control over the policy and operations of the Controlled Affiliate.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time−to−time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Controlled Affiliate shall use its best efforts in the Service Area to promote and build the value of the Licensed Marks and Name.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that Plan ceases to be authorized to use the Licensed Marks and Name.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to

the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement,

a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area

established by this Agreement, the payment shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the capital benchmark formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

J. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated

pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

K. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

L. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibits 5, 5A and 5B as amended from time−to−time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of March 11, 1999

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three−fourths of the Plans and three−fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2000

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:

Date:

Plan:

By:

Date:

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:

Date:

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2001

PREAMBLE

The standards for licensing Controlled Affiliates are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote. Each licensed Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

The Controlled Affiliate License provides a flexible vehicle to accommodate the potential range of health and workers' compensation related products and services Plan Controlled Affiliates provide. The Controlled Affiliate License collapses former health Controlled Affiliate licenses (HCC, HMO, PPO, TPA, and IDS) into a single license using the following business−based criteria to provide a framework for license standards:

- Percent of Controlled Affiliate controlled by parent: Greater than 50 percent or 50 percent?

- Risk assumption: yes or no?

- Medical care delivery: yes or no?

- Size of the Controlled Affiliate: If the Controlled Affiliate has health or workers' compensation administration business, does such business constitute 15 percent or more of the parent's and other licensed health subsidiaries' contract enrollment?

For purposes of definition:

- A “smaller Controlled Affiliate:” (1) comprises less than fifteen percent (15%) of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers’ compensation insurance and has total premium revenue less than 15 percent of the sponsoring Plan’s net subscription revenue.

- A “larger Controlled Affiliate” comprises fifteen percent (15%) or more of Plan’s and its licensed Controlled Affiliates’ total contract enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate’s status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate’s health and workers’ compensation administration business reaches or surpasses fifteen percent (15%) of the total contract enrollment of the Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk−Based Capital (HRBC)" as defined by the NAIC and state−established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

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* For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's contract enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Plan and all other licensed Controlled Affiliates' contract enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended November 15, 2001

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

As described in Preamble section of Exhibit A to the Affiliate License Agreement, each controlled affiliate seeking licensure must answer four questions. Depending on the controlled affiliate's answers, certain standards apply:

1. What percent of the controlled affiliate is controlled by the parent Plan?

More than 50%

Standard 1A, 4 50%

50%

Standard 1B, 4

100% and Primary Business is Government Non−Risk

Standard 4*,10A Standard 1B, 4

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* Applicable only if using the names and marks.

IN ADDITION,

2. Is risk being assumed?

Yes

Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance

Standards 7A−7E

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 2 (Guidelines 1.1,1.2) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance

Standard 6H

No

Controlled Affiliate comprises < 15% of total contract enrollment of Plan and its licensed affiliates

Standard 2 (Guidelines 1.1,1.3) and Standard 11

Controlled Affiliate comprises ≥ 15% of total contract enrollment of Plan and its licensed affiliates

Standard 6H

Controlled Affiliate's Primary Business is Government Non−Risk

Standard 10B

IN ADDITION,

3. Is medical care being directly provided?

Yes

Standard 3A

No

Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total contract enrollment of Plan and its licensed controlled affiliates?

Yes

Standards 6A−6I

Controlled Affiliate is a former primary licensee

No

Controlled Affiliate is not a former primary licensee

Controlled Affiliate's Primary Business is Government Non−Risk

Standards 5,8,9,11

Standards 5,8

Standards 8, 10(C)

Standard 1 − Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own more than 50% of any for−profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a licensed Plan or Plans authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to separate License Agreement(s) with BCBSA, other than such Controlled Affiliate's License Agreement(s), (the "Controlling Plan(s)"), have the legal authority, directly or indirectly through wholly−owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof ; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plan(s) do(es) not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Controlling Plan(s).

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Controlling Plan(s) before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Plan or Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, a Plan or Plans directly or indirectly through wholly−owned subsidiaries shall own at least 50% of any for−profit Controlled Affiliate.

Standard 2 − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk−assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk−assuming Controlled Affiliate ceases operations for any reason, sponsoring Plan(s) will provide for services to its (their) customers.

Standard 3 − State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 − Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Standard 5 − Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its licensed Plan(s) shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 − Other Standards for Larger Controlled Affiliates

Standards 6(A) − (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Such programs are applicable to licensees, and include:

1. Transfer Program;

2. BlueCard Program;

3. Inter–Plan Teleprocessing System (ITS)

4. Electronic Claims Routing Process; and

5. National Account Programs, effective January 1, 2002.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in

Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter−licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Best Efforts

During each year, a Controlled Affiliate shall use its best efforts in the designated Service Area to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended November 15, 2001

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

A) BCBSA Controlled Affiliate Licensure Information Request; and

B) Biennial trade name and service mark usage material, including disclosure material; and

C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and

D) Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

E) Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report.

Amended November 15, 2001

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 − Other Standards for Risk−Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) − (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure materials; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk−Based Capital Worksheets for Property and Casualty Insurers, Annual Financial Forecast; and

Amended June 16, 2000

Quarterly Financial Report, Quarterly Estimated Risk−Based Capital for Property and Casualty Insurers, Insurance Department Examination Report.

D. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and

E. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended November 16, 2000

Standard 8 − Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9 − Participation in National Programs by Smaller Controlled Affiliates

A smaller Controlled Affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter−Plan Teleprocessing System (ITS);
- Transfer Program;
- Electronic Claims Routing Process, effective until the mandated date for implementation of the HIPAA standard transaction; and
- National Account Programs, effective January 1, 2002.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's BlueCard Program obligations in a form, and from a guarantor, acceptable to BCBSA.

C. Reporting requirements include:

- The Semi−annual Health Risk−Based Capital (HRBC) Report.

Amended November 15, 2001

Standard 10 − Other Standards for Controlled Affiliates Whose Primary Business is Government Non−Risk

Standards 10(A) − (C) that follow apply to Controlled Affiliates whose primary business is government non−risk.

Standard 10(A) − Organization and Governance

A Controlled Affiliate shall be organized and operated in such a manner that it is 1) wholly owned by a licensed Plan or Plans and 2) the sponsoring licensed Plan or Plans have the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which it does not concur.

Standard 10(B) − Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 10(C):− Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Affiliate Licensure Information Request; and

B. Biennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement (if required) as filed with the State Insurance Department (with all attachments), Annual NAIC Risk−Based Capital Worksheets (if required) as filed with the State Insurance Department (with all attachments), and Insurance Department Examination Report (if applicable)*; and

D. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in the Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 11: Participation in Electronic Claims Routing Process

The Standard is:

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exihibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Electronic Claims Routing Process effective upon the mandated date for implementation of the HIPAA standard transaction.

Amended November 15, 2001

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE

CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK AND GOVERNMENT NON−RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's subscription revenue and contracts arising from products using the marks. The payment by each sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

For Controlled Affiliates whose primary business is government non−risk:

An amount equal to its pro−rata share of each sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's government non−risk beneficiaries.

FOR NONRISK PRODUCTS:

An amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT

APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their November 15, 2001 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as ("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non−exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or, anything in any other license to Controlled Affiliate notwithstanding, in its legal or trade name.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time–to–time.

Amended as of November 17, 1994

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time–to–time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly–owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for–profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time–to–time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time–to–time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- 05% of gross revenue per year from branded group products, plus
- .5% of gross revenue per year from branded individual products plus
- 14% of gross revenue per year from branded individual annuity products.

Amended as of November 20, 1997

The foregoing percentages shall be reduced by one−half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three−fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless six (6) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2000

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:

Date:

Controlled Affiliate

By:

Date:

Plan

By:

Date:

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

LIFE INSURANCE COMPANIES

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time−to−time upon the affirmative vote of three−fourths (3/4) of the Plans and three−fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 − Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 − State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 − Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The

LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 − Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then−current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 − Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 − Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

EXHIBIT 2

Membership Standards

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards. Compliance with any Membership Standard may be excused, at the Plans' discretion, if the Plans agree that compliance with such Standard would require the Plan to violate a law or governmental regulation governing its operation or activities.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise general and administrative expenses.

Standard 1: A Plan's Board shall not be controlled by any special interest group, and shall act in the interest of its Corporation in providing cost−effective health care services to its customers. A Plan shall maintain a governing Board, which shall control the Plan, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of November 19, 1998

EXHIBIT 2

Membership Standards

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. BCBSA Membership Information Request;

B. Biennial trade name and service mark usage material, including disclosure material under

Standard 7;

C Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;

D. Quarterly Financial Report, Semi−annual "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC, Annual Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and

• Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year−end "Health Risk−Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 15, 2001

EXHIBIT 2

Membership Standards

E. Quarterly Enrollment Report, Semi−Annual Benefit Cost Management Report and Member Touchpoint Measures Index (MTM) starting 12/31/00 and semi−annually thereafter; and

• Plans that are a Shell Holding Company as defined in the Preamble hereto are not required to furnish any items identified in Paragraph E.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

A. Transfer Program;

B. Inter−Plan Teleprocessing System (ITS);

C. BlueCard Program;

D. Electronic Claims Routing Process; and

E. National Account Programs, effective January 1, 2002

Amended as of November 15, 2001

EXHIBIT 2

Membership Standards

Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter−Plan nature or where the Association is a party.

Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Plan Performance and Financial Standards Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.

Standard 10: During each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts in the designated Service Area to promote and build the value of the Blue Cross and Blue Shield Marks.

Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 18, 1999

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF

LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision−making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended June 15, 2001

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non−Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non−Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non−BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

8. For claim payments in a Participating Plan's area (on non−BlueCard claims), Participating Plans are strongly encouraged, but not required, to pass along to the Control Plan part or all of local provider discounts and differentials for use by the Control Plan in negotiating financial arrangements with National Accounts. However, since the size, basis, form and use of local differentials can vary substantially among Plans and also by individual National Account characteristics, the degree and form of any discount or differential passed along to the Control Plan shall be strictly a matter of negotiated contractual agreement between a Participating Plan and the Control Plan and may also vary from one National Account to another. In order to facilitate the quotation of national account pricing and the offering of a variety of National Account delivery systems, all Plans are strongly encouraged to periodically publish to

other Plans and the BCBSA their National Account contracting policies with respect to the handling of differentials.

The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account. The exact form and substance of this may vary from one National Account to another and shall be a matter of explicit negotiation and contractual relationship between the National Account and the Control Plan. The specifics in an agreement between the Control Plan and the National Account may vary in form (e.g., a guaranteed offset against retentions, or a direct pass through, or a guaranteed aggregate percentage discount, or no pass back at all, etc.), and the Control Plan has the responsibility and the Authority to negotiate precise arrangements. However, irrespective of the final arrangements between the Control Plan and the National Account, a Participating Plan's liability for passing along differentials shall be limited to the contractual agreement the Participating Plan has with the Control Plan on a specific National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expenditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan may use the Licensed Marks and Name outside its Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

b. distributing business cards other than in marketing and selling;

c. contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its service area;

d. issuing a small sign containing the legal name or trade name of the Plan or its licensed Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

Amended March 16, 2001

e. advertiing in publications or electronic media solely to persons for employment;

f. adverising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

g. advertising by direct mailwhere the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate.

h. negotiating rates witha health care provider for services to a specific member in case management, provided that:

(1) the health care provider does not contract with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Licensee(s) in whose Service Area the health care provider is located consent(s) in advance.

Amended November 15, 2001

EXHIBIT 5

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for−profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time−consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre−MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that one or more members of the Mediation Committee be disqualified from the proceeding and the grounds for such request;

ix. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

x. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on the BCBSA and on the complaining party (or parties) and on the Chairman of the Mediation Committee;

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation;

iv. any request, if applicable, that one or more members of the Mediation Committee be disqualified from the proceeding and the grounds for such request; and

v. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.B., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) and on the Chairman of the Mediation Committee, a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C.

2. Mediation

A. Mediation Committee

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has established a Mediation Committee. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged to exhaust the mediation procedure.

B. Election To Mediate

If any party elects first to pursue Mediation, and if it appears to the Corporate Secretary that the dispute falls within the jurisdiction of the Mediation Committee, as set forth in Exhibit 5−A hereto, then the Corporate Secretary will promptly furnish the Mediation Committee with copies of the Complaint, Answer, Counterclaim and Reply to Counterclaim, and other documents referenced in Paragraph 1, above.

C. Selection of Mediators

The parties shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of the mediator(s) who may include members of the Mediation Committee and/or experienced mediators from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties cannot agree upon the number of mediators desired, that number shall default to three. In the event the parties cannot agree upon the selection of mediator(s), the Chairman will select the mediator(s), at least one of which shall be an experienced mediator from an independent entity, consistent with the provisions set forth in this Paragraph. No member of the Mediation Committee who is a representative of any party to the Mediation may be

selected to mediate the dispute. The Chairman shall also endeavor not to select as a mediator any member of the Mediation Committee whom a party has requested to be disqualified. If, after due regard for availability, expertise, and such other considerations as may best promote an expeditious Mediation, the Chairman believes that he or she must consider for selection a member of the Mediation Committee whom a party has requested to be disqualified, the other members of the Committee eligible to be selected to mediate the dispute shall decide the request for disqualification. By agreeing to participate in the Mediation of a dispute, a member of the Mediation Committee represents to the party (or parties) thereto that he or she knows of no grounds which would require his or her disqualification.

D. Binding Decision

Before the date of the Mediation Hearing described below, the Corporate Secretary will contact the party (or parties) to determine whether they wish to be bound by any recommendation of the selected mediators for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

E. Mediation Procedure

The Chairman shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediators, unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. By no later than five (5) days prior to the date designated for the Mediation Hearing, each party shall supply and serve a list of all persons who will be attending the Mediation Hearing, and indicate who will have the authority to resolve the dispute.

iii. Each party will be given one−half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross−examination nor questioning of opposing representatives will be

permitted. At the close of each presentation, the selected mediators will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediators may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediators may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iv. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediators, will sit in on the negotiations.

v. After the close of the presentations, the selected mediators may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

vi. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vii. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediators, and decisions or recommendations in any Mediation proceeding shall be executed by each party.

viii. Upon request of the selected mediators, or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

F. Notice Of Termination Of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediators, or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within forty (40) days after the Complaint was served, whichever comes first, any party or any one of the selected mediators may so notify the Corporate Secretary, who shall promptly issue a Notice of termination of mediation to all parties, to the selected mediators, and to the MDR Administrator, defined below. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the selected mediators, the Mediation process may continue at the same time the MDR process is invoked. The Notice described above would serve to initiate the MDR proceeding and would not terminate the proceedings.

3. Mandatory Dispute Resolution (MDR)

If all parties elect not to first pursue Mediation, or if a notice of termination of Mediation is issued as set forth in Paragraph 2.F., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to MDR.

A. MDR Administrator

The Administrator shall be an independent entity such as the Center for Public Resources, Inc. or Endispute, Inc., specializing in alternative dispute resolution. The Administrator shall be designated initially, and may be changed from time to time, by the affirmative vote of a majority of the Plans present and voting and a majority of the total then current weighted vote of all the Plans present and voting.

B. Initial Conference

Within five (5) days after a Notice of Termination has issued, or within five (5) days after the time for filing and serving the Reply to any Counterclaim if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This Initial Conference may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph C shall be followed.

Amended September 21, 2000

C. Panel Selection Process

The Administrator shall designate at least seven potential arbitrators. The exact number designated shall be sufficient to give each party at least two peremptory strikes. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted two peremptory strikes. From the remaining designees, the Administrator shall select a three member Panel. The Administrator shall set the dates for exercising all strikes and shall complete the Panel Selection Process within fifteen (15) days of the Initial Conference. Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

D. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, appended as Exhibit "5−B" hereto, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

E. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

F. Administrative Conference And Preliminary Arbitration Hearing

Within ten (10) days of the Panel being selected, the Presiding Arbitrator will schedule an Administrative Conference to discuss scheduling of the Arbitration Hearing and any other matter appropriate to be considered including: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on−site inspection by the Panel.

G. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served as of the date of the Administrative Conference as set forth in Paragraph 3.F., above. Within twenty (20) days after receipt of a request for documents, a party shall produce all relevant and non−privileged documents to the requesting party. In his or her discretion, the Presiding Arbitrator may require the parties to provide lists in such detail as is deemed appropriate of all documents as to which privilege is claimed and may further require in−camera inspection of the same.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to 21 days prior to the Arbitration Hearing. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

iii. ***Depositions*** As a general rule, the parties will not be permitted to take deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause, provided that no deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(b)(4)(A)(i) prior to the expiration of the discovery period.

v. ***Discovery cut−off***: The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed forty−five (45) days from its commencement, without the agreement of all parties.

vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator. The Presiding Arbitrator is authorized to resolve all discovery disputes, which resolution will be binding on the parties unless modified by the Arbitration Panel. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

H. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini−trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

I. Subpoenas On Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., a party may request the issuance of a subpoena on a third party, to compel testimony or documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

J. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

K. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party may submit to the other party (or parties) and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

L. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

M. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney−client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post−hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

N. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non−parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

O. Return Of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

B. Temporary Or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults And Proceedings In The Absence Of A Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the

Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification Or Disability Of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

G. Extensions of Time

Any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (i) the Chairman of the Mediation Committee if the proceeding is then in Mediation; (ii) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (iii) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (i) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (ii) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

Amended September 21, 2000

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

K. Recovery of Attorney Fees and Expenses

Motions to Compel

Nothwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub−sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Section 3−N hereof, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have 20 days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

Amended September 21, 2000

MEDIATION COMMITTEE

REPORTS TO: Board of Directors

CHARGE: 1. Develop and implement processes for resolving misunderstandings or disagreements between Plans or between Plans and the Association under the following circumstances:

a. Matters at issue regarding relationships between Plans or between Plans and the Association.

b. Matters at issue regarding relationships between Plans or between Plans and the Association.

c. Matters at issue under the Inter−Plan Bank, Reciprocity, and Transfer Programs.

d. Matters at issue regarding contractor selection or performance under the Medicare Part A Program.

2. Determination of equalization allowances and/or cost allowances under FEP shall not be considered by this Committee.

MEMBERSHIP: Six to Eight

STAFF: Senior Vice President and General Counsel

Exhibit 21

WELLPOINT HEALTH NETWORKS INC.
LIST OF SUBSIDIARY ENTITIES

Company	State of Incorporation
Affiliated Healthcare, Inc.	Texas
AHI Healthcare Corporation	Texas
American Managing Company	Texas
Atlanta Healthcare Partners, Inc.	Georgia
BCC Holdings Corporation, Inc.	California
BC Life & Health Insurance Company	California
Blue Cross and Blue Shield of Georgia, Inc.	Georgia
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Georgia
Blue Cross of California	California
C&S Properties, Inc.	Missouri
Cerulean Companies, Inc.	Georgia
Comprehensive Integrated Marketing Services	California
Cost Care, Inc.	Massachusetts
CSRA Healthcare Partners, Inc.	Georgia
Diversified Life Insurance Agency of Missouri, Inc.	Missouri
Fourty−Four Fourty−Four Forest Park Redevelopment Corp.	Missouri
Foxfield Ventures II, Inc.	Delaware
Greater Georgia Life Insurance Company	Georgia
Group Benefits of Georgia, Inc.	Georgia
Group Benefits Plus	California
HealthLink, Inc.	Illinois
HealthLink HMO, Inc.	Missouri
Health Ventures Partner, LLC	Illinois (LLC)
Healthy Alliance Life Insurance Co.	Missouri
HMO Missouri, Inc.	Missouri
MCS Health Management Options, Inc.*	Puerto Rico
National Capital Health Plan, Inc.	Virginia
UNICARE National Capital Preferred Provider Organization, Inc.	Maryland
Park Square I, Inc.	California
Park Square II, Inc.	California
Park Square Holdings, Inc.	California
Precision Rx, Inc.	Texas
Preferred Health Plans of Missouri, Inc.	Missouri
Professional Claim Services, Inc.	New York
R&P Realty, Inc.	Missouri
RightCHOICE Insurance Company	Illinois
RightCHOICE Managed Care, Inc.	Delaware
The Epoch Group, L.C.*	Missouri (LLC)
The Industry MSO, Inc.*	California
TriState Inc.	Delaware
UNICARE Health Plan of Oklahoma, Inc.	Oklahoma
UNICARE Health Plan of Virginia, Inc.	Virginia
UNICARE Health Plans	Illinois (partnership)
UNICARE Health Plans of the Midwest, Inc.	Illinois
UNICARE Health Insurance Company of the Midwest	Illinois
UNICARE Life & Health Insurance Company	Delaware
UNICARE Illinois Services, Inc.	Illinois
UNICARE National Services, Inc.	Delaware
UNICARE of Texas Health Plans, Inc.	Texas
UNICARE Service Co.	California
UNICARE Specialty Services, Inc.	Delaware
WellPoint Association Services Group, Inc.	Washington
WellPoint Behavioral Health, Inc.	Delaware
WellPoint California Services, Inc.	Delaware
WellPoint Dental Services, Inc.	Delaware
WellPoint Development Company, Inc.	Delaware

* less than majority stock interest

WELLPOINT HEALTH NETWORKS INC. LIST OF SUBSIDIARY ENTITIES

QuickLinks −− Click here to rapidly navigate through this document

Exhibit 23.1

CONSENT OF INDEPENDENT ACCOUNTANTS

We hereby consent to the incorporation by reference in the Registration Statements on Form S−8 (File Nos. 333−05111, 333−33013, 333−42073, 333−81687, 333−90791, 333−37958, 333−55314, 333−81872 and 333−83462), Form S−3 (File No. 333−08519) and Form S−4 (File No. 333−73382) of WellPoint Health Networks Inc. of our report dated January 31, 2002, except Note 3 as to which the date is March 15, 2002, and Note 22 as to which the date is March 18, 2002, relating to the financial statements, which appears in this Form 10−K.

PricewaterhouseCoopers LLP

Los Angeles, California
March 29, 2002

QuickLinks

CONSENT OF INDEPENDENT ACCOUNTANTS

Created by 10KWizard Technology www.10KWizard.com

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934

AMENDMENT NO. 1
ON
FORM 10−K/A

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2001

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number 001−13083

WELLPOINT HEALTH NETWORKS INC.
(Exact name of Registrant as specified in its charter)

Delaware (State of incorporation)	**95−4635504** (I.R.S. Employer Identification No.)
1 WellPoint Way **Thousand Oaks, CA** (Address of principal executive offices)	**91362** (Zip Code)

Registrant's telephone number, including area code: (818) 234−4000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, $0.01 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S−K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of the Form 10−K or any amendment to this Form 10−K. ☐

State the aggregate market value of the voting stock held by non−affiliates of the Registrant as of March 18, 2002: $8,895,428,927 (based on the last reported sale price of $62.48 per share on March 18, 2002, on the New York Stock Exchange).

Common Stock, $0.01 par value of Registrant outstanding as of March 18, 2002: 143,239,794 shares.

DOCUMENTS INCORPORATED BY REFERENCE

None.

EXPLANATORY NOTE

This Amendment No. 1 on Form 10−K/A is being filed in order to, among other things, amend Items 10, 11, 12 and 13 of the Company's Annual Report on Form 10−K for the period ended December 31, 2001 (the "Form 10−K"). The Form 10−K as filed with the Securities and Exchange Commission on April 1, 2002 omitted such items in reliance on General Instruction G(3) of Form 10−K (including items 10, 11, 12 and 13 as so amended). This Amendment No. 1 on Form 10−K/A also contains an updated discussion of the Company's pending transaction with CareFirst, Inc. (appearing in "Item 1. Business") and of the Company's correspondence with the Internal Revenue Service regarding a private letter ruling received in September 1998 (appearing in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Tax Issues Relating to the WellPoint and RightCHOICE Recapitalizations"). The entire Form 10−K is being filed as part of this Amendment.

WELLPOINT HEALTH NETWORKS INC.

FORM 10−K ANNUAL REPORT

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PART I

Item 1. Business

General

WellPoint Health Networks Inc. (the "Company" or "WellPoint") is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. As a result of the January 31, 2002 completion of the Company's merger with RightCHOICE Managed Care, Inc. ("RightCHOICE"), the Company's medical membership has increased to approximately 12.5 million members as of January 31, 2002. The Company offers a broad spectrum of quality network−based managed care plans. WellPoint provides these plans to the large and small employer, individual, Medicaid and senior markets. The Company's managed care plans include preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs") and point−of−service ("POS") and other hybrid plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial services, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products, including pharmacy, dental, workers' compensation managed care services, utilization management, life insurance, preventive care, disability insurance, behavioral health, COBRA and flexible benefits account administration.

The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in various parts of the country under the name UNICARE or HealthLink. Historically, the Company's primary market for its managed care products has been California. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks. The Company's customer base is diversified, with extensive membership among large and small employer groups and individuals and a growing presence in the Medicare and Medicaid markets.

In 1996, the Company began pursuing a nationwide expansion strategy through selective acquisitions and start−up activities in key geographic areas. With the acquisitions in March 1996 of the Life & Health Benefits Management division ("MMHD") of Massachusetts Mutual Life Insurance Company (the "MMHD Acquisition") and in March 1997 of certain portions of the health and related life group benefit operations (the "GBO") of John Hancock Mutual Life Insurance

Company (the "GBO Acquisition"), the Company significantly expanded its operations outside of California. The Company's acquisition strategy during this period was primarily focused on large employer group plans that offered indemnity and other health insurance products that were less intensively managed than the Company's products in California. From 1987 until 1996, the Company transitioned substantially all of its California indemnity insurance customers to managed care products. An element of the Company's geographic expansion strategy during this period was to replicate its experience in California in motivating traditional indemnity members to transition to the Company's broad range of managed care products.

More recently, the Company has focused on acquiring businesses that provide significant concentrations of members in strategic locations outside of California. In connection with this strategy, the Company completed its acquisitions of RightCHOICE in January 2002, Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross and Blue Shield of Georgia ("Georgia Blue"), in March 2001 and Rush Prudential Health Plans ("Rush Prudential") in March 2000. The Company's pending acquisition of CareFirst, Inc. ("CareFirst") is also an element of this strategy.

As of December 31, 2001, the Company's primary internal business divisions were focused on large employer group business, individual and small employer group business, and senior and specialty business. Revenues (with sales to external customers and sales or transfers to other segments shown separately), operating profit or loss and identifiable assets attributable to each of the Company's reportable segments are set forth in Note 19 to the Consolidated Financial Statements, which are included elsewhere in this Annual Report on Form 10−K. As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002. As a result of these changes, the Company currently anticipates that its Quarterly Report on Form 10−Q for the quarterly period ending March 31, 2002 (and subsequent filings under the Securities Exchange Act of 1934) will reflect the following two reportable segments: Health Care business and Specialty business.

Recent Completed Transactions and Pending Transactions

Acquisition of RightCHOICE

On January 31, 2002, the Company completed its merger (the "RightCHOICE Merger") with RightCHOICE, pursuant to the Agreement and Plan of Merger dated October 17, 2001 (the "RightCHOICE Merger Agreement"), by and among the Company, RWP Acquisition Corp., a wholly owned subsidiary of the Company, and RightCHOICE. As a result of the merger, RightCHOICE has now become a wholly owned subsidiary of WellPoint, and WellPoint now holds the exclusive license to use the Blue Cross and Blue Shield names and marks in 85 counties in the state of Missouri.

Pursuant to the RightCHOICE Merger Agreement, each issued and outstanding share of RightCHOICE Common Stock at the closing of the RightCHOICE Merger was converted into the right to receive $66 in cash or 0.6161 shares of WellPoint Common Stock. Stockholders of RightCHOICE were given the option to elect to receive cash for any or all of the shares of RightCHOICE Common Stock that they owned as of the effective time of the RightCHOICE Merger, subject to a proration provision to ensure that 30% of the outstanding shares of RightCHOICE Common Stock were converted into cash and the remaining 70% were converted into WellPoint Common Stock. Total consideration paid to all holders of RightCHOICE Common Stock in the merger was approximately $379.0 million in cash and 8,255,052 shares of WellPoint Common Stock (prior to the Company's two−for−one stock split in the form of a stock dividend, which was effected on March 15, 2002). As of December 31, 2001, RightCHOICE had approximately 3.0 million members. During the year ended December 31, 2001, RightCHOICE had total revenues of $1.2 billion and net income of $66.4 million.

Acquisition of Cerulean

On March 15, 2001, the Company completed its acquisition of Cerulean. The Merger Agreement provided for the merger (the "Cerulean Merger") of Water Polo Acquisition Corp., a wholly owned subsidiary of WellPoint, with and into Cerulean. As a result of the Cerulean Merger, Cerulean has now become a wholly owned subsidiary of WellPoint. At the effective time of the Merger, the shareholders of Cerulean became entitled to receive aggregate cash consideration of $700 million. As of December 31, 2000, Cerulean, through Georgia Blue and its various other subsidiaries, served approximately 1.8 million medical members in the state of Georgia.

Pending Acquisition of CareFirst

On November 20, 2001, the Company entered into a definitive agreement (the "CareFirst Merger Agreement") to acquire CareFirst. CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services. As of December 31, 2001, CareFirst served approximately

3.1 million members in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware.

The CareFirst portfolio of products ranges from traditional fee−for−service health care insurance to fully managed care. CareFirst administers the largest Federal Employees Health Plan in the nation. CareFirst affiliate companies also offer third−party administrative services and claims processing for self−insured groups.

Under the terms of the CareFirst Merger Agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion.

The Company will pay at least $450 million of the purchase price in cash and the balance in shares of the Company's Common Stock based on its average closing price in the 20 trading day period ending the fifth trading day prior to the closing of the CareFirst transaction. In the event that the average closing price is below $35 per share, the Company may issue a five−year subordinated note in lieu of a portion of the purchase price to be paid in its Common Stock. The subordinated note will rank *pari passu* with the Company's Zero Coupon Convertible Subordinated Debentures due 2019.

Before the CareFirst transaction is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law.

The conversion will require the approval of insurance regulators in each of the areas where CareFirst and its affiliates are domiciled—Maryland, Delaware and the District of Columbia. In addition, Group Hospitalization and Medical Services, Inc., CareFirst's operating affiliate in the District of Columbia, must have its federal charter amended or repealed by the United States Congress (subject to presidential approval) and obtain approval from the Washington, D.C. corporation counsel. The acquisition of CareFirst will also be subject to regulatory approval in the States of Maryland and Delaware and in the District of Columbia, and to antitrust clearance by the U.S. Department of Justice and the Federal Trade Commission.

The transaction is subject to the receipt of a private letter ruling from the Internal Revenue Service (the "IRS") that the conversion of CareFirst will constitute a tax−free reorganization and that gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. Although there can be no assurances that WellPoint and CareFirst will obtain the necessary approvals, the conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the CareFirst Merger Agreement.

On the closing date, one non−employee member of the existing Board of Directors of CareFirst will be appointed to the Company's Board of Directors. The chief executive officer of CareFirst will be named the president of the Company's southeast business region. Other senior executives of CareFirst will be assigned significant responsibilities with respect to the business of the Company in that area.

In April 2002, the Maryland legislature adopted legislation that would, among other things, require that the consideration paid by the Company in the CareFirst transaction consist entirely of cash, prohibit certain change−in−control payments to CareFirst management previously approved by CareFirst's Board of Directors and delay for 90 days the effectiveness of any decision by the Maryland Insurance Administrastion regarding CareFirst's for−profit conversion and consummation of the CareFirst transaction in order to allow the Maryland legislature to review the decision. The Company is currently assessing the effects of this legislation on the proposed transaction.

Managed Health Care Overview

An increasing focus on costs by employers and consumers over the last decade has spurred the growth of HMO, PPO, POS and other forms of managed care plans as alternatives to traditional indemnity health insurance. Typically, HMOs and PPOs, as well as hybrid plans incorporating features of each (such as POS plans), develop health care provider networks by entering into contracts with hospitals, physicians and other health care professionals to deliver health care at favorable rates that incorporate health care utilization management and other measures that encourage the delivery of medically necessary care as well as network credentialing and quality assurance. HMO, PPO and POS members generally are charged periodic, prepaid premiums, and copayments or deductibles. PPOs, POS plans and a number of HMOs allow out−of−network usage, typically at substantially higher out−of−pocket costs to members. HMO members generally select one primary care physician from a network who is responsible for coordinating health care services for the member, while PPOs and other "open access" plans generally allow members to select physicians without coordination through a primary care physician. Hybrid plans, such as POS plans, typically involve the selection of primary care physicians similar to HMOs, but allow members to choose non−network physicians at higher out−of−pocket costs similar to PPOs.

The California Market. The desire of California−based employers for a range of health care choices that promote effective cost controls and quality care has contributed to substantial market acceptance of managed health care in California, where the total penetration of managed health care companies is generally higher than the national average. Initial developments in California with respect to managed care were focused on HMOs and other tightly controlled plans. Over the last few years, this emphasis has decreased as consumers and media scrutiny have generally criticized the reduced choice typical of HMO plans and as greater regulatory restrictions have been placed on HMO offerings. The Company believes that this movement towards PPOs and other open access plans will continue in the future.

Other States. Outside of California, the past decade has seen significant transformations in the health care sector. Although market acceptance of the array of managed health care plans continues to grow throughout the United States, it still varies widely from state to state. In some states, especially larger population centers, members are offered health care choices focused on HMO or other closed−access plans. In other states, members are typically offered a spectrum of health care choices which are more focused on PPOs or traditional indemnity health models than in California. Indemnity insurance usually allows members substantial freedom of choice in selecting health care providers but without significant financial incentives or cost−control measures typical of managed care plans. Indemnity insurance plans typically require annual deductible obligations of members. Upon satisfaction of the deductible, the member is reimbursed for health care expenses on a full or partial basis of the indicated charges. Health plan reimbursement is often limited to the health plan's assessment of the reasonable and customary charges prevailing in a region for the particular health care procedure. As in California, initial developments in managed care in other states have generally focused on more restrictive plans. More recently, consumer and general public sentiment has shifted towards open access plans.

Customer Segmentation

WellPoint's products are generally developed and marketed with an emphasis on the differing needs of various customer groups. In particular, the Company's product development and marketing efforts take into account the differing characteristics between the various customer groups served by the Company, including individuals and small employers, large employers (generally with 51 or more employees), seniors and Medicaid recipients, as well as the unique needs of educational and public entities, federal employee health and benefit programs, national employers and state−run programs servicing high−risk and under−served markets. Individual business units are responsible for enrolling, underwriting and servicing customers in specific segments. The Company believes that one of the keys

to its success has been its focus on distinct customer groups defined generally by employer size and geographic region, which better enables the Company to develop benefit plans and services that meet the needs of these distinct markets. Although the Company has experienced increased competition over the last several years, the Company has long been a market leader in the California individual and small employer group market.

Individual and Small Group Business

Marketing

Sales representatives are generally assigned to a specific geographic region to allow WellPoint to tailor its marketing efforts to the particular health care needs of each regional market. Individual and small employer group products are marketed in California primarily through independent agents and brokers, who are overseen by WellPoint's sales departments, and through WellPoint's direct sales staff. UNICARE's individual and small employer group products are generally distributed on a regional basis by independent sales agents in the various localized markets in which UNICARE operates. The Company's Blue Cross and Blue Shield products in Georgia and Missouri are also distributed by independent sales agents working in conjunction with the Company's internal sales staff. The Company expects that, over time, the development of Internet−based distribution methods may affect the sales and marketing process in the individual and small employer group market. In this regard, in 1999 the Company entered into sales distribution arrangements with certain Internet−based sales agents and introduced its Agent Connect program, which allows individual agents and brokers to create customized Internet websites and incorporate basic information regarding the Company's health plan offerings.

Products

PPO and Other Plans. The Company's PPO products are generally marketed in California under the name "Prudent Buyer," in Georgia under the name "Blue Choice PPO," in Missouri under the name "Alliance PPO" and in various parts of the country under the names "UNICARE" and "HealthLink" and are designed to address the specific needs of different customer groups. The Company's PPO plans generally require periodic, prepaid premiums and may have copayment obligations for services rendered by network providers that are often similar to the copayment obligations of its HMO plans. Unlike WellPoint's HMO and other "closed−access" plans, members are not required to select a primary care physician who is responsible for coordinating their care and may be subject to annual deductible requirements. PPO members have the option to receive health care services from non−network health care professionals, typically at substantially higher out−of−pocket costs to members. In 1998, the Company introduced its unique Employee Elect product, which allows small employers to offer their employees a menu of PPO and HMO options. In January 2001, the Company introduced its PlanScape family of individual PPO plans in California. The PlanScape plans are marketed towards purchasers with varying price preferences and offer a variety of coverage options and premium amounts. The Company's PPO members in California, Missouri and Georgia may also participate in the Blue Cross Blue Shield Association's Blue Card program, which allows members to access other Blue Cross Blue Shield plans' PPO providers throughout the nation.

The Company believes that an important growth opportunity in the individual market lies in the development of products that are priced attractively for previously uninsured people. In 2000, the Company introduced a new PPO product in California and selected other locations that offers significantly lower premiums in exchange for certain limited benefits while still offering primary care physician visits, preventive care benefits and catastrophic coverage. During 2001, the Company also introduced this product in Georgia.

HMO Plans. The Company offers a variety of HMO products to its HMO members in California, Georgia, Illinois and Missouri. HMO members are generally charged periodic, prepaid premiums that

do not vary based on the amount of services rendered, as well as co−payments (per−visit charges). Members choose a primary care physician from the HMO network who is usually responsible for coordinating health care services for the member. Certain plans permit members to receive services from health care professionals that are not a part of the Company's HMO network at a substantial out−of−pocket cost to members which includes a deductible and higher copayment obligations.

Large Group Business

During the last several years, WellPoint's large employer group business has experienced considerable growth. The Company attributes this growth in California primarily to the strength of the California economy and, throughout the country, to the enhancement of the Company's reputation for customer service and value especially among large, established companies.

Marketing and Products

WellPoint's managed health care plans to large employers are generally sold by WellPoint sales personnel, in conjunction with an employer's broker or consultant, to develop a package of managed health care benefits specifically tailored to meet the employer's needs. WellPoint believes that a key component of its success in this market segment is the Company's strength in developing complex, highly customized benefits packages that respond to the diverse needs of larger employers and their employee population. For example, in 1999, the Company introduced its Blue Cross Preferred PPO product in California, which provides certain enhanced benefits desired by high−technology companies in competitive labor markets.

Many of WellPoint's HMO and PPO products offered to individuals and small employer groups are also offered to large employer groups. In addition to competitive pricing and exemplary customary service, a key competitive factor in the sale of large employer group products is the ability to offer a spectrum of health plan choices. With the completion of the Company's acquisitions of RightCHOICE, Cerulean and Rush Prudential, the Company is able to offer a mix of products, including HMO and PPO products, to customers in Missouri, Georgia and the greater Chicago area. One component of the Company's expansion strategy outside of California is to evaluate acquisition opportunities that will allow the Company to complement its product offerings in selected target areas.

Management Services

In addition to fully insured products, WellPoint provides administrative services to large group employers that maintain self−funded health plans. In California, the Company often has been able to capitalize on this relationship by subsequently introducing WellPoint's underwritten managed care products. The Company's managed care services revenues have expanded considerably during the last several years as a result of the MMHD, GBO and Cerulean acquisitions. These businesses are comprised of a higher percentage of administrative services business than the Company's traditional California business. Georgia Blue currently provides administrative services for several accounts sponsored by the state of Georgia. These accounts comprise in excess of 24% of Georgia Blue's membership.

WellPoint offers managed care services, including underwriting, actuarial services, medical cost management, claims processing and administrative services for self−funded employers. WellPoint also enables employers with self−funded health plans to use WellPoint's provider networks and to realize savings through WellPoint's favorable provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. As of December 31, 2001, WellPoint served self−insured health plans covering approximately 3.4 million medical members.

In connection with the RightCHOICE transaction, the Company has acquired RightCHOICE's subsidiary, HealthLink. HealthLink provides provider network contracting services and review, management and coordination of health care services used by members. HealthLink currently serves the states of Missouri, Illinois, Iowa, Arkansas, Indiana, Kentucky and West Virginia. HealthLink's services are provided to employers that fund their own health plans, commercial insurers, unions and Taft−Hartley trusts. HealthLink also derives a portion of its revenues from providers for support and administrative services. As of December 31, 2001, HealthLink had approximately 1.1 million group health PPO administrative services members and 0.9 million workers' compensation members. In addition, one of HealthLink's wholly owned subsidiaries had approximately 12,000 HMO members. One of the Company's business strategies is to expand the HealthLink business in selected regions of the country.

Senior Plans

WellPoint offers numerous Medicare supplement plans, which typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. For example, WellPoint offers a PPO−based product that offers supplemental Medicare coverage and a hybrid product which allows seniors over the age of 65 to maintain their full Medicare benefits for any out−of−network benefits while enrolled in a supplemental plan that allows them to choose their own physician with a copayment. As of December 31, 2001, these Medicare supplemental plans served approximately 338,000 members. As of December 31, 2001, RightCHOICE's Medicare supplemental plans had approximately 47,000 members. These products are marketed under the "Blue Horizons" name.

WellPoint also offers an HMO plan under a Medicare + Choice contract in certain locations in California and Georgia. These contracts generally entitle WellPoint to a fixed per−member premium which is subject to adjustment annually by the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare program, based on certain demographic information relating to the Medicare population and the cost of providing health care in a particular geographic area. In addition to physician care, hospitalization and other benefits covered by Medicare, the benefits under these plans (which vary by county) typically include routine physical exams, hearing tests, immunizations, eye examinations, counseling and health education services. As of December 31, 2001, the Company's Medicare + Choice HMO plans served approximately 61,000 members.

Medicaid Plans and Other State−Sponsored Programs

The California Department of Health Services ("DHS") administers Medi−Cal, California's Medicaid program. WellPoint has been awarded contracts to offer Medi−Cal managed care programs in various California counties. Under these programs, WellPoint provides health care coverage to Medi−Cal program members and DHS (or a delegated local agency) pays WellPoint a fixed payment per member per month. As of December 31, 2001, approximately 941,000 members were enrolled in WellPoint's Medi−Cal managed care programs in various California counties and in other state−sponsored programs. The Company has also obtained contracts to serve Medicaid members in locations outside of California, including parts of Oklahoma, Virginia and Massachusetts. As of December 31, 2001, the plans serving these members had approximately 95,000 members. In 2000, the Company entered into a joint venture with Medical Card Systems, Inc., a Puerto Rico−based group health and life insurer, to pursue contracts under the Health Reform Program in Puerto Rico.

Managed Health Care Networks and Provider Relations

The Company's health care networks and provider relations reflect the different market positions of the Company's various operating subsidiaries and local market dynamics in the various jurisdictions in which the Company does business.

Blue Cross of California

WellPoint's extensive managed health care provider networks in California include its HMO, PPO and specialty managed care networks. WellPoint uses its large California membership to negotiate physician contracts at favorable rates that promote delivery of quality care and encourage effective utilization management. Under these contracts, physicians are paid either a fixed per member monthly amount (known as a capitation payment) or on the basis of a fixed fee schedule. In selecting physicians for its networks, WellPoint uses its credentialing programs to evaluate the applicant's professional qualifications and experience, including license status, malpractice claims history and hospital affiliations.

The following is a more detailed description of the principal features of WellPoint's California PPO and HMO networks.

PPO Network. There were approximately 3.6 million members (including administrative services members) enrolled in WellPoint's California PPO health care plans as of December 31, 2001, approximately 35% of whom were individuals or employees of small groups.

WellPoint endeavors to manage and control costs for its PPO plans by negotiating favorable arrangements with physicians, hospitals and other health care professionals, and requiring participation in the Company's various medical management programs. In addition, WellPoint manages costs through pricing and product design decisions intended to influence the behavior of both members and health care professionals.

WellPoint's California PPO plans provide for the delivery of specified health care services to members by contracting with physicians, hospitals and other health care professionals. Hospital contracts are on a nonexclusive basis and generally provide for per diem payments (a fixed fee schedule where the daily rate is based on the type of service) that provide for rates that are below the hospitals' standard billing rates. Physician contracts are also on a nonexclusive basis and specify fixed fee schedules that are below standard billing rates. WellPoint is able to obtain prices for hospitals and physician services below standard billing rates because of the volume of business it offers to health care professionals that are part of its network. Rates are generally negotiated on an annual or multi−year basis with hospitals. Rates for physicians in the Company's PPO network are set from time to time by the Company.

HMO Network. Membership in the Company's California HMO was approximately 2.3 million members as of December 31, 2001.

The physician network of participating medical groups ("PMGs") is comprised of both multi−specialty medical group practices and individual practice associations ("IPAs"). Substantially all primary care physicians or PMGs in the Company's California HMO network are reimbursed on a capitated basis. These arrangements specify fixed per member per month payments to providers and may result in a marginally higher medical loss ratio than a non−capitated arrangement, but significantly reduce risk to WellPoint. Generally, HMO network hospital contracts are on a nonexclusive basis and provide for a per diem payment, which is below the hospitals' standard billing rates.

Contractual arrangements with PMGs typically include provisions under which WellPoint provides limited stop−loss protection. If the PMG's actual charges for medical services provided to a member exceed an agreed−upon threshold amount, WellPoint will pay the group a portion of the excess amount. Rates are generally negotiated with PMGs and hospitals on an annual or multi−year basis. To encourage PMGs to contain costs for claims for non−capitated services such as inpatient hospital, outpatient surgery, hemodialysis, emergency room, skilled nursing facility, ambulance, home health and alternative birthing center services, WellPoint's PMG agreements provide for a settlement payment to the PMG based upon the PMG's effective utilization of such non−capitated services. PMGs are also eligible for additional incentive payments based upon their satisfaction of quality criteria and management of

outpatient prescription drugs. In 2001, BCC announced plans to modify the incentive compensation arrangements for PMGs serving the Company's California HMO members to place greater emphasis on assessment of health outcomes, patient satisfaction information and generic outpatient drug utilization. This information will be reflected in a Quality Score Card prepared by BCC with respect to a particular PMG. BCC will seek to implement this modification as agreements with PMGs are renewed over the next two to three years.

Blue Cross Blue Shield of Georgia

In 1995, Cerulean began using jointly owned integrated delivery systems for managed health care products, with community health partnership networks ("CHPNs") as the cornerstone of this strategy. CHPNs are locally based equity ventures between Georgia Blue and a local physician group or hospital. The physician or hospital joint ventures, as well as other health care professionals with which the CHPN maintains contracts, provide clinical services. Georgia Blue provides sales, management and administrative services, including information systems and data management services. Georgia Blue's HMO affiliate collects premium and fee revenues from subscribers and retains a flat percentage as a contribution to surplus. After deduction for premium taxes and administrative payments for Georgia Blue, the remaining premium revenue is used for payment of medical expenses and contributions to the CHPN's retained earnings. As of December 31, 2001, Georgia Blue had one active CHPN, in the greater Atlanta area. Outside of Atlanta, networks for Georgia Blue's HMO products are maintained without the use of a CHPN. The HMO membership in Atlanta that uses the CHPN Network accounts for a significant percentage of Georgia Blue's HMO membership.

Georgia Blue has developed extensive physician and hospital networks that serve Georgia Blue's PPO Plans and certain of its indemnity products. For these products, Georgia Blue uses a variety of reimbursement methods, including per diem payments, maximum allowable charge, case rates, discounted fee−for−service and fee schedules.

Blue Cross Blue Shield of Missouri

The health care services received by Blue Cross Blue Shield of Missouri members are provided primarily by physicians, hospitals and other health care professionals in proprietary provider networks. Blue Cross Blue Shield of Missouri maintains multiple managed care provider networks, including PPO and HMO networks. Networks are developed based upon the geographic locale of the provider, the appropriateness of the provider's specialty and the particular region for that network, as well as the convenience and accessibility of the membership. As with the Company's other networks, physicians' credentials and experience and other factors are evaluated. The managed care contracts with providers incorporate utilization management and quality improvement provisions. Network physicians receive either a monthly capitation payment or are paid on the basis on a fixed fee schedule which is generally lower than standard billing rates. PPO physicians are compensated on the basis of a fixed fee schedule. Most of the primary care physicians in the HMO provider networks are compensated on a capitated basis, while most specialist physicians are compensated on the basis on a fixed fee schedule. Hospital contracts generally provide for inpatient per diem payments, which provide for a reimbursement that is below the hospital's standard billing rates for an inpatient stay.

HealthLink

HealthLink has developed extensive PPO networks in Missouri, Illinois, Indiana and various other states in which it operates. HealthLink's current network expansion efforts are concentrated on developing and supplementing the HealthLink provider networks in existing and adjacent areas of regional Missouri, Illinois, Indiana, Arkansas and Kentucky. HealthLink has also developed an HMO network concentrated in eastern and central Missouri and southern and central Illinois. To serve its workers' compensation members, HealthLink has developed workers compensation PPO networks serving portions of Missouri, Illinois and Indiana. Physician and hospital representation in HealthLink's various networks takes into account a number of factors, including the particular specialty or offered services of a contracting physician or facility. Managed care contracts generally incorporate utilization management and quality improvement features. Many of these contracts also obligate contracting providers to pay HealthLink a monthly fee for administrative services provided by HealthLink.

UNICARE

Due to the more recent development of the Company's UNICARE national operations, UNICARE's relations with health care professionals are more varied than the Company's relations in California. Since 1996, the Company has conducted its network development efforts in various states, including Georgia, Illinois, Indiana, Maryland, Ohio, Texas and Virginia.

As a result of the Rush Prudential acquisition, UNICARE added Rush Prudential's existing networks to its proprietary networks in the greater Chicago area. As part of the MMHD acquisition, the Company also acquired a majority ownership interest in a PPO entity, UNICARE National Capital Preferred Provider Organization ("UNICARE NCPPO"), which operates in the Maryland/Virginia area and is a joint venture with local health care providers.

A large number of UNICARE members are served by third−party provider networks, which generally lack the selectivity and discounts typical of the Company's proprietary networks. One of the Company's strategies for the expansion of its UNICARE operations is to continue building and acquiring proprietary network systems in certain geographies similar to the Company's networks in California, which provide a continuum of managed care products to various customer segments. As UNICARE expands its operations, it intends to build or acquire such network operations and, as appropriate, to replace or supplement the current third−party network arrangements. During the last three years, UNICARE has consolidated its third−party network relationships in an effort to further contain its administrative expenses.

Ancillary Networks

WellPoint evaluates current and emerging high volume or high cost services to determine whether developing an ancillary service network will yield cost control benefits. In establishing these ancillary service networks, WellPoint seeks to enter into capitation or fixed−fee arrangements with providers of these services. WellPoint regularly collects and analyzes industry data on high cost or high volume unmanaged services to identify the need for specialty managed care networks. For example, WellPoint has created Centers of Expertise for certain transplant services.

Utilization Management

In order to better manage quality in its proprietary provider networks, WellPoint adopts utilization management processes and guidelines that are intended to reduce unnecessary or inappropriate procedures, admissions and other medical costs. The utilization management systems seek to provide access to quality care to WellPoint's members based on medical necessity where final decisions are made by physicians. In its California HMO, WellPoint permits PMGs to oversee most utilization management for their particular medical group under WellPoint's guidelines. Currently, substantially all

of the PMGs in WellPoint's California HMO network have established committees to oversee utilization management. For its California PPO network, WellPoint uses treatment guidelines, requires pre−admission approvals of hospital stays and concurrent review of all admissions and retrospectively reviews physician practice patterns. Utilization management also includes an outpatient program, with pre−authorization and retrospective review, ongoing supervision of inpatient and outpatient care of members, case management and discharge planning capacity. Review of practice patterns may result in modifications and refinements to the PPO plan offerings and network contractual arrangements. In addition, WellPoint manages health care costs by periodically reviewing cost and utilization trends within its provider networks. Cases are reviewed in the aggregate to identify a high volume of a particular type of service to identify the most effective method of treatment while more effectively managing costs. In addition, the Company reviews high−cost procedures in an effort to provide new quality, cost−effective treatment by utilizing new technologies or by creating additional networks, such as its networks of home health agencies.

For the Company's UNICARE managed care health plans, utilization management is provided by UNICARE through the Company's subsidiary CostCare, Inc. ("CCI"). As part of the GBO acquisition, the Company acquired CCI, which provides medical management services. The Company has integrated CCI's traditional utilization management and case management services into UNICARE offerings. CCI products include a disease state management program, a high−risk pregnancy identification and management program and a nurse health information line. Certain of the Company's plans in California also feature similar programs. In September 2001, CCI (which operates as UNICARE/Cost Care) received a one−year accreditation for its utilization management program from the Utilization Review Accreditation Commission ("URAC"), a private organization providing voluntary accreditation of utilization review entities. Additionally, in February 2000, CCI received a two−year accreditation from URAC for its health information line program.

In 2000, the National Committee for Quality Assurance ("NCQA") awarded Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. its second full, three−year accreditation. Georgia Blue's PPO organization was the first PPO in Georgia to receive accreditation from URAC. In 1999, NCQA awarded the Company's subsidiary HMO Missouri, Inc. a three−year accreditation. Blue Cross Blue Shield of Missouri's Alliances PPO and the HealthLink PPO have also received accreditation from URAC.

In 1996, Blue Cross Blue Shield of Missouri developed its innovative Physician Group Partners Program, which is designed to increase collaborative managed care initiatives with primary care physicians in Blue Cross Blue Shield of Missouri's HMO and to provide those physicians with the opportunity to earn additional compensation by improving patient satisfaction and improving performance levels using nationally recognized health care industry standards. The program has subsequently been expanded to include a specialist program. The Physician Group Partners Program strives to establish long−term business relationships with physicians. Blue Cross Blue Shield of Missouri believes that this program has resulted in reduced integration and oversight of physicians, enhanced member satisfaction and improved quality measure scores. Blue Cross Blue Shield of Missouri has also implemented additional initiatives to enhance its business relationships with the physician community. As WellPoint begins its integration of the RightCHOICE operations, WellPoint intends to explore the various programs implemented by Blue Cross Blue Shield of Missouri and consider their applicability to other regions of the country in which WellPoint operates.

Underwriting

In establishing premium rates for its health care plans, WellPoint uses underwriting criteria based upon its accumulated actuarial data, with adjustments for factors such as claims experience, member mix and industry differences to evaluate anticipated health care costs. WellPoint's underwriting practices in the individual and small group market are subject to legislation in California, Georgia,

Illinois, Missouri and other states affecting the individual and small employer group market. Because UNICARE's members are in every state, the Company's underwriting practices, especially in the individual and small group market, are subject to a variety of legislative and regulatory requirements and restrictions. See "Government Regulation."

Quality Management

Quality management for most of the Company's business is overseen by the Company's Quality Management Department and is designed to ensure that necessary care is provided by qualified personnel. Depending on the local markets, quality management encompasses plan level quality performance, provider credentialing, provider and member grievance monitoring and resolution, medical group auditing, monitoring medical group compliance with Company standards for medical records and medical offices, physician peer review and a quality management committee.

Specialty Managed Health Care and Other Plans and Services

WellPoint offers a variety of specialty managed health care and other services. WellPoint believes that these specialty networks and plans complement and facilitate the marketing of WellPoint's medical plans and help in attracting employer groups and other members that are increasingly seeking a wider variety of options and services. WellPoint also markets these specialty products on a stand−alone basis to other health plans and other payors.

Pharmacy Products

WellPoint offers pharmacy services and pharmacy benefit management services to its members. WellPoint's pharmacy services incorporate features such as drug formularies (a WellPoint−developed listing of preferred, cost−effective drugs), a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Pharmacy benefit management services provided by WellPoint include management of drug utilization through outpatient prescription drug formularies, retrospective review and drug education for physicians, pharmacists and members. In December 2000, the Company completed its acquisition of a mail−order pharmacy facility, which now operates under the name PrecisionRx. The Company believes that PrecisionRx will enhance the competitiveness of its pharmacy benefit management services. As of December 31, 2001, WellPoint had approximately 32.8 million pharmacy members.

Dental Plans

WellPoint's California dental plans include Dental Net, its California dental HMO, and Blue Cross Dental Select HMO, a hybrid plan, a dental PPO, and traditional indemnity plans. The Company's dental products outside of California currently include a dental PPO in Texas, Georgia and almost all of the other states in which the Company operates. As a result of the MMHD and GBO acquisitions, the Company has acquired significant additional dental membership outside of California. The Company's dental plans provide primary and specialty dental services, including orthodontic services, and as of December 31, 2001, served approximately 2.6 million dental members.

Life Insurance

The Company offers primarily term−life and accidental death and dismemberment ("AD&D") insurance to employers, generally in conjunction with the Company's health plans. The MMHD, GBO and Cerulean acquisitions have expanded the Company's life insurance business both inside and outside of California. As of December 31, 2001, the Company provided life insurance products to approximately 2.3 million persons.

Mental Health Plans

WellPoint offers specialized mental health and substance abuse programs. The plans cover mental health and substance abuse treatment services on both an inpatient and an outpatient basis. In addition, approximately 260 employee assistance and behavioral managed care programs have been implemented for a wide variety of businesses throughout the United States. As of December 31, 2001, there were approximately 5.1 million members covered under WellPoint's mental health plans.

Utilization Management

In connection with the GBO acquisition, the Company acquired CCI. CCI, which now operates under the trade name UNICARE/CostCare, provides stand−alone utilization management and other medical management services to other health plans and self−funded employers. CCI utilization management services are also integrated into UNICARE product offerings. As of December 31, 2001, the Company had approximately 1.7 million utilization management members.

Disability Plans

The Company offers short− and long−term disability programs, usually in conjunction with the Company's health plans. As of December 31, 2001, the Company provided long−term or short−term disability coverage to approximately 541,000 individuals.

Long−Term Care Insurance

In 1997, the Company began offering a group of long−term care insurance products to its California members through its indirect wholly owned subsidiary BC Life & Health Insurance Company ("BC Life"). These plans, which are marketed under the Blue Cross Long Term Care trade name, involve six different products. The Company's long−term care products include tax−qualified and non−tax qualified versions of a skilled nursing home care plan and comprehensive policies covering skilled, intermediate and custodial long−term care and home health care services.

Workers' Compensation Managed Care Services

In California, the Company offers workers' compensation managed care services, including bill review, network access, medical cost management and utilization management, to employers who self−insure their workers' compensation coverage, as well as to workers' compensation carriers. The Company's HealthLink subsidiary also provides workers' compensation managed care services to its clients in the central portion of the United States. See "Large Group Business—Management Services."

Market Research and Advertising

WellPoint conducts market research and advertising programs to develop products and marketing techniques tailored specifically to customer segments. WellPoint uses print and broadcast advertising to promote its health care plans. In addition, the Company engages in promotional activities with agents, brokers and consultants. WellPoint incurred costs of approximately $59.6 million, $61.8 million and $40.8 million on advertising for the years ended December 31, 2001, 2000 and 1999, respectively.

Competition

The managed health care industry in California is competitive on both a regional and statewide basis. In addition, in recent years there has been a trend of increasing consolidation among both national and California−based health care companies, which may further increase competitive pressures. WellPoint competes with other companies that offer similar managed health care plans, some of which

have greater resources than WellPoint. In addition, the development and growth of companies offering Internet−based connections between health care professionals, employers and members, along with a variety of services, may create additional competitors. Currently, WellPoint is a market leader in offering managed health care plans to individuals and small employer groups in California. The medical loss ratio attributable to WellPoint's individual and small group business has historically been lower than that for its large employer group business. As a result, a larger portion of WellPoint's profitability on a per−member basis is due to the individual and small group business. WellPoint has experienced increased competition in this market over the last several years, which could adversely affect its medical loss ratio and future financial condition, cash flows or results of operations. See "Factors That May Affect Future Results of Operations."

The markets in which the Company operates outside of California are also highly competitive. Because of the many different markets in which the Company now serves members, the Company faces unique competitive pressures in regional markets as well as on a national basis. The Company competes with other companies that offer managed health care plans as well as traditional indemnity insurance products. Many of these companies have greater financial and other resources than the Company or greater market share on either a regional or national basis. As the Company continues to geographically expand its operations, it will be subject to national competitive factors as well as unique competitive conditions that may affect the more localized markets in which the Company operates.

WellPoint believes that significant factors in the selection of a managed health care plan by employers and individual members include price, the extent and depth of provider networks, flexibility and scope of benefits, quality of services, market presence, reputation (which may be affected by public rankings or accreditation by voluntary organizations such as NCQA and URAC) and financial stability. WellPoint believes that it competes effectively against other health care industry participants.

Government Regulation

California

DMHC and DOI Regulation. WellPoint offers its managed health care products in California principally through its wholly owned indirect subsidiary Blue Cross of California, which is subject to regulation by the California Department of Managed Health Care (the "DMHC") under the Knox−Keene Health Care Service Plan Act of 1975 (the "Knox−Keene Act"). The insurance business conducted by the Company's subsidiary BC Life & Health Insurance Company ("BC Life") is regulated by the California Department of Insurance (the "California DOI"). Each entity is subject to various minimum capital and other requirements, such as restrictions on the payment of dividends or the issuance of capital stock, established by its respective regulatory authority. Blue Cross of California's managed health care programs are also subject to extensive DMHC regulation regarding benefit and coverage levels, relationships with health care providers, administrative capacity, marketing and advertising, procedures for quality assurance and subscriber and enrollee grievance resolution. Any material modifications to the organization or operations of Blue Cross of California are subject to prior review and approval by the DMHC. BC Life must obtain approval from the California DOI for all of its group insurance policies and certain aspects of its individual policies prior to issuing those policies, as well as certain other material actions which BC Life may propose to take. The failure to comply with applicable regulations can subject BCC or BC Life to various penalties, including fines or the imposition of restrictions on the conduct of its operations.

California Health Care Reform Legislation

Since September 1999, California Legislature has adopted a number of health care reform measures. The following is a summary of the material terms of the most significant of these laws.

The Managed Health Care Insurance Accountability Act of 1999 ("SB 21") established an explicit duty on managed care entities to exercise ordinary care in arranging for the provision of medically necessary health care services to their subscribers and imposed liability for all harm legally caused by the failure to exercise such ordinary care. Managed care entities may be held liable if their failure to exercise ordinary care results in the denial, delay or modification of a health care service recommended for or furnished to the subscriber and the subscriber suffers "substantial harm." For purposes of the statute, "substantial harm" is defined as the loss of life, loss of or significant impairment of a limb or bodily function, significant disfigurement, severe and chronic pain or significant financial loss. Liability may be established for health care services regardless of whether the recommending health care provider is a contracting provider with the managed care entity. Managed care plans may not seek indemnity from a health care provider for the liability imposed by the statute. A cause of action may not be maintained under the statute against a managed care entity unless the subscriber has exhausted independent medical review procedures, except in instances where substantial harm has occurred or will imminently occur prior to the completion of the independent medical review.

Assembly Bill 55 ("AB 55") established an independent medical review system. Every health plan enrollee, whether currently under the regulatory supervision of the DMHC or the California DOI, must be provided with an opportunity to seek an independent medical review whenever health care services have been denied, modified or delayed by a managed care entity or one of its contracting physicians, if this decision was based on a finding that the proposed services are not medically necessary. There is no minimum dollar level for claims to be subject to the independent review process and the enrollee does not have any responsibility for the payment of any application or processing fee. An enrollee's provider may assist and advocate in the review. All health plan contracts must provide an opportunity to seek an independent review. The statute does not apply to decisions by a health plan that health care services are not covered under the plan issued to the subscriber.

Assembly Bill 88 ("AB 88") required that any health care service plan contract or disability insurance policy must provide coverage for the diagnosis and medically necessary treatment of severe mental illness under the same terms and conditions applied to other medical conditions.

Assembly Bill 78 ("AB 78") provided for the creation of the DMHC, which now regulates the health care service plan operations previously under the supervision of the California Department of Corporations. The DMHC is advised by an advisory committee consisting of 22 members, 11 of whom are appointed by the Governor, 10 of whom are appointed by the joint recommendation of the Governor, the Speaker of the California Assembly and the California Senate Committee on Rules and one of whom is the Director of the Department (who is appointed by the Governor). This advisory committee is required to issue an annual report, which will include a report card issued to the public on the comparative performance of managed care organizations. This bill also established an Office of Patient Advocate, who is appointed by the California Governor, to represent the interest of enrollees. The Office of Patient Advocate is charged with the responsibility of helping enrollees secure health care services and will have access to the records of the DMHC. Under the legislation, the new DMHC has been granted expanded powers, including the ability to order the discontinuance of "unsafe or injurious practices."

Senate Bill 260 ("SB 260") established a Financial Solvency Standards Board (the "Board") comprised of the Director of the Department of Managed Care (the "Director") and seven members appointed by the Director. The Board reviews financial solvency matters affecting the delivery of health care services and recommends financial solvency requirements relating to plan operations, plan−affiliate operations and transactions, plan−provider contractual relationships and provider−affiliate operations and transactions. Every contract between a health care service plan and a risk−bearing organization (i.e., any provider group that provides services in exchange for fixed capitation payments) must include a requirement that the risk−bearing organization furnish financial information to the health care service plan. In addition, the health care service plan must disclose information to the risk−bearing organization

that enables the organization to be informed regarding its financial risk. Plans must provide payment of all risk arrangements, excluding capitation payments, within 180 days after the close of each fiscal year. Risk−bearing organizations may not be at financial risk for the provision of health care services unless a particular contract provision allocating such risk has first been negotiated and agreed to between the health care service plan and the risk−bearing organization. In addition, no contract between a health care service plan and a risk−bearing organization may include any provision that requires a health care provider to accept rates or methods of payments unless the provisions have first been negotiated and agreed to between the plan and the risk−bearing organization.

Senate Bill 559 ("SB 559") imposed certain disclosure obligations and other limitations on health care plans, such as the Company, that make their networks of contracted providers available to other entities. Under SB 559, health care plans must disclose to contracting providers that they intend to make their health care networks and the negotiated discounts available to other payors such as self−insured employers or workers' compensation insurance companies. Providers may decline to be included in any list of contracted providers made available to any payor entity that does not provide financial incentives to, or otherwise actively encourage, the payor's members to use the list of contracting providers when obtaining medical care.

Assembly Bill 1455 ("AB 1455") imposed new time limits for the payment of uncontested covered claims and required health care service plans to pay interest on uncontested claims not paid promptly within the required time period. AB 1455 also granted the DMHC additional authority to impose monetary penalties and other sanctions on health plans engaging in certain "unfair payment practices" (as defined in AB 1455).

The California Legislature has also adopted legislation that imposes restrictions on the categories of persons that may be involved in medical management activities and on the conduct of such activities. Various other newly adopted bills mandate coverage for certain benefits, such as the provision of oral contraceptives, and place further limitations on health plan operations.

Federal

A variety of federal laws have been adopted in the last several years effecting the Company's operations and a significant number of measures have also been proposed for future adoption. The following is a summary of the significant enacted measures as well as proposed measures.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the implementing regulations that have thus far been adopted impose new obligations for issuers of health insurance coverage and health benefit plan sponsors. HIPAA requires certain guaranteed issuance and renewability of health coverage for individuals and small groups (generally 50 or fewer employees) and limits exclusions based on preexisting conditions. Most of the insurance reform provisions of HIPAA became effective for "plan years" beginning July 1, 1997.

HIPAA also establishes new requirements regarding the confidentiality of patient health information and regarding standard formats for the transmission of health care data. In December 2000, the Department of Health and Human Services promulgated final regulations regarding the privacy of "protected health information." The rules would, among other things, require that health plans give patients a clear written explanation of how they intend to use, keep and disclose patient health information, prohibit health plans from conditioning payment or coverage on a patient's agreement to disclose health information for other purposes, and create federal criminal penalties for health plans, providers and claims clearinghouses that knowingly and improperly disclose information or obtain information under false pretenses. Final regulations regarding the standard formats for the transmission of health care information have also been released, with an effective date of October 2002. In December 2001, legislation was enacted which offered health entities the option of extending the date for compliance with these regulations until October 2003. The Company currently

expects that it will file for such extension. The privacy and standardization regulations could have the effect of increasing the Company's expenses.

Maternity length of stay and mental health parity benefits measures became effective for plan years beginning January 1, 1998. The maternity stay provision requires health plans to cover the cost of a 48−hour hospital stay (96 hours following a Caesarian section). This measure does not mandate the length of hospital stays but requires that longer stays be covered if deemed necessary by the mother or her physician (in consultation with the mother). Although many states already guarantee minimum hospital stays for mothers and newborns, these measures have further increased WellPoint's claims expense.

Balanced Budget Act. In August 1997, President Clinton signed into law the Balanced Budget Act of 1997 (the "Balanced Budget Act"). The Balanced Budget Act included a number of measures affecting the provision of health care. The act placed restrictions on the variation in Medicare reimbursement amounts (so−called "risk adjusters") between counties. CMS has released proposed risk adjusters, which are currently expected to be implemented in phases through the year 2005. In addition, the Balanced Budget Act ostensibly expanded the managed health plan options available to Medicare enrollees to include PPO, POS and high deductible health plans intended for MSAs. Regulations regarding these changes were adopted in June 1998. Finally, the Balanced Budget Act implemented certain changes with respect to Medicare supplement programs, including guaranteed coverage issues. Certain of the changes under the Balanced Budget Act could have the result of increasing the Company's costs.

Medicare Legislation. WellPoint's health benefits programs include products that are marketed to Medicare beneficiaries as a supplement to their Medicare coverage. These products are subject to Federal regulations intended to provide Medicare supplement customers with standard minimum benefits and levels of coverage and full disclosure of coverage terms and assure that fair sales practices are employed in the marketing of Medicare supplement coverage.

In California and Georgia, WellPoint provides a senior plan product under a Medicare + Choice contract that is subject to regulation by CMS. Under this contract and CMS regulations, if WellPoint's premiums received for Medicare−covered health care services provided to senior plan Medicare members are more than the Company's projected costs associated with the provision of health care services provided to senior plan members, then WellPoint must provide its senior plan members with additional benefits beyond those required by Medicare or reduce its premiums, or deductibles or co−payments, if any. CMS has the right to audit HMOs operating under Medicare contracts to determine the quality of care being rendered and the degree of compliance with CMS' contracts and regulations.

Future Health Care Reform. A number of legislative proposals have been made at the Federal and state levels over the past several years. These proposals would, among other things, mandate benefits with respect to certain diseases or medical procedures, require plans to offer an independent external review of certain coverage decisions or establish health plan liability in a manner similar to the California legislation discussed above or the Georgia and Texas legislation discussed in the following section. The United States Congress is currently considering a number of alternative health care reform measures that would, among other things, mandate external review of treatment denial decisions and provide for managed care liability. There have also been proposals made at the Federal level to implement greater restrictions on employer−funded health plans, which are generally exempted from state regulation by ERISA.

WellPoint is unable to evaluate what legislation may be proposed and when or whether any legislation will be enacted and implemented. However, many of the proposals, if adopted, could have a material adverse effect on WellPoint's financial condition, cash flows or results of operations, while others, if adopted, could potentially benefit WellPoint's business.

Other States

The Company's activities in other states are subject to state regulation applicable to the provision of managed health care services and the sale of traditional health indemnity insurance. As a result of the Company's various acquisitions, the Company and certain of its subsidiaries are also subject to regulation by the DOI in Delaware (which is the state of incorporation and domicile of UNICARE Life & Health Insurance Company, one of the Company's principal operating subsidiaries outside of California), Georgia, Illinois, Indiana, Missouri, Texas and in all other states. As the Company expands its offering of managed care products in new geographic locations, it will be subject to additional regulation by governmental agencies applicable to the provision of health care services. The Company believes it is in compliance in all material respects with all current state regulatory requirements applicable to its business as presently conducted. However, changes in government regulations could affect the level of services which the Company is required to provide or the rates which the Company can charge for its health care products and services.

As the Company continues to expand its operations outside of California, new legislative and regulatory developments in Delaware, Georgia, Illinois, Missouri, Texas and various other states will have greater potential effect on the Company's financial condition, cash flows or results of operations. In 1999 the Georgia Legislature adopted several new bills, including one that requires managed care plans to offer coverage for services rendered by out−of−network providers and one that establishes a Consumers' Insurance Advocate with authority to review and comment upon matters pending before the Department of Insurance. Over the past few years, there has also been an increase in other states in proposed legislation regarding, among other things, mandated benefits, prompt payment of claims, health plan liability, third−party review of health plan coverage determinations and health plan relationships with providers. The Company expects that this trend of increased legislation will continue. These laws may have the effect of increasing the Company's claims expense.

In 1997, the Texas legislature adopted SB 386 which, among other things, purports to make managed care organizations ("MCOs") such as the Company liable for the failure by the MCO, its employees or agents to exercise ordinary care when making "health care treatment decisions" (as defined in the legislation). The legislation was effective as of September 1, 1997. In September 1998, the United States District Court for the Southern District of Texas ruled, in part, that the MCO liability provisions of SB 386 are not preempted by ERISA. To date, this legislation has not adversely affected the Company's results of operations. However, although the Company maintains insurance covering such liabilities, to the extent that this legislation (or similar legislation that may be subsequently adopted at the Federal or state level) effectively expands the scope of liability of MCOs, such as the Company, it may have a material adverse effect on the Company's results of operations, financial condition and cash flows. Even if the Company is not held liable under any litigation, the existence of potential MCO liability may cause the Company to incur greater costs in defending such litigation.

In connection with the GBO acquisition, the Company has entered into a reinsurance arrangement, on a 100% coinsurance basis, of the insured business of the GBO. This business includes a small number of insured persons in Canada covered by group policies issued to U.S.−based employers. As a result, the Company may be subject to certain rules and regulations of applicable Canadian regulatory agencies.

Service Marks

WellPoint and its subsidiaries have filed for registration of and maintain several service marks, trademarks and trade names at the Federal level and in various states in which it operates. WellPoint and various of its operating subsidiaries are currently parties to license agreements with the Blue Cross Blue Shield Association (the "BCBSA") which allow them to use the Blue Cross or Blue Shield names and marks in California, Georgia and parts of Missouri with respect to WellPoint's HMO and PPO

network−based plans. The BCBSA is a national trade association of Blue Cross and Blue Shield licensees. Each licensee is an independent legal organization and is not responsible for the obligations of other BCBSA member organizations. A Blue Cross or Blue Shield license requires payment of a fee to the BCBSA and compliance with various requirements established by the BCBSA, including the maintenance of specified minimum capital. The failure to meet such capital requirements can subject the Company to certain corrective action, while the failure to meet a lower specified level of capital can result in termination of the Company's license agreement with the BCBSA. WellPoint considers the licensed Blue Cross and Blue Shield names and their registered service marks, trademarks and trade names important in the operation of its business.

Employees

At December 31, 2001, WellPoint and its subsidiaries employed approximately 13,900 persons. Approximately 145 of the Company's employees are presently covered by a collective bargaining agreement with the Office and Professional Employees International Union, Local 29. Approximately 163 of the Company's office clerical employees in the greater Detroit area are presently covered by a collective bargaining agreement with the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Local No. 614. As of December 31, 2001, RightCHOICE and its subsidiaries employed approximately 2,300 persons. WellPoint believes that its relations with its employees are good, and it has not experienced any work stoppages.

Executive Officers

Leonard D. Schaeffer, age 56, has been Chairman of the Board of Directors and Chief Executive Officer of the Company since August 1992. Mr. Schaeffer has also been Chief Executive Officer of BCC since 1986 and Chairman of the Board of Directors since 1989. From 1982 to 1986, Mr. Schaeffer served as President of Group Health, Inc., an HMO in the midwestern United States. Prior to joining Group Health, Inc., Mr. Schaeffer was the Executive Vice President and Chief Operating Officer of the Student Loan Marketing Association, a financial institution that provides a secondary market for student loans, from 1980 to 1981. From 1978 to 1980, Mr. Schaeffer was the Administrator of HCFA (now known as CMS), which administers the Federal Medicare and Medicaid programs. Mr. Schaeffer serves as a director of Allergan, Inc. and Providian Financial Corporation.

D. Mark Weinberg, age 49, has been Executive Vice President and Chief Development Officer since February 2002. From March 1999 until February 2002, he was Executive Vice President, Individual and Small Group Division of the Company. From October 1995 until March 1999, he served as Executive Vice President, UNICARE Businesses of the Company. From August 1992 until May 1996, Mr. Weinberg served as a director of the Company. From February 1993 to October 1995, Mr. Weinberg was Executive Vice President, Consumer and Specialty Services of the Company. Prior to February 1993, Mr. Weinberg was Executive Vice President of BCC's Consumer Services Group from December 1989 to February 1993 and was Senior Vice President of Individual and Senior Services of BCC from April 1987 to December 1989. From 1981 to 1987, Mr. Weinberg held a variety of positions at Touche Ross & Co. From 1976 to 1981, Mr. Weinberg was general manager for the CTX Products Division of PET, Inc.

Joan E. Herman, age 48, joined the Company in June 1998 as Executive Vice President, Specialty Division. From April 1999 until March 2000, Ms. Herman was Executive Vice President, Senior and Specialty Businesses. Since March 2000, Ms. Herman has been Executive Vice President, Senior Specialty and State−Sponsored Programs Division. From 1982 until joining the Company, Ms. Herman was with Phoenix Home Life Mutual Insurance Company, a mutual insurance company, most recently serving as Senior Vice President. Ms. Herman is a member of the Society of Actuaries and American Academy of Actuaries.

David S. Helwig, age 45, has been Executive Vice President, Blue Cross of California Businesses since February 2002. From March 2001 until February 2002, he was Executive Vice President, Large Group Division of the Company. From May 2000 until March 2001, Mr. Helwig was Senior Vice President, Western Region, Large Group Businesses of the Company and from March 1999 until May 2000, Mr. Helwig served as Senior Vice President and Chief Actuary for the Company. From 1995 until March 1999, Mr. Helwig served as Senior Vice President of Individual and Small Group Services for the Company and from May 1994 until 1995, Mr. Helwig was Senior Vice President of Consumer Services for CaliforniaCare Health Plans, a subsidiary of the Company. From 1991 to May 1994, Mr. Helwig was Senior Vice President and Chief Actuary of Blue Cross of California and from February 1993 until May 1994, Mr. Helwig also served as Chief Financial Officer and Treasurer of Blue Cross of California.

Rebecca Kapustay, age 50, has been Executive Vice President, Blue Cross and Blue Shield of Georgia since March 2001. From 1979 until 1992, Ms. Kapustay held various positions with Blue Cross of California of increasing responsibility in both operations and data processing. From 1993 until April 1994, Ms. Kapustay was General Manager of the Company and from May 1994 until 2000, Ms. Kapustay held various positions with the Company including Senior Vice President, California Operations and more recently Senior Vice President, Large Group Services.

John A. O'Rourke, age 58, joined the Company in February 2002 as Executive Vice President, Central Business Region. From February 1997 until January 2002, Mr. O'Rourke was Chairman and Chief Executive Officer of RightCHOICE Managed Care, Inc. From January 1985 until joining RightCHOICE, Mr. O'Rourke was President and Chief Executive Officer of HealthLink. Prior to joining HealthLink Mr. O'Rourke was Deputy Director of the Office of HMOs in the U.S. Department of Health and Human Services.

David C. Colby, age 48, joined the Company in September 1997 as Executive Vice President and Chief Financial Officer. From April 1996 until joining the Company, Mr. Colby was Executive Vice President, Chief Financial Officer and Director of American Medical Response, Inc., a health care services company focusing on ambulance services and emergency physician practice management. From July 1988 until March 1996, Mr. Colby was with Columbia/HCA Healthcare Corporation, most recently serving as Senior Vice President and Treasurer. From September 1983 until July 1988, Mr. Colby was Senior Vice President and Chief Financial Officer of The Methodist Hospital in Houston, Texas.

Thomas C. Geiser, age 51, has been Executive Vice President, General Counsel and Secretary of the Company since May 1996. From July 1993 until May 1996, Mr. Geiser held the position of Senior Vice President, General Counsel and Secretary. Prior to joining the Company, he was a partner in the law firm of Brobeck, Phleger & Harrison from June 1990 to June 1993 and a partner in the law firm of Epstein Becker Stromberg & Green from May 1985 to May 1990. Mr. Geiser joined the law firm of Hanson, Bridgett, Marcus, Vlahos & Stromberg as an associate in March 1979 and became a partner in the firm, leaving in May 1985.

Woodrow A. Myers, Jr., M.D., age 48, has been Executive Vice President, Chief Medical Officer of the Company since September 2000. From 1995 until September 2000, he served as Director, Healthcare Management of Ford Motor Company. From 1991 until 1995, Dr. Myers served as Senior Vice President and Corporate Medical Director of The Associated Group (now known as Anthem Blue Cross Blue Shield). From 1990 to 1991, Dr. Myers was the Commissioner of Health for the City of New York. Dr. Myers serves as a director of Somnus Medical Technologies.

Alice F. Rosenblatt, age 53, has been Executive Vice President, Actuarial and Integration Planning and Implementation, and Chief Actuary of the Company since March 2002. From March 1999 to February 2002, Ms. Rosenblatt was Senior Vice President, Actuarial and Integration Planning and Implementation and Chief Actuary of the Company. From August 1998 to February 1999, she was Senior Vice President, Mergers and Acquisitions Integration and from October 1996 to July 1998, she

was Senior Vice President, Chief Actuary of the Company. From February 1994 until September 1996, Ms. Rosenblatt was a partner with Coopers & Lybrand LLP. From May 1989 until December 1993, Ms. Rosenblatt served as the Senior Vice President and Chief Actuary of Blue Cross Blue Shield of Massachusetts. From 1987 until 1989, Ms. Rosenblatt served as the Chief Actuary and Senior Vice President of Blue Cross of California's health maintenance organization and group services.

May 1996 Recapitalization and Restrictions on Ownership and Transfer of Securities

The Company's predecessor, WellPoint Health Networks Inc., a Delaware corporation ("Old WellPoint"), was organized in 1992 as a public for−profit subsidiary of Blue Cross of California ("BCC"), to own and operate substantially all of the managed health care businesses of BCC. In order to fulfill BCC's public benefit obligations to the State of California arising out of the creation of Old WellPoint, BCC and Old WellPoint undertook a recapitalization (the "Recapitalization") which was concluded on May 20, 1996. As a result of the Recapitalization, among other things, Old WellPoint merged into BCC, a special dividend of $995.0 million was made to the shareholders of Old WellPoint and the California HealthCare Foundation (the "Foundation") became the holder of 53,360,000 shares, or approximately 80%, of the surviving WellPoint entity. As of January 2001, the Foundation ceased to own any shares of WellPoint Common Stock.

In connection with the Recapitalization, BCC relinquished its rights under the Blue Cross License Agreement dated January 1, 1991, between Blue Cross of California and the BCBSA. The BCBSA and the Company entered into a new License Agreement (the "License Agreement"), pursuant to which the Company became the exclusive licensee for the right to use the Blue Cross name and related service marks in California and became a member of the BCBSA. See "Service Marks."

At the time of the Recapitalization, pursuant to an agreement with the BCBSA, the Company's Certificate of Incorporation included an "Ownership Limit" with respect to the Company's voting securities. At such time, the "Ownership Limit" was established as one share less than 5% of the Company's outstanding voting securities. In December 1997, the Company and the BCBSA, in accordance with the provisions of Article VII, Section 14(f)(2) of the Company's Certificate of Incorporation, agreed to modify the Ownership Limit to the following: (i) for any "Institutional Investor," one share less than 10% of the Company's outstanding voting securities; and (ii) for any "Noninstitutional Investor," other than the Foundation, one share less than 5% of the Company's outstanding voting securities. For these purposes, "Institutional Investor" means any person if (but only if) such person is (1) a broker or dealer registered under Section 15 of the Securities Exchange Act of 1934 (the "Exchange Act"), (2) a bank as defined in Section 3(a)(6) of the Exchange Act, (3) an insurance company as defined in Section 3(a)(19) of the Exchange Act, (4) an investment company registered under Section 8 of the Investment Company Act of 1940, (5) an investment adviser registered under Section 203 of the Investment Advisers Act of 1940, (6) an employee benefit plan, or pension fund which is subject to the provisions of the Employee Retirement Income Security Act of 1974 or an endowment fund, (7) a parent holding company, provided the aggregate amount held directly by the parent, and directly and indirectly by its subsidiaries which are not persons specified in paragraphs (1) through (6), does not exceed one percent of the securities of the subject class, or (8) a group, provided that all the members are persons specified in paragraphs (1) through (7). In addition, every filing made by such person with the SEC under Regulation 13D−G (or any successor Regulation) under the Exchange Act with respect to such person's beneficial ownership must contain a certification (or a substantially similar one) that the WellPoint Common Stock acquired by such person was acquired in the ordinary course of business and was not acquired for the purpose of and does not have the effect of changing or influencing the control of WellPoint and was not acquired in connection with or as a participant in any transaction having such purpose or effect. For such purposes, "Noninstitutional Investor" means any person that is not an Institutional Investor.

In December 1997, the Company and the BCBSA also agreed that the License Agreement would be subject to termination in the event that any entity other than the Foundation became the beneficial owner of 20% or more of WellPoint's then−outstanding Common Stock or other equity securities which (either by themselves or in combination) represented an ownership interest of 20% or greater. WellPoint also agreed that it would not issue any class or series of securities other than shares of Common Stock, non−voting, non−convertible debt securities or such other securities as WellPoint may approve, provided that WellPoint will provide the BCBSA with at least 30 days advance notice of the issuance of such securities and the BCBSA will have the authority to determining how such securities will be treated for purposes of determine a particular holder's beneficial ownership of Common Stock.

In July 1999, WellPoint issued an aggregate of $299 million in principal amount at maturity of Zero Coupon Convertible Subordinated Debentures Due 2019 (the "Debentures"). The BCBSA has determined that it will treat a holder of Debentures at a particular time as beneficially owning shares of Common Stock equal to the greater of (i) the number of shares into which the Debentures could be converted upon exercise of the conversion right of the Debentures at such time, and (ii) the number of shares of Common Stock which the holder would receive if WellPoint paid the holder in shares of Common Stock upon exercise of the holder's redemption right (assuming redemption of the Debentures at a price equal to the original issue price plus then−accrued original issue discount and based on the then−current market price of the Common Stock). This deemed beneficial ownership will be aggregated with a Debentureholder's other beneficial ownership of Common Stock for purposes of determining if the Ownership Limit provisions have been violated. Any Debentureholder's deemed beneficial ownership of Common Stock may fluctuate as a result of changes in the market price of the Common Stock.

In connection with the Recapitalization, BCC also received a ruling from the IRS that, among other things, the conversion of BCC from a nonprofit public benefit corporation to a for−profit entity (the "BCC Conversion") qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. The Foundation and the Company have entered into an Indemnification Agreement which provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes.

In August 1997, pursuant to approval by the stockholders at the Company's 1997 Annual Meeting, the Company reincorporated in the state of Delaware. Each of the material agreements (other than the Indemnification Agreement) entered into in connection with the Recapitalization was amended and restated on substantially similar terms at the time of the reincorporation.

In connection with the RightCHOICE transaction, the Missouri Foundation for Health (the "Missouri Foundation"), which was formerly the largest stockholder of RightCHOICE, acquired 4,805,200 shares of WellPoint Common Stock, or approximately 6.7% of the then−outstanding WellPoint Common Stock. Because the Missouri Foundation did not qualify as an Institutional Investor for purposes of the Ownership Limit, the Company requested and received a waiver of the Ownership Limit requirements from the BCBSA. In connection therewith, the Missouri Foundation committed to sell sufficient shares of WellPoint Common Stock such that its ownership would be reduced to below 5% of WellPoint's outstanding voting securities on or prior to January 31, 2003. As of March 2002, the Missouri Foundation had sold sufficient shares to reduce its ownership to below 5% of WellPoint's outstanding voting securities.

Factors That May Affect Future Results of Operations

Certain statements contained in "Item 1. Business," such as statements concerning the Company's geographic expansion and other business strategies, the effect of recent health care reform legislation, changes in the competitive environment and small group membership growth and other statements

contained herein regarding matters that are not historical facts, are forward−looking statements (as such term is defined in the Securities Exchange Act of 1934). Such statements involve a number of risks and uncertainties that may cause actual results to differ from those projected. Factors that can cause actual results to differ materially include, but are not limited to, those discussed below. Readers are cautioned not to place undue reliance on these forward−looking statements, which speak only as of the date hereof.

Federal and State Health Care Regulation; Legislative Reform; Activities as Government Contractor

WellPoint's operations are subject to substantial regulation by Federal, state and local agencies. Such regulation may either relate to the Company's business operations or to the financial condition of regulated subsidiaries. With regard to the former, regulation typically covers prescribed benefits, prompt payment of claims, relationships with providers, marketing, advertising, quality assurance and member grievance resolution. With regard to the latter, regulation typically governs the amount of capital required to be retained in regulated subsidiaries and the ability of such subsidiaries to pay dividends. From time to time, the Company and its subsidiaries receive requests for information from regulatory agencies or are notified that such agencies or other officials are conducting reviews, investigations or other proceedings with respect to certain of the Company's activities. There can be no assurance that any past or future regulatory action by any such agencies will not have a material adverse effect on the profitability or marketability of WellPoint's health plans, the Company's ability to access capital from the operations of its regulated subsidiaries or on its financial condition, cash flows or result of operations.

In addition to capital requirements imposed by the DMHC and certain Departments of Insurance, the Company and its BCBSA−licensed affiliates are required to maintain certain levels of capital to satisfy BCBSA requirements. During 1998, the National Association of Insurance Commissioners (the "NAIC"), the trade association representing state insurance regulators, adopted a risk−based capital formula for licensed managed care organizations called Managed Care Organization Risk−Based Capital ("MCORBC"). The NAIC also approved an accompanying Risk−Based Capital for Health Organizations Model Act (the "Model Act"), which will serve as a model for states considering enacting new legislation. The BCBSA adopted the MCORBC formula effective as of December 31, 1999. If adopted by states, the minimum capital requirements under the Model Act are not expected to have a material impact on the Company, although there can be no assurances that new minimum capital requirements will not increase the Company's capital requirements in the future.

The health care industry has become the subject of greater legislative and media scrutiny in recent years. In 1999, California adopted a considerable number of health care reform measures, including legislation providing for health plan liability and independent review of health plan decisions. See "Government Regulation." An increasing number of proposals are being considered by the United States Congress and state legislatures relating to health care reform and the Company expects that some of such proposals will be enacted. There can be no assurance that compliance with recently enacted or future legislation will not have a material adverse impact on WellPoint's claims expense, financial condition, cash flows or results of operations.

The Company provides insurance products to Medi−Cal beneficiaries in various California counties under contracts with the DHS (or a delegated local agency). The Company also provides administrative services for CMS in various capacities, including certain Medicare programs and under its Blue Cross Senior Secure plan. There can be no assurance that acting as a government contractor in these circumstances will not increase the risk of heightened scrutiny by such government agencies, or that the profitability from this business will not be adversely affected through inadequate premium rate increases due to governmental budgetary issues. Future actions by any regulatory agencies may have a material adverse effect on the Company's business.

As a result of the PrecisionRx transaction completed in December 2000, one of the Company's subsidiaries conducts business as a mail order pharmacy. The pharmacy business is subject to extensive federal, state and local regulations which are in many instances different from those under which the Company's traditional health care businesses operate. The failure to properly adhere to these and other applicable regulations could result in the imposition of civil and criminal penalties, which could adversely affect the Company's result of operations or financial condition. In addition, pharmacies are exposed to risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Although the Company intends to maintain professional liability insurance, there can be no assurances that the coverage limits under such insurance programs will be adequate to protect against future claims or that the Company will be able to maintain insurance on acceptable terms in the future.

Pending Transaction with CareFirst

WellPoint has entered into the CareFirst Merger Agreement pursuant to which CareFirst will become a wholly owned subsidiary of the Company (See "Recent Completed Transactions and Pending Transactions—Pending Acquisition of CareFirst.") Completion of this transaction is subject to the satisfaction of a number of conditions, including approval of the insurance regulators in each of Maryland, Delaware and the District of Columbia. In addition, one of CareFirst's operating affiliates must have its federal charter amended or repealed by the United States Congress (subject to presidential approval) and must obtain approval from the Washington D.C. Corporation Counsel. There can be no assurances that the required approvals will be obtained. If all conditions to closing are not met on or before November 20, 2004, each of WellPoint and CareFirst will have the right to terminate the CareFirst Merger Agreement. As a result, there can be no assurances that the transaction will be consummated.

As a condition to approval of the transaction, regulatory agencies may seek to impose requirements or limitations on the way that the combined company conducts it business. Although neither WellPoint nor CareFirst is obligated to agree to any material requirements or limitations in order to obtain approval, if either or both companies were to agree to any such conditions, such requirements or limitations or additional costs associated therewith could adversely affect WellPoint's ability to integrate the operations of CareFirst with those of WellPoint. Accordingly, a material adverse effect on WellPoint's revenue, results of operations and cash flows following the CareFirst transaction could result.

Indebtedness from Completed and Pending Acquisitions

In connection with the RightCHOICE and Cerulean transactions, the Company incurred significant additional indebtedness to fund the cash payments made to the acquired companies' stockholders. In addition, the Company currently expects to incur additional indebtedness to fund some or all of the cash payments to be made in connection with the pending CareFirst transaction. This existing or new indebtedness may result in a significant percentage of the Company's cash flow being applied to the payment of interest, and there can be no assurance that the Company's operations will generate sufficient future cash flow to service this indebtedness. The Company's current indebtedness, as well as any indebtedness that the Company may incur in the future (such as indebtedness incurred to fund repurchases of its Common Stock or to fund the CareFirst or other transactions), may adversely affect the Company's ability to finance its operations and could limit the Company's ability to pursue business opportunities that may be in the best interests of the Company and its stockholders.

Class Action Lawsuits and Other Evolving Theories of Recovery

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from

coverage under its HMO, PPO and other plans. The Company is, in the ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of

Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Health Care Costs and Premium Pricing Pressures

WellPoint's future profitability will depend in part on accurately predicting health care costs and on its ability to control future health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. Changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups and numerous other factors affecting health care costs may adversely affect WellPoint's ability to predict and control health care costs as well as WellPoint's financial condition, results of operations or cash flows. Periodic renegotiations of hospital and other provider contracts, coupled with continued consolidation of physician, hospital and other provider groups, may result in increased health care costs or limit the Company's ability to negotiate favorable rates. In the past few years, large physician practice management companies have experienced extreme financial difficulties (including bankruptcy), which may subject the Company to increased credit risk related to provider groups and cause the Company to incur duplicative claims expense.

In addition to the challenge of controlling health care costs, the Company faces competitive pressure to contain premium prices. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, the Company expects that price will continue to be a significant basis of competition. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates for government−sponsored programs. WellPoint's financial condition or results of operations would be adversely affected by significant premium decreases by any of its major competitors or by any limitation on the Company's ability to increase or maintain its premium levels.

Integration of Acquisitions; Geographic Expansion Strategy; Future Acquisitions

One component of the Company's business strategy has been to diversify into new geographic markets, particularly through strategic acquisitions. The Company has completed a number of significant acquisitions since 1996. Since the relevant dates of acquisition, the Company has worked extensively on the integration of the acquired MMHD, GBO and Rush Prudential businesses. The Company has also completed significant work on the integration of the Cerulean businesses. The Company expects to begin its integration of RightCHOICE during the remainder of 2002. The Company is continuing the consolidation of these acquired operations into its operations, which will require considerable expenditures and a significant amount of management time. Due to the complex nature of the merger integration process, particularly the information systems designed to serve these businesses, the Company may temporarily experience increases in claims inventory or other service−related issues that may negatively affect the Company's relationship with its customers and contribute to increased attrition of such customers. The success of these acquisitions will, among other things, also require the integration of a significant number of the employees into the Company's existing operations and the completion of the integration of separate information systems. No assurances can be given regarding the ultimate success of the integration of these acquisitions into the Company's business.

As the Company pursues its geographic expansion strategy, the Company's market share in new markets will not be as significant, and its provider networks not as extensive, as in California, Georgia and Missouri, and the Company will not have the benefit of the Blue Cross or Blue Shield names and marks which are important components of its success in California, Georgia and Missouri. The

Company no longer has the benefit of the MassMutual, John Hancock or Rush Prudential trade names. There can be no assurance that the absence of one or more of these elements will not adversely affect the success of the Company's geographic expansion strategy.

The Company actively considers acquisition opportunities on a regular basis, both in connection with its geographic expansion strategy and its California operations. The Company currently has no existing agreements or commitments to effect any material acquisition, other than CareFirst. Accordingly, there can be no assurance that the Company will be able to identify additional acquisition, candidates available for sale at reasonable prices or consummate any acquisition or that any discussions will result in an acquisition. Any such acquisitions may require significant additional capital resources and there can be no assurance that the Company will have access to adequate capital resources to effect such future acquisitions. To the extent that the Company consummates acquisitions, there can be no assurance that such acquisitions will be successfully integrated into the Company or that such acquisitions will not adversely affect the Company's results of operations, cash flows and financial condition.

Prior to the Company's acquisition of the GBO, John Hancock Mutual Life Insurance Company ("John Hancock") entered into a number of reinsurance arrangements with respect to personal accident insurance and the occupational accident component of workers' compensation insurance, a portion of which was originated through a pool managed by Unicover Managers, Inc. Under these arrangements, John Hancock assumed risks as a reinsurer and transferred certain of such risks to other companies. These arrangements have become the subject of disputes, including a number of legal proceedings to which John Hancock is a party. The Company believes that it has a number of defenses to avoid any ultimate liability with respect to these matters and believes that such liabilities were not transferred to the Company as part of the GBO acquisition. However, if the Company were to become subject to such liabilities, the Company could suffer losses that might have a material adverse effect on its financial condition, results of operations or cash flows.

Competition

Managed health care organizations operate in a highly competitive environment that is subject to significant change from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other managed health care organizations, the development of companies offering Internet−based connections between providers, employers and members and other market pressures. A significant portion of the Company's operations are in California, where the managed health care industry is especially competitive. In addition, the managed health care industry in California has undergone significant changes in recent years, including substantial consolidation. Outside of California, the Company faces competition from other regional and national companies, many of which have (or due to future consolidation, may have) significantly greater financial and other resources and market share than the Company. If competition were to further increase in any of its markets, WellPoint's financial condition, cash flows or results of operations could be materially adversely affected.

A substantial portion of WellPoint's California business is in the individual and small employer group market, where the loss ratio is significantly lower than in the large employer group market. The individual and small employer group business constituted approximately 31.0% of WellPoint's total premium revenue for the year ended December 31, 2001. WellPoint has experienced increasing competition in the individual and small employer group market over the past several years, which could adversely affect WellPoint's loss ratio and future financial condition or results of operations. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations."

Dependence on Independent Agents and Brokers

The Company is dependent on the services of independent agents and brokers in the marketing of its health care plans, particularly with respect to individuals, seniors and small employer group members. Such independent agents and brokers are typically not exclusively dedicated to the Company and may frequently also market health care plans of the Company's competitors. The Company faces intense competition for the services and allegiance of independent agents and brokers.

Employee Matters

The Company is dependent on retaining existing employees and attracting and retaining additional qualified employees to meet its future needs. The Company faces intense competition for qualified employees and there can be no assurance that the Company will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. There can be no assurance that an inability to retain existing employees or attract additional employees will not have a material adverse effect on the results of operations of the Company. The Company is especially dependent on attracting and retaining qualified information technology personnel and other skilled professionals.

Tax Issues Relating to the WellPoint and RightCHOICE Recapitalizations

In connection with the Recapitalization, BCC received a ruling from the IRS that, among other things, the BCC Conversion qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. If the ruling were subsequently revoked, modified or not honored by the IRS (due to a change in law or for any other reason), WellPoint, as the successor to BCC, could be subject to Federal income tax on the difference between the value of BCC at the time of the BCC Conversion and BCC's tax basis in its assets at the time of the BCC Conversion. The potential tax liability to WellPoint if the BCC Conversion is treated as a taxable transaction is currently estimated to be approximately $696 million, plus interest (and possibly penalties). BCC and the Foundation entered into an Indemnification Agreement that provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes. In the event a tax liability should arise against which the Foundation has agreed to indemnify WellPoint, there can be no assurance that the Foundation will have sufficient assets to satisfy the liability in full, in which case WellPoint would bear all or a portion of the cost of the liability, which could have a material adverse effect on WellPoint's financial condition.

On November 30, 2000, RightCHOICE completed a reorganization (the "RightCHOICE Recapitalization") with its majority stockholder, RightCHOICE Managed Care, Inc., a Missouri corporation ("Old RightCHOICE"). As part of the RightCHOICE Recapitalization, the Missouri Foundation became the holder of approximately 80% of RightCHOICE Common Stock. In connection with the RightCHOICE Recapitalization, the predecessor of Old RightCHOICE, Blue Cross and Blue Shield of Missouri, received a ruling from the IRS that, among other things, the conversion of Blue Cross and Blue Shield of Missouri from a non−profit corporation to a for−profit corporation qualified as a reorganization under the Internal Revenue Code and that Blue Cross and Blue Shield of Missouri recognized no gain or loss for federal income tax purposes. If the IRS subsequently revoked, modified or decided not to honor the ruling due to a change in law or for any other reason, RightCHOICE, as the successor to Old RightCHOICE, could be subject to federal income tax on the difference between the value of each of Blue Cross and Blue Shield of Missouri's assets at the time of the RightCHOICE Recapitalization and its tax basis in its assets at the time of the RightCHOICE Recapitalization. RightCHOICE is now a wholly owned subsidiary of WellPoint. RightCHOICE and the Missouri Foundation entered into an indemnification agreement that provides, with certain exceptions, that the

Missouri Foundation will indemnify RightCHOICE against the tax liability as a result of the IRS's revocation or modification, in whole or in part, of its ruling, or an IRS determination that RightCHOICE's conversion was a taxable transaction for federal income tax purposes. If a tax liability should arise against which the Missouri Foundation has agreed to indemnify RightCHOICE, the Missouri Foundation may not have sufficient assets to pay the liability. RightCHOICE would then bear all or a portion of the liability, which could have a material adverse effect on RightCHOICE's and the Company's financial condition.

Item 2. Properties.

Effective as of January 1, 1996, the Company entered into a lease for Blue Cross of California's Woodland Hills, California headquarters facility, which provides for a term expiring in December 2019 with two options to extend the term for up to two additional five−year terms. In 1997, the Company entered into a lease, which expires in December 2019, for a new facility located in Thousand Oaks, California housing certain corporate and specialty services. This facility was completed in January 1999. The Company and its subsidiaries have additional offices in the greater Los Angeles and Ventura County area. As a result of the Company's continuing national expansion efforts, the Company leases or owns offices in various other locations, including Atlanta and Columbus, Georgia; St. Louis, Missouri; Springfield, Massachusetts; Charlestown, Massachusetts; the greater Chicago, Illinois area; Dearborn, Michigan; and Plano, Texas. As a result of the PrecisionRx acquisition, the Company now owns an approximately 79,000 square foot mail−order pharmacy distribution facility in the greater Fort Worth, Texas area.

Item 3. Legal Proceedings.

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in the ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et. al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in

early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Item 4. Submission of Matters to a Vote of Security Holders.

None.

PART II

Item 5. Market for the Registrant's Common Equity and Related Stockholder Matters

The Company's Common Stock has been traded on the New York Stock Exchange under the symbol "WLP" since the Company's initial public offering on January 27, 1993. The following table sets forth for the periods indicated the high and low sale prices for the Common Stock. The information shown below has been adjusted to reflect the Company's two−for−one stock split in the form of a stock dividend, which was effective on March 15, 2002.

	High	Low
Year Ended December 31, 2000		
First Quarter	$ 39.25	$ 28.47
Second Quarter	39.94	33.38
Third Quarter	48.19	35.19
Fourth Quarter	60.75	45.78
Year Ended December 31, 2001		
First Quarter	57.88	42.38
Second Quarter	50.09	40.83
Third Quarter	54.97	46.40
Fourth Quarter	61.45	49.75

On March 18, 2002 the closing price on the New York Stock Exchange for the Company's Common Stock was $62.48 per share. As of March 18, 2002, there were approximately 621 holders of record of Common Stock.

The Company did not pay any dividends on its Common Stock in 2000 or 2001. Management currently expects that all of WellPoint's future income will be used to expand and develop its business. The Board of Directors currently intends to retain the Company's net earnings during 2002.

Item 6. Selected Financial Data.

	Year Ended December 31,				
	2001	2000	1999	1998	1997
	(In thousands, except per share data, membership data and operating statistics)				
Consolidated Income Statements(A)(B)					
Revenues:					
Premium revenue	$ 11,577,170	$ 8,583,663	$ 6,896,857	$ 5,934,812	$ 5,068,947
Management services and other revenue	609,693	451,847	429,336	433,960	377,138
Investment income	241,784	193,448	159,234	109,578	196,153
	12,428,647	9,228,958	7,485,427	6,478,350	5,642,238
Operating Expenses:					
Health care services and other benefits	9,436,264	6,935,398	5,533,068	4,776,345	4,087,420
Selling expense	502,571	394,217	328,619	280,078	249,389
General and administrative expense	1,666,587	1,265,155	1,075,449	975,099	836,581
Nonrecurring costs	—	—	—	—	14,535
	11,605,422	8,594,770	6,937,136	6,031,522	5,187,925
Operating Income	823,225	634,188	548,291	446,828	454,313
Interest expense	49,929	23,978	20,178	26,903	36,658
Other expense, net	74,714	45,897	40,792	27,939	31,301
Income from Continuing Operations before provision for income taxes, extraordinary gain and cumulative effect of accounting change	698,582	564,313	487,321	391,986	386,354
Provision for Income Taxes	283,836	222,026	190,110	72,438	156,917
Income from Continuing Operations before extraordinary gain and cumulative effect of accounting change	414,746	342,287	297,211	319,548	229,437
Loss from Discontinued Operations	—	—	—	(88,268)	(2,028)
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891	—	—
Cumulative effect of accounting change, net of tax	—	—	(20,558)	—	—
Net Income	$ 414,746	$ 342,287	$ 278,544	$ 231,280	$ 227,409
Per Share Data(A)(C)(D):					
Income from Continuing Operations before extraordinary gain and cumulative effect of accounting change:					
Earnings Per Share	$ 3.27	$ 2.74	$ 2.25	$ 2.31	$ 1.67
Earnings Per Share Assuming Full Dilution	$ 3.15	$ 2.64	$ 2.19	$ 2.28	$ 1.65
Extraordinary gain:					
Earnings Per Share	$ —	$ —	$ 0.02	$ —	$ —
Earnings Per Share Assuming Full Dilution	$ —	$ —	$ 0.01	$ —	$ —
Cumulative Effect Of Accounting Change:					
Earnings (Loss) Per Share	$ —	$ —	$ (0.16)	$ —	$ —
Earnings (Loss) Per Share Assuming Full Dilution	$ —	$ —	$ (0.15)	$ —	$ —
Loss from Discontinued Operations:					
Earnings (Loss) Per Share	$ —	$ —	$ —	$ (0.64)	$ (0.02)
Earnings (Loss) Per Share Assuming Full Dilution	$ —	$ —	$ —	$ (0.63)	$ (0.01)
Net Income:					
Earnings Per Share	$ 3.27	$ 2.74	$ 2.11	$ 1.67	$ 1.65
Earnings Per Share Assuming Full Dilution	$ 3.15	$ 2.64	$ 2.05	$ 1.65	$ 1.64
Operating Statistics(A)(E):					
Loss ratio	81.5%	80.8%	80.2%	80.5%	80.6%
Selling expense ratio	4.1%	4.4%	4.5%	4.4%	4.6%
General and administrative expense ratio	13.7%	14.0%	14.7%	15.3%	15.4%
Net income ratio	3.4%	3.8%	3.8%	3.6%	4.2%

	December 31,				
	2001	2000	1999	1998	1997
Balance Sheet Data(A):					

Cash and investments	$ 4,986,069	$ 3,780,050	$ 3,258,666	$ 2,764,302	$ 2,560,537
Total assets	$ 7,472,133	$ 5,504,706	$ 4,593,234	$ 4,225,834	$ 4,234,124
Long−term debt	$ 837,957	$ 400,855	$ 347,884	$ 300,000	$ 388,000
Total equity(G)	$ 2,132,579	$ 1,644,417	$ 1,312,700	$ 1,315,223	$ 1,223,169
Medical Membership(F)	10,146,945	7,869,119	7,300,003	6,892,000	6,638,000

(A)

Financial information for 1997 has been restated to present workers' compensation business as a discontinued operation.

(B)

The Company's consolidated results of operations for the years presented above include the results of several acquisitions which are components of the Company's national expansion strategy. (See "Item 7. Management's Discussion and Analysis Of Financial Condition And Results Of Operations.")

(C)

Per share data for each period presented has been restated to reflect the two−for−one stock split in the form of a stock dividend which occurred on March 15, 2002.

(D)

Per share data includes nonrecurring costs of $0.06 per share for 1997 based on a restated basis to reflect the two−for−one stock split which occurred on March 15, 2002.

(E)

The loss ratio represents health care services and other benefits as a percentage of premium revenue. All other ratios are shown as a percentage of premium revenue and management services and other revenue.

(F)

Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by each contract.

(G)

No cash dividends were declared in each of the years presented.

Item 7. Management's Discussion And Analysis Of Financial Condition And Results Of Operations

This discussion contains forward−looking statements, which involve risks and uncertainties. The Company's actual results may differ materially from those anticipated in these forward−looking statements as a result of certain factors including, but not limited to, those set forth under "Factors That May Affect Future Results of Operations."

General

The Company is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. As a result of the January 31, 2002 closing of the RightCHOICE transaction, the Company's medical membership has increased to approximately 12.5 million as of January 31, 2002. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include HMOs, PPOs, POS plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial services, network access, medical cost management and claims processing. The Company also provides a broad array of specialty and other products, including pharmacy, dental, utilization management, life insurance, preventive care, disability insurance, behavioral health, COBRA and flexible benefits account administration. The Company markets its products in California primarily under the name Blue Cross of California, in Georgia primarily under the name Blue Cross Blue Shield of Georgia, in various parts of Missouri (including the greater St. Louis area) under the name Blue Cross Blue Shield of Missouri and in other states primarily under the name UNICARE or HealthLink. The Company holds the exclusive right in California to market its products under the Blue Cross name and mark and in Georgia and in 85 counties in Missouri (including the greater St. Louis area) to market its products under the Blue Cross Blue Shield names and marks.

Acquisition of Cerulean

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross Blue Shield of Georgia, Inc. (See Note 2 to the Consolidated Financial Statements). Cerulean, principally through its Blue Cross and Blue Shield of Georgia subsidiary, offers insured and administrative services products primarily in the State of Georgia. Cerulean has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. Cerulean has also historically experienced a higher medical loss ratio than the Company's core businesses due to its higher percentage of Large Employer Group business and fewer managed care offerings. Accordingly, Cerulean's higher loss and administrative expense ratios have contributed to an increase in those ratios for the Company. The acquisition increased the Company's Georgia medical membership by approximately 1.9 million members as of March 31, 2001. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company estimates that it will incur up to $140.6 million in expenses, primarily related to change in control payments to Cerulean management and transaction costs. This acquisition was accounted for under the purchase method of accounting.

Acquisition of RightCHOICE

On October 17, 2001, the Company entered into an Agreement and Plan of Merger with RightCHOICE, through its wholly owned subsidiary, RWP Acquisition Corp. (See Note 22 to the Consolidated Financial Statements). On January 31, 2002, the Company completed this transaction, pursuant to which RightCHOICE became a wholly owned subsidiary of the Company. The acquisition price for RightCHOICE was approximately $1.4 billion, which was paid with $379.0 million in cash and approximately 8.3 million shares (on a pre−stock split basis) of WellPoint Common Stock.

RightCHOICE, through its exclusive license to use the "Blue Cross" and "Blue Shield" names and service marks, is the largest provider of managed health care benefits in the state of Missouri based on number of members. As of January 31, 2002, RightCHOICE served approximately 2.2 million medical members in Missouri, Arkansas, Illinois, Indiana, Iowa, Kentucky and West Virginia. RightCHOICE has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher concentration of administrative services business. Accordingly it is expected that RightCHOICE's higher administrative expense ratios will ultimately contribute to an increase in the administrative expense ratio for the Company.

Pending Acquisition of CareFirst

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to approximately 3.1 million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that the gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

National Expansion and Other Recent Developments

In an effort to pursue the expansion of the Company's business outside the state of California, the Company acquired two businesses in 1996 and 1997, the Life and Health Benefits Management Division ("MMHD") of Massachusetts Mutual Life Insurance Company and the Group Benefits Operations (the "GBO") of John Hancock Mutual Life Insurance Company. The acquisitions of Rush Prudential and PrecisionRx in 2000 and the acquisition of Cerulean in 2001 were also components of this expansion strategy. In 2001 the Company entered into definitive agreements to expand into the Midwest with its acquisition of RightCHOICE which closed on January 31, 2002 and into the Mid−Atlantic region with the pending acquisition of CareFirst which is expected to close in 2003.

As a result of these acquisitions, the Company has significantly expanded its operations outside of California. In order to integrate its acquired businesses and implement the Company's regional expansion strategy, the Company will need to develop satisfactory networks of hospitals, physicians and other health care service providers, develop distribution channels for its products and successfully convert acquired books of business to the Company's existing information systems, which will require continued investments by the Company.

In response to rising medical and pharmacy costs, the Company has from time to time implemented premium increases with respect to certain of its products. The Company will continue to evaluate the need for further premium increases, plan design changes and other appropriate actions in the future in order to maintain or restore profit margins. There can be no assurances, however, that

the Company will be able to take subsequent pricing or other actions or that any actions previously taken or implemented in the future will be successful in addressing any concerns that may arise with respect to the performance of certain businesses.

Legislation

Federal legislation enacted during the last several years seeks, among other things, to insure the portability of health coverage and mandates minimum maternity hospital stays. California legislation enacted since 1999, among other things, establishes an explicit duty on managed care entities to exercise ordinary care in arranging for the provision of medically necessary health care services and establishes a system of independent medical review. In 1997, Texas adopted legislation purporting to make managed care organizations such as the Company liable for their failure to exercise ordinary care when making health care treatment decisions. Similar legislation has also been enacted in Georgia and in other states in which the Company operates. These and other proposed measures may have the effect of dramatically altering the regulation of health care and of increasing the Company's loss ratio and administrative costs or decreasing the affordability of the Company's products.

Results of Operations

The Company's revenues are primarily generated from premiums earned for risk−based health care and specialty services provided to its members, fees for administrative services, including claims processing and access to provider networks for self−insured employers and investment income. Operating expenses include health care services and other benefits expenses, consisting primarily of payments for physicians, hospitals and other providers for health care and specialty products claims; selling expenses for broker and agent commissions; general and administrative expenses; interest expense; depreciation and amortization expense; and income taxes.

The Company's consolidated results of operations for the year ended December 31, 2001 include the results of Cerulean from March 15, 2001, the acquisition date.

The Company's consolidated results of operations for the year ended December 31, 2000 include the results of Rush Prudential from March 1, 2000 and PrecisionRx from December 5, 2000, their respective dates of acquisition.

The following table sets forth selected operating ratios. The loss ratio for health care services and other benefits is shown as a percentage of premium revenue. All other ratios are shown as a percentage of premium revenue and management services and other revenue combined.

	Year Ended December 31,		
	2001	2000	1999
Operating Revenues:			
Premium revenue	95.0%	95.0%	94.1%
Management services and other revenue	5.0%	5.0%	5.9%
	100.0%	100.0%	100.0%
Operating Expenses:			
Health care services and other benefits (loss ratio)	81.5%	80.8%	80.2%
Selling expense	4.1%	4.4%	4.5%
General and administrative expense	13.7%	14.0%	14.7%

Membership

The following table sets forth membership data and the percent change in membership:

	As of December 31,		
	2001	2000	Percent Change
Medical Membership(a)(b)(c):			
Large Employer Group(d)			
California			
HMO	2,000,026	1,800,932	11.1 %
PPO and Other	2,131,865	1,982,474	7.5 %
Total California	4,131,891	3,783,406	9.2 %
Texas	205,458	197,037	4.3 %
Georgia	1,543,900	43,160	3,477.2 %
Illinois	430,689	459,282	(6.2)%
Other States	1,251,271	1,205,883	3.8 %
Total Large Employer Group	7,563,209	5,688,768	32.9 %
Individual and Small Employer Group			
California			
HMO	308,213	355,400	(13.3)%
PPO and Other	1,256,478	1,228,230	2.3 %
Total California	1,564,691	1,583,630	(1.2)%
Texas	176,473	167,845	5.1 %
Georgia	346,357	34,185	913.2 %
Illinois	90,555	67,550	34.1 %
Other States	87,486	96,546	(9.4)%
Total Individual and Small Employer Group	2,265,562	1,949,756	16.2 %
Senior(e)			
California			
HMO	38,715	34,930	10.8 %
PPO and Other	177,268	173,311	2.3 %
Total California	215,983	208,241	3.7 %
Texas	317	222	42.8 %
Georgia	71,616	1,050	6,720.6 %
Illinois	12,112	10,936	10.8 %
Other States	18,146	10,146	78.8 %
Total Senior	318,174	230,595	38.0 %
Total Medical Membership	10,146,945	7,869,119	28.9 %
Membership by Network(f)			
Proprietary Networks	8,017,883	6,246,519	28.4 %
Affiliate Networks	1,317,946	994,166	32.6 %
Non−Network	811,116	628,434	29.1 %
Total Medical Membership	10,146,945	7,869,119	28.9 %
Management Services Membership			
California	1,367,147	1,309,994	4.4 %
Georgia	895,780	23,166	3,766.8 %
Other States	1,155,659	1,210,239	(4.5)%

Total Management Services Membership	3,418,586	2,543,399	34.4 %

(a) Membership numbers are approximate and include some estimates based upon the number of contracts at the relevant date and an actuarial estimate of the number of members represented by the contract.

(b) Classification between states for employer groups is determined by the zip code of the subscriber.

(c) Medical membership includes management services members, which are primarily included in the Large Employer Group segment.

(d) Large Employer Group membership includes 1,075,026 and 813,468 state−sponsored program members as of December 31, 2001 and 2000, respectively.

(e) Senior membership includes members covered under both Medicare risk and Medicare supplement products.

(f) Proprietary networks consist of California, Georgia, Texas and other WellPoint−developed or WellPoint−controlled networks. Affiliate networks consist of third−party networks that incorporate provider discounts and some basic managed care elements. Non−network consists of fee for service and percentage−of−billed charges contracts with providers.

Specialty Membership

	As of December 31,		
	2001	2000	Percent Change
Pharmacy	32,754,990	29,038,815	12.8 %
Dental	2,630,225	2,245,490	17.1 %
Utilization Management	1,734,675	2,103,396	(17.5)%
Life	2,310,030	2,020,069	14.4 %
Disability	540,826	569,266	(5.0)%
Behavioral Health	5,144,220	4,352,988	18.2 %

Comparison of Results for the Year Ended December 31, 2001 to the Year Ended December 31, 2000

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint Common Stock for each share held. Share and per share data for all periods presented below have been adjusted to give effect to the stock split.

The following table depicts premium revenue by business segment:

	Year Ended December 31,	
	2001	2000
	(In thousands)	
Large Employer Group	$ 7,188,430	$ 5,011,562
Individual and Small Employer Group	3,583,839	3,030,503
Corporate and Other	804,901	541,598
Consolidated	$ 11,577,170	$ 8,583,663

Premium revenue increased 34.9%, or $2,993.5 million, to $11,577.2 million for the year ended December 31, 2001 from $8,583.7 million for the year ended December 31, 2000. The increase was primarily due to $1,905.2 million of premium revenue related to the Cerulean and Rush Prudential acquisitions, representing 63.6% of the increase. Excluding acquisitions, premium revenue would have increased 12.7% for the year ended December 31, 2001. The increase excluding acquisitions was primarily due to an increase in insured member months of approximately 5.8% primarily in the Large Employer Group business segment, and the implementation of premium increases overall.

The following table depicts management services and other revenue by business segment:

	Year Ended December 31,	
	2001	2000
	(In thousands)	
Large Employer Group	$ 500,290	$ 379,142
Individual and Small Employer Group	268	2,865
Corporate and Other	109,135	69,840
Consolidated	$ 609,693	$ 451,847

Management services and other revenue increased approximately $157.9 million to $609.7 million for the year ended December 31, 2001 from $451.8 million for the year ended December 31, 2000. The increase was primarily due to $124.5 million of management services revenue related to the Cerulean and Rush Prudential acquisitions, representing 78.8% of the increase. Excluding acquisitions, management services revenue would have increased 7.4% for the year ended December 31, 2001. The

increase excluding acquisitions was primarily due to an increase in pharmacy benefit management services revenues.

Investment income was $241.8 million for the year ended December 31, 2001 compared to $193.4 million for the year ended December 31, 2000, an increase of 25.0%, or $48.4 million. The Cerulean and Rush Prudential acquisitions represented $24.9 million, or 51.4%, of the increase. Excluding acquisitions, investment income would have increased $23.5 million or 12.2%. The increase excluding acquisitions was primarily due to lower net realized losses in 2001 of $3.0 million as compared to net realized losses in 2000 of $21.6 million. Additionally, net investment income, excluding acquisitions, increased $6.4 million to $220.3 million for the year ended December 31, 2001 in comparison to $213.9 million for the year ended December 31, 2000. The increase resulted from higher average investment balances during the year ended December 31, 2001 versus 2000.

The loss ratio attributable to managed care and related products for the year ended December 31, 2001 increased to 81.5% compared to 80.8% for the year ended December 31, 2000, due in part to the incremental effect of the Cerulean acquisition on the Company's overall results. The acquired Cerulean business has traditionally experienced a higher loss ratio than the Company's core businesses due to its higher percentage of Large Employer Group business and fewer managed care offerings. Excluding Cerulean, the loss ratio increased slightly to 80.9% for the year ended December 31, 2001. The health care services and other benefits expense includes an estimate of claims incurred during the period but which have not been reported to the Company. This estimate is actuarially determined based on a variety of factors and is inherently subject to a number of highly variable circumstances. See "Critical Accounting Policies" for a more complete discussion of this item and its potential effect on the Company's reported results of operations.

Selling expense consists of commissions paid to outside brokers and agents representing the Company. The selling expense ratio for the year ended December 31, 2001 decreased to 4.1% compared to 4.4% for the year ended December 31, 2000. The acquired Cerulean business has traditionally experienced a lower selling expense ratio due primarily to its lower percentage of Individual and Small Employer Group business. Excluding Cerulean, the selling expense ratio would have remained unchanged at 4.4% for the year ended December 31, 2001.

The general and administrative expense ratio decreased to 13.7% for the year ended December 31, 2001 from 14.0% for the year ended December 31, 2000. The acquired Cerulean business has historically experienced a higher administrative expense ratio than the Company's core businesses due to its higher percentage of administrative services business. Excluding Cerulean, the administrative expense ratio would have been 13.6% for the year ended December 31, 2001. The lower administrative expense ratio for the year ended December 31, 2001, excluding Cerulean, is primarily attributable to savings from the integration of information systems centers related to acquired businesses onto the Company's information systems platform, economies of scale associated with premium revenue growth in relation to fixed corporate administrative expenses in addition to technology investments made by the Company (e.g., electronic claims submission, internet self−service and interactive voice response).

Interest expense increased $25.9 million to $49.9 million for the year ended December 31, 2001 compared to $24.0 million for the year ended December 31, 2000. The increase in interest expense was related to the higher average debt balance for the year ended December 31, 2001 in comparison to the year ended December 31, 2000, primarily due to the Cerulean acquisition. The weighted average interest rate for all debt for the year ended December 31, 2001, including the fees associated with the Company's borrowings and interest rate swap agreements, was 6.70%.

The Company's net income for the year ended December 31, 2001 was $414.7 million, compared to $342.3 million for the year ended December 31, 2000. Earnings per share totaled $3.27 and $2.74 for the years ended December 31, 2001 and 2000, respectively. Earnings per share assuming full dilution totaled $3.15 and $2.64 for years ended December 31, 2001 and 2000, respectively.

Earnings per share for the year ended December 31, 2001 is based upon weighted average shares outstanding of 126.9 million, excluding potential common stock, and 132.4 million shares, assuming full dilution. Earnings per share for the year ended December 31, 2000 is based on 125.1 million shares, excluding potential common stock, and 130.2 million shares, assuming full dilution. Earnings per share and weighted average shares above reflect the two−for−one stock split which occurred on March 15, 2002.

Comparison of Results for the Year Ended December 31, 2000 to the Year Ended December 31, 1999

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint Common Stock for each share held. Share and per share data for all periods presented below have been adjusted to give effect to the stock split.

The following table depicts premium revenue by business segment:

	Year Ended December 31,	
	2000	1999
	(In thousands)	
Large Employer Group	$ 5,011,562	$ 3,889,032
Individual and Small Employer Group	3,030,503	2,551,961
Corporate and Other	541,598	455,864
Consolidated	$ 8,583,663	$ 6,896,857

Premium revenue increased 24.5%, or $1,686.8 million, to $8,583.7 million for the year ended December 31, 2000 from $6,896.9 million for the year ended December 31, 1999. The Rush Prudential acquisition contributed $378.1 million or 22.4% of the overall premium revenue increase. Also contributing to increased premium revenue was an increase in insured member months of 12.5% in the Large Employer Group and Individual and Small Employer Group business segments, in addition to the implementation of premium increases in both segments.

The following table depicts management services and other revenue by business segment:

	Year Ended December 31,	
	2000	1999
	(In thousands)	
Large Employer Group	$ 379,142	$ 367,060
Individual and Small Employer Group	2,865	4,579
Corporate and Other	69,840	57,697
Consolidated	$ 451,847	$ 429,336

Management services and other revenue increased approximately $22.5 million to $451.8 million for the year ended December 31, 2000 from $429.3 million for the year ended December 31, 1999. The Rush Prudential acquisition contributed $4.2 million, or 18.6% of the overall increase. Also contributing to the increased management services revenue was the implementation of price increases, partially offset by a decrease in non−insured member months of approximately 0.9%, related to attrition of previously acquired businesses.

Investment income was $193.4 million for the year ended December 31, 2000 compared to $159.2 million for the year ended December 31, 1999, an increase of 21.5%, or $34.2 million. The Rush Prudential acquisition accounted for $5.3 million or 15.4% of the increase. An increase in net interest and dividend income of $16.2 million to $212.7 million for the year ended December 31, 2000 in comparison to $196.5 million for the year ended December 31, 1999 also contributed to the overall net

increase in investment income. This increase was primarily due to higher average investment balances in 2000 versus 1999, partially offset by a reduction in other interest income related to interest income received in 1999 related to the Company's refund from the Internal Revenue Service. Net realized losses on investment securities totaled $21.6 million for the year ended December 31, 2000 in comparison to losses of $33.8 million for the year ended December 31, 1999.

The loss ratio attributable to managed care and related products for the year ended December 31, 2000 increased to 80.8% compared to 80.2% for the year ended December 31, 1999, due in part to the incremental effect of the Rush Prudential acquisition on the Company's overall results. The acquired Rush Prudential business has traditionally experienced a higher loss ratio than the Company's core business. Excluding the acquired operations of Rush Prudential, the loss ratio would have been 80.5%. The increase in the loss ratio excluding Rush Prudential was primarily due to growth in the Company's Large Employer Group business segment which has historically experienced a higher loss ratio than the Company's Individual and Small Employer Group business.

The selling expense ratio decreased slightly to 4.4% for the year ended December 31, 2000 from 4.5% for the year ended December 31, 1999.

The general and administrative expense ratio decreased to 14.0% for the year ended December 31, 2000 from 14.7% for the year ended December 31, 1999. The overall decline is primarily attributable to savings from the integration of information systems centers related to acquired businesses on the Company's information systems platform, a reduction in Year 2000 remediation expense from 1999 levels, economies of scale associated with premium revenue growth in relation to fixed corporate administrative expenses in addition to technology investments made by the Company (e.g., electronic claims submission, internet self−service and interactive voice response).

Interest expense increased $3.8 million to $24.0 million for the year ended December 31, 2000 compared to $20.2 million for the year ended December 31, 1999. The increase in interest expense was related to the higher average debt balance due to the Rush Prudential acquisition, which was partially offset by a decrease in the effective interest rate due to the issuance of the Company's Zero Coupon Convertible Subordinated Debentures (the "Debentures") in July 1999. The weighted average interest rate for all debt for the year ended December 31, 2000, including the fees associated with the Company's borrowings and interest rate swap agreements, was 6.16%.

The Company's income before extraordinary gain and the cumulative effect of accounting change for the year ended December 31, 2000 was $342.3 million, compared to $297.2 million for the year ended December 31, 1999. Earnings per share before extraordinary gain and cumulative effect of accounting change totaled $2.74 and $2.25 for the years ended December 31, 2000 and 1999, respectively. Earnings per share before extraordinary gain and cumulative effect of accounting change assuming full dilution totaled $2.64 and $2.19 for years ended December 31, 2000 and 1999, respectively.

Earnings per share for the year ended December 31, 2000 is based upon weighted average shares outstanding of 125.1 million, excluding potential common stock, and 130.2 million shares, assuming full dilution. Earnings per share for the year ended December 31, 1999 is based on 132.1 million shares, excluding potential common stock, and 136.2 million shares, assuming full dilution. The decrease in weighted average shares outstanding primarily resulted from the repurchase of approximately 5.0 million shares during the year ended December 31, 2000. For weighted average shares outstanding assuming full dilution, the decline was partially offset by the impact of the assumed conversion of the Debentures.

Effective January 1, 1999, the Company changed its method of accounting for start−up costs related to the Company's provider network and distribution channel development and is now expensing these

costs. The cumulative effect of this change of $20.6 million, net of tax, was reflected in the results of operations for the year ended December 31, 1999.

Financial Condition

The Company's consolidated assets increased by $1,967.4 million, or 35.7%, to $7,472.1 million as of December 31, 2001 from $5,504.7 million as of December 31, 2000. The Cerulean acquisition accounted for $1,058.1 million, or 53.8% of the increase. The remaining increase in total assets was primarily due to growth in cash and investments as a result of operating cash flow. Cash and investments totaled $5.0 billion, or 66.7% of total assets, as of December 31, 2001. Receivables and goodwill and intangible assets represented 11.3% and 14.6% of total assets at December 31, 2001, respectively.

Overall claims liabilities increased $327.6 million, or 17.3%, to $2,219.8 million as of December 31, 2001 from $1,892.2 million as of December 31, 2000. The Cerulean acquisition accounted for $266.2 million, or 81.3% of the total increase. The remaining increase in claims liabilities of $61.4 million was a result of an increase in insured membership (excluding the Cerulean acquisition) of 3.4%.

As of December 31, 2001, the Company's long−term indebtedness was $838.0 million, of which $153.9 million was related to the Debentures, $235.0 million was related to the Company's revolving credit facility and $449.1 million was related to the Company's 6 $^{3}/_{8}$% Notes due 2006 (the "2001 Notes"). (See Note 8 to the Consolidated Financial Statements). As a result of the Cerulean acquisition, the Company incurred $500.0 million of indebtedness under its revolving credit facility. During the quarter ended June 30, 2001, the Company used the proceeds from the aforementioned 2001 Notes to reduce the outstanding balance of the Company's revolving credit facility. As of December 31, 2000, the Company's long−term indebtedness was $400.9 million, of which $250.0 million was related to the Company's revolving credit facility and $150.9 million was related to the Debentures.

Stockholders' equity totaled $2,132.6 million as of December 31, 2001, an increase of $488.2 million from $1,644.4 million as of December 31, 2000. The increase was primarily due to net income of $414.7 million for the year ended December 31, 2001 in addition to $86.1 million of net proceeds from the reissuance of treasury stock related to the Company's employee stock option and purchase plans. Partially offsetting these increases were a decrease in other comprehensive income of $5.2 million, primarily related to an increase in the minimum pension liability of $22.5 million and an increase in unrealized losses on foreign currency adjustments of $0.3 million, offset by an increase in net unrealized gains on investment securites of $17.6 million. During the third quarter of 2001, the Company purchased 75,000 shares (on a pre−stock split basis) of its Common Stock, which reduced the stockholders' equity by approximately $7.4 million.

Liquidity and Capital Resources

The Company's primary sources of cash are premium and management services revenues received and investment income. The primary uses of cash include health care claims and other benefits, capitation payments, income taxes, repayment and repurchases of long−term debt, interest expense, broker and agent commissions, administrative expenses, common stock repurchases and capital expenditures. In addition to the foregoing, other uses of cash include costs of provider networks and systems development, and costs associated with the integration of acquired businesses.

The Company generally receives premium revenue in advance of anticipated claims for related health care services and other benefits. The Company's investment policies are designed to provide safety and preservation of capital, sufficient liquidity to meet cash flow needs, the integration of investment strategy with the business operations and objectives of the Company, and attainment of a competitive after−tax total return.

The Company's strategy for achieving its investment goals is broad diversification of its investments, both across and within asset classes. As of December 31, 2001, the Company's portfolio consisted primarily of investment grade fixed−maturity securities. The Company's portfolio also included large capitalization and small capitalization domestic equities, foreign equities, tax−exempt municipal bonds where the after−tax return is higher than the comparable taxable securities, and a small amount of non−investment grade debt securities. The fixed−income assets include both short and long−duration securities with an attempt to match the Company's funding needs. The investment policy contains limitations regarding concentrations in individual securities and industries and generally prohibits speculative and leveraged investments. Cash and investment balances maintained by the Company are sufficient to meet applicable regulatory financial stability and net worth requirements, including license requirements of the Blue Cross Blue Shield Association.

Cash flow provided by operating activities was $806.2 million for the year ended December 31, 2001, compared with $647.9 million for the year ended December 31, 2000. Cash flow from operations for the year ended December 31, 2001 was due primarily to net income of $414.7 million, increases in accounts payable and accrued expenses of $94.7 million, due to the timing of other operating liability payments, and an increase in medical claims payable of $110.0 million, which related to the growth of insured members, and the timing of other operating liability payments.

Net cash used in investing activities in 2001 totaled $857.2 million, compared with $557.4 million in 2000. The cash used in 2001 was attributable primarily to the purchase of investments of $4.9 billion, property and equipment, net of sales proceeds of $84.5 million, and the purchase of Cerulean, net of acquired cash, of $561.7 million. Proceeds from investments sold and matured totaled $4.7 billion, partially offsetting the aforementioned purchases.

Net cash provided by financing activities totaled $512.6 million in 2001 compared to net cash used in financing activities of $28.6 million in 2000. The increase was primarily related to additional debt incurred to finance the Cerulean acquisition of $500.0 million, in addition to the receipt of proceeds from the issuance of stock related to the Company's employee stock option and purchase programs of $86.1 million less $7.4 million in Company stock repurchases. During 2001, the Company decreased indebtedness under its revolving credit facility by $15.0 million.

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities (which are generally referred to collectively in this Annual Report on Form 10−K as the Company's "revolving credit facility") bear interest at rates determined by reference to the bank's base rate or to the London Inter Bank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million, expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, originally expired as of March 29, 2002. Any amount outstanding under this facility as of March 29, 2002 may be converted into a one−year term loan at the option of the Company. In March 2002, the Company amended this facility to provide for a one−year extension with an expiration date of March 28, 2003. Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control (See Note 8 to the Consolidated Financial Statements). The total amount outstanding under these facilities was $235.0 million as of December 31, 2001. The total amount outstanding under the Company's prior revolving credit facility was $250.0 million as of December 31, 2000.

As a part of a hedging strategy to limit its exposure to variable interest rate increases, the Company entered into interest rate swap agreements in order to reduce the volatility of interest expense resulting from changes in interest rates. The swap agreements are contracts to exchange variable−rate interest payments (weighted average rate for the year ended December 31, 2001 of 4.81%) for fixed−rate interest payments (weighted average rate for the year ended December 31, 2001 of 7.45%) without the exchange of the underlying notional amounts. As of December 31, 2001, the Company had entered into $200.0 million of fixed rate swap agreements, which consisted of a $150.0 million notional amount swap agreement at 6.99% maturing on October 17, 2003 and a $50.0 million notional amount swap agreement at 7.06% maturing on October 17, 2006.

During 2001, the Company entered into foreign currency forward exchange contracts for each of the fixed maturity securities on hand denominated in foreign currencies in order to hedge asset positions with respect to currency fluctuations related to these securities. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and as a result entered into a hedge to offset the remaining currency hedge. Subsequent to the implementation of SFAS No. 133, all gains and losses from both effective and ineffective forward exchange contracts have been reported in investment income offset by the related gains and losses on the Company's available−for−sale foreign securities (See Note 15 to the Consolidated Financial Statements).

Certain of the Company's subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory agencies, including the California Department of Managed Health Care and the Departments of Insurance in various states. As of December 31, 2001 (or the most recent date with respect to which compliance is required), those subsidiaries of the Company were in compliance with all minimum capital requirements.

On June 15, 2001, the Company issued $450.0 million aggregate principal amount at maturity of 6 3/8% Notes due June 15, 2006 (the "2001 Notes"). The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities which indirectly financed a portion of the Cerulean acquisition. The 2001 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest is computed on the basis of a 360−day year of twelve 30−day months.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

With the anticipated acquisition of RightCHOICE on January 31, 2002, the Company on January 16, 2002 issued $350.0 million aggregate principal amount at maturity of 6 3/8% Notes due January 15, 2012 (the "2002 Notes") The net proceeds of this offering totaled approximately $348.9 million. The 2002 Notes bear interest at a rate of 6 3/8% per annum, payable semi−annually in arrears on January 15 and July 15 of each year commencing July 15, 2002. Interest is computed on the basis of a 360−day year of twelve 30−day months.

The 2002 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2002 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2002 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the

2002 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the Reference Treasury Dealer (J.P. Morgan Securities Inc. or Deutsche Banc Alex. Brown or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2002 Notes to the redemption date.

The 2001 and 2002 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2001 and 2002 Notes. The indenture governing the 2001 and 2002 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2001 and 2002 Notes.

The Company enters into operating leases primarily for office space, electronic data processing and office equipment. As of December 31, 2001, minimum annual rental commitments on operating leases having initial or remaining noncancellable lease terms in excess of one year during the years 2002 through 2006 were $89.6 million, $71.5 million, $49.0 million, $37.8 million and $29.6 million, respectively, with $245.6 million in minimum commitments thereafter.

The Company's obligations relating to debt and leases at December 31, 2001 were as follows:

	Total	2002	2003	2004	2005	2006	Thereafter
				(In millions)			
6 3/8% Notes due 2006	$ 450.0	$ —	$ —	$ —	$ —	$ 450.0	$ —
Revolving credit facility	235.0	—	35.0	—	—	200.0	—
Zero coupon convertible subordinated debentures	218.0	—	—	—	—	—	218.0
Operating leases	523.1	89.6	71.5	49.0	37.8	29.6	245.6
Total contractual obligations	$ 1,426.1	$ 89.6	$ 106.5	$ 49.0	$ 37.8	$ 679.6	$ 463.6

The Company's committed credit availability as of December 31, 2001 was as follows:

			Amount of Available Commitment Expiration per Period				
	Total committed	Total available	2002	2003	2004	2005	2006
			(In millions)				
Revolving Credit—committed and available	$ 1,000.0	$ 765.0	—	$ 215.0	—	—	$ 550.0

The Company believes that cash flow generated by operations and its cash and investment balances, supplemented by the Company's ability to borrow under its existing revolving credit facilities or through public or private financing sources, will be sufficient to fund continuing operations and expected capital requirements for the foreseeable future.

Pending Acquisition

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst. The definitive agreement provides that the Company will pay at least $450.0 million of the purchase price in cash and the balance in shares of the Company's Common Stock and under certain circumstances a five−year subordinated note. The transaction, which is subject to regulatory approvals, is currently expected to be completed within 18−24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003. (See "Item 1. Business" and Note 23 to the Consolidated Financial Statements for further discussion.)

Tax Issues Relating to the WellPoint and RightCHOICE Recapitalizations

In connection with the Recapitalization, BCC received a ruling from the IRS that, among other things, the BCC Conversion qualified as a tax−free transaction and that no gain or loss was recognized by BCC for Federal income tax purposes. If the ruling were subsequently revoked, modified or not honored by the IRS (due to a change in law or for any other reason), WellPoint, as the successor to BCC, could be subject to Federal income tax on the difference between the value of BCC at the time of the BCC Conversion and BCC's tax basis in its assets at the time of the BCC Conversion. The potential tax liability to WellPoint if the BCC Conversion is treated as a taxable transaction is currently estimated to be approximately $696 million, plus interest (and possibly penalties). BCC and the Foundation entered into an Indemnification Agreement that provides, with certain exceptions, that the Foundation will indemnify WellPoint against the net tax liability as a result of a revocation or modification, in whole or in part, of the ruling by the IRS or a determination by the IRS that the BCC Conversion constitutes a taxable transaction for Federal income tax purposes. In the event a tax liability should arise against which the Foundation has agreed to indemnify WellPoint, there can be no assurance that the Foundation will have sufficient assets to satisfy the liability in full, in which case WellPoint would bear all or a portion of the cost of the liability, which could have a material adverse effect on WellPoint's financial condition.

During the quarter ended September 30, 1998 the Company received a private letter ruling from the IRS with respect to the treatment of certain payments made at the time of the Recapitalization and the acquisition of the commercial operations of BCC. The ruling allowed the Company to deduct as an ordinary and necessary business expense the $800 million cash payment made by BCC in May 1996 to one of two newly formed charitable foundations. As a result of and in reliance on the ruling, the Company experienced a reduction in its income tax expense of $85.5 million and the Company reduced its goodwill resulting from the Recapitalization by $194.5 million during the year ended December 31, 1998. The Company filed for refund claims of approximately $198.6 million of previous year income tax payments and reduced income tax payments during 1998 and 1999 by approximately $81.4 million. In August 1999, the Company received a cash refund (including applicable accrued interest) of approximately $183.0 million, which was reflected in the statement of cash flows for such year. The Company has refund claims pending of approximately $39.3 million.

In March 2002, the Company received a letter from the IRS notifying the Company that the IRS was considering revoking the September 1998 private letter ruling. The letter stated that the IRS was considering, in essence, reversing its earlier position and concluding that the $800 million payment was not an ordinary and necessary business expense. The letter further stated that the IRS was withdrawing the private letter ruling and that the Company could no longer rely on the private letter ruling. Under Section 7805(b) of the Code, the IRS has discretionary authority to limit the retroactive effect of any revocation of a letter ruling. In March 2002, the Company submitted a written request for such relief under Section 7805(b).

On April 9, 2002, the Company received a letter from the IRS notifying the Company that its request had been granted and that the September 1998 private letter ruling would not be revoked on a retroactive basis. Based on this April 9, 2002 letter, the Company intends to continue to rely on the September 1998 private letter ruling in its treatment of the $800 million cash payment made in May 1996.

On November 30, 2000 RightCHOICE completed a reorganization (the "RightCHOICE Recapitalization") with its majority stockholder, RightCHOICE Managed Care, Inc., a Missouri corporation ("Old RightCHOICE"). As part of the RightCHOICE Recapitalization, The Missouri Foundation For Health (the "Missouri Foundation") became the holder of approximately 80% of RightCHOICE Common Stock. In connection with the RightCHOICE Recapitalization, the predecessor of Old RightCHOICE, Blue Cross and Blue Shield of Missouri, received a ruling from the

IRS that, among other things, the conversion of Blue Cross and Blue Shield of Missouri from a non−profit corporation to a for−profit corporation qualified as a reorganization under the Internal Revenue Code and that Blue Cross and Blue Shield of Missouri recognized no gain or loss for federal income tax purposes. If the IRS subsequently revoked, modified or decided not to honor the ruling due to a change in law or for any other reason, RightCHOICE, as the successor to Old RightCHOICE, could be subject to federal income tax on the difference between the value of each of Blue Cross and Blue Shield of Missouri's assets at the time of the RightCHOICE Recapitalization and its tax basis in its assets at the time of the RightCHOICE Recapitalization. RightCHOICE is now a wholly owned subsidiary of WellPoint. RightCHOICE and the Missouri Foundation entered into an indemnification agreement that provides, with certain exceptions, that the Missouri Foundation will indemnify RightCHOICE against the tax liability as a result of the IRS's revocation or modification, in whole or in part, of its ruling, or an IRS determination that RightCHOICE's conversion was a taxable transaction for federal income tax purposes. If a tax liability should arise against which the Missouri Foundation has agreed to indemnify RightCHOICE, the Missouri Foundation may not have sufficient assets to pay the liability. RightCHOICE would then bear all or a portion of the liability, which could have a material adverse effect on RightCHOICE's and the Company's financial condition.

Critical Accounting Policies

The preparation of financial statements in conformity with generally accepted accounting principles requires the Company's management to make a variety of estimates and assumptions. These estimates and assumptions affect, among other things, the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Actual results can differ from the amounts previously estimated, which were based on the information available at the time the estimates were made.

The critical accounting policies described below are those that the Company believes are important to the portrayal of the Company's financial condition and results, and which require management to make difficult, subjective and/or complex judgments. Critical accounting policies cover accounting matters that are inherently uncertain because the future resolution of such matters is unknown. The Company believes that critical accounting policies include medical claims payable, reserves for future policy benefits and intangible assets and goodwill.

Medical Claims Payable

Medical claims payable includes claims in process and a provision for the Company's estimate of incurred but not reported claims. Such estimates are developed using actuarial principles and assumptions which consider, among other things, contractual requirements, historical utilization trends and payment patterns, medical inflation, product mix, seasonality, membership and other relevant factors. Claim processing expenses are also accrued based on an estimate of expenses necessary to process such claims. Such reserves are continually monitored and reviewed with any adjustments reflected in current operations. Capitation costs represent monthly fees paid one month in advance to physicians, certain other medical service providers and hospitals in the Company's HMO networks as retainers for providing continuing medical care. The Company maintains various programs that provide incentives to physicians, certain other medical service providers and hospitals participating in its HMO networks through the use of risk−sharing agreements and other programs. Payments under such agreements are made based on the providers' performance in controlling health care costs while providing quality health care. Expenses related to these programs, which are based in part on estimates, are recorded in the period in which the related services are rendered. Management believes that its reserves for medical claims payable are adequate to satisfy its ultimate claim liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The Company's future results of operations will depend in part on its ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. WellPoint's ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above−listed or other factors may adversely affect the Company's future profitability.

Reserves for Future Policy Benefits

The estimated reserves for future policy benefits relate to life and disability insurance policies written in connection with health care contracts. Reserves for future life benefit coverage are based on projections of past experience. Reserves for future policy and contract benefits for certain long−term disability products and group paid−up life products are based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon the Company's experience. Reserves are continually monitored and reviewed, and as settlements are made or reserves adjusted, differences are reflected in current operations. The current portion of reserves for future policy benefits relates to the portion of such reserves which management expects to pay within one year. Management believes that its reserves for future policy benefits are adequate to satisfy its ultimate benefit liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Intangible Assets and Goodwill

The Company has made several acquisitions in the past several years that included a significant amount of intangible assets and goodwill. Under generally accepted accounting principles in effect through December 31, 2001, these assets were amortized over their useful lives, and were tested periodically to determine if they were recoverable from operating earnings on an undiscounted basis over their useful lives.

The Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, such potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity.

Effective January 1, 2002, intangible assets and goodwill will be accounted for under SFAS No. 142, "Goodwill and Other Intangible Assets." The new rules eliminate amortization of goodwill and other intangibles with indefinite lives, but these assets will be subject to the impairment tests. (See "New Accounting Pronouncements" and Note 7 to the Consolidated Financial Statements for a more complete discussion of the Company's intangible assets and goodwill). Management is required to make assumptions and estimates, such as the discount factor, in determining estimated fair value. Such estimated fair values might produce significantly different results if other reasonable assumptions and estimates were to be used.

New Accounting Pronouncements

In June 2001, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 141, "Business Combinations" ("SFAS No. 141"). SFAS No. 141 addresses financial accounting and reporting for business combinations and supersedes APB Opinion No. 16, "Business Combinations," and FASB Statement No. 38, "Accounting for Preacquisition Contingencies of Purchased Enterprises." Upon adoption of SFAS No. 141, all business combinations must be accounted for using the purchase method. The use of the pooling of interests method is now prohibited. The provisions of the new standard apply to all business combinations initiated after June 30, 2001. For business combinations accounted for using the purchase method before July 1, 2001, the provisions of this statement will be effective in the first quarter of 2002. The adoption of SFAS No. 141 did not have a material effect on the financial statements of the Company.

In July 2001, the FASB issued SFAS No. 142, "Goodwill and Other Intangible Assets," which supersedes APB Opinion No. 17, "Intangible Assets." This statement addresses the accounting and reporting of goodwill and other intangible assets subsequent to their acquisition. SFAS No. 142 provides that (i) goodwill and indefinite−lived intangible assets will no longer be amortized, (ii) impairment will be measured using various valuation techniques based on discounted cash flows, (iii) goodwill will be tested for impairment at least annually at the reporting unit level, (iv) intangible assets deemed to have an indefinite life will be tested for impairment at least annually and (v) intangible assets with finite lives will be amortized over their useful lives. The statement provides specific guidance on testing goodwill and intangible assets for impairment, and requires that reporting units be identified for the purpose of assessing potential future impairments. Goodwill and intangible assets acquired after June 30, 2001 were subjected to the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. Utilizing internal and external resources, the Company is in the process of adopting SFAS No. 142 and is identifying its reporting units and the amounts of goodwill, intangible assets, other assets and liabilities to be allocated to those reporting units.

SFAS No. 142 requires that goodwill be tested annually for impairment using a two−step process. The first step is to identify a potential impairment and, in transition, this step must be measured as of the beginning of the fiscal year. However, companies have six months from the date of adoption to complete the first step. The Company expects to complete the first step of the goodwill impairment test during the first quarter of 2002. The second step of the goodwill impairment test measures the amount of impairment loss (measured as of the beginning of the year of adoption), if any, and must be completed by December 31, 2002. Intangible assets deemed to have an indefinite life will be tested for impairment using a one−step process which compares the fair value to the carrying amount of the asset as of the beginning of the year. This process will be completed during the first quarter of 2002. The Company is in the process of completing these impairment tests for goodwill and other intangible assets and, based on current information, does not anticipate transitional impairment losses. The Company expects the adoption of SFAS No. 142 to benefit earnings, net of taxes, of approximately $31.7 million compared to 2001.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 143, "Accounting for Asset Retirement Obligations" ("SFAS No. 143"). SFAS No. 143 is effective for financial statements issued for fiscal years beginning after June 15, 2002. The Company will adopt SFAS No. 143 on January 1, 2003. The provisions of SFAS No. 143 require companies to record an asset and related liability for the costs associated with the retirement of a long−lived tangible asset if a legal liability to retire the asset exists. The Company is in the process of analyzing the provisions of SFAS No. 143; however, the effect of adoption is not expected to have a significant impact on the Company's financial condition and results of operations.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long−Lived Assets" ("SFAS No. 144"). SFAS No. 144 is

effective for financial statements issued for fiscal years beginning after December 15, 2001. This statement addresses financial accounting and reporting for the impairment or disposal of long−lived assets and supersedes SFAS No. 121, "Accounting for the Impairment of Long−Lived Assets and for Long−Lived Assets to be Disposed of" and the accounting and reporting provisions of APB 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," for the disposal of a segment of business (as previously defined in that opinion). SFAS No. 144 retains the basic principles of SFAS No. 121 for long−lived assets to be disposed of by sale or held and used and broadens discontinued operations presentation to include a component of an entity that is held for sale or that has been disposed. Components must have operations and cash flows that can be clearly distinguished from the rest of the entity. The Company is in the process of analyzing the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. The adoption of this standard is not expected to have a significant impact on the Company's financial results.

Factors That May Affect Future Results Of Operations

Certain statements contained herein, such as statements concerning potential or future loss ratios, the effects as the Company continues to integrate its recently acquired operations and other statements regarding matters that are not historical facts, are forward−looking statements (as such term is defined in the Securities Exchange Act of 1934). Such statements involve a number of risks and uncertainties that may cause actual results to differ from those projected. Factors that can cause actual results to differ materially include, but are not limited to, those discussed below and those discussed from time to time in the Company's various filings with the Securities and Exchange Commission.

The Company's operations are subject to substantial regulation by federal, state and local agencies in all jurisdictions in which the Company operates. Many of these agencies have increased their scrutiny of managed health care companies in recent periods or are expected to increase their scrutiny, as newly passed legislation becomes effective. From time to time, the Company and its subsidiaries receive requests for information from regulatory agencies or are notified that such agencies are conducting reviews, investigations or other proceedings with respect to certain of the Company's activities. The Company also provides insurance products to Medi−Cal beneficiaries in various California counties under contracts with the California Department of Health Services (or delegated local agencies) and provides administrative services to the Centers for Medicare and Medicaid Services ("CMS") in various capacities. There can be no assurance that acting as a government contractor in these circumstances will not increase the risk of heightened scrutiny by such government agencies or that such scrutiny will not have a material adverse effect on the Company, either through negative publicity about the Company or through an adverse impact on the Company's results of operations. In addition, profitability from this business may be adversely affected through inadequate premium rate increases due to governmental budgetary issues. Future actions by any regulatory agencies may have a material adverse effect on the Company's business.

In connection with the RightCHOICE and Cerulean transactions, the Company incurred significant additional indebtedness to fund the cash payments made to the acquired companies' stockholders. In addition, the Company currently expects to incur additional indebtedness to fund some or all of the cash payments to be made in connection with the pending CareFirst transaction. This existing or new indebtedness may result in a significant percentage of the Company's cash flow being applied to the payment of interest, and there can be no assurance that the Company's operations will generate sufficient future cash flow to service this indebtedness. The Company's current indebtedness, as well as any indebtedness that the Company may incur in the future (such as indebtedness incurred to fund repurchases of its Common Stock or to fund the CareFirst or other transactions), may adversely affect

the Company's ability to finance its operations and could limit the Company's ability to pursue business opportunities that may be in the best interests of the Company and its stockholders.

As part of the Company's business strategy, the Company has acquired substantial operations in new geographic markets over the last five years. These businesses, some of which include substantial indemnity−based insurance operations, have experienced varying profitability or losses in recent periods. Since the relevant dates of acquisition of Rush Prudential and Cerulean, the Company has continued to work extensively on the integration of these businesses. The Company has also begun its integration of the RightCHOICE business. However, there can be no assurances regarding the ultimate success of the Company's integration efforts or regarding the ability of the Company to maintain or improve the results of operations of the businesses of completed or pending transactions. The Company has incurred and will, among other things, need to continue to incur considerable expenditures for provider networks, distribution channels and information systems in addition to the costs associated with the integration of these acquisitions. The integration of these complex businesses may result in, among other things, temporary increases in claims inventory or other service−related issues that may negatively affect the Company's relationship with its customers and contribute to increased attrition of such customers. The Company's results of operations could be adversely affected in the event that the Company experiences such problems or is otherwise unable to implement fully its expansion strategy.

The Company and certain of its subsidiaries are subject to capital surplus requirements by the California Department of Managed Health Care, the Georgia Department of Insurance, the Missouri Department of Insurance, various other state Departments of Insurance and the Blue Cross Blue Shield Association. Although the Company believes that it is currently in compliance with all applicable requirements, there can be no assurances that such requirements will not be increased in the future.

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict treatment or reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to *Shane v. Humana, et al.*, a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the *Shane* lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in

early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status. The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The Company's future results will depend in large part on accurately predicting health care costs incurred on existing business and upon the Company's ability to control future health care costs through product and benefit design, underwriting criteria, utilization management and negotiation of favorable provider contracts. Changes in mandated benefits, utilization rates, demographic characteristics, health care practices, provider consolidation, inflation, new pharmaceuticals/technologies, clusters of high−cost cases, the regulatory environment and numerous other factors are beyond the control of any health plan provider and may adversely affect the Company's ability to predict and control health care costs and claims, as well as the Company's financial condition, results of operations or cash flows. Periodic renegotiations of hospital and other provider contracts coupled with continued consolidation of physician, hospital and other provider groups may result in increased health care costs and limit the Company's ability to negotiate favorable rates. Recently, large physician practice management companies have experienced extreme financial difficulties, including bankruptcy, which may subject the Company to increased credit risk related to provider groups and cause the Company to incur duplicative claims expense. Additionally, the Company faces competitive pressure to contain premium prices. Fiscal concerns regarding the continued viability of government−sponsored programs such as Medicare and Medicaid may cause decreasing reimbursement rates for these programs. Any limitation on the Company's ability to increase or maintain its premium levels, design

products, implement underwriting criteria or negotiate competitive provider contracts may adversely affect the Company's financial condition or results of operations.

Managed care organizations, both inside and outside California, operate in a highly competitive environment that has undergone significant change in recent years as a result of business consolidations, new strategic alliances, aggressive marketing practices by competitors and other market pressures. Additional increases in competition could adversely affect the Company's financial condition, cash flows or results of operations. Additional increases in competition (including competition from market entrants offering Internet−based products and services), could adversely affect the Company's financial condition.

As a result of the Company's acquisitions, the Company operates on a select geographic basis nationally and offers a spectrum of health care and specialty products through various risk−sharing arrangements. The Company's health care products include a variety of managed care offerings as well as traditional fee−for−service coverage. With respect to product type, fee−for−service products are generally less profitable than managed care products. A component of the Company's expansion strategy is to transition over time the traditional insurance members of the Company's acquired businesses to more managed care products.

With respect to the risk−sharing nature of products, managed care products that involve greater potential risk to the Company generally tend to be more profitable than management services products and those managed care products where the Company is able to shift risks to employer groups. Individuals and small employer groups are more likely to purchase the Company's higher−risk managed care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government−sponsored programs involve the Company's higher−risk managed care products. Over the past few years, the Company has experienced a slight decline in margins in its higher−risk managed care products and to a lesser extent on its lower−risk managed care and management services products. This decline is primarily attributable to product mix change, product design, competitive pressure and greater regulatory restrictions applicable to the small employer group market. From time to time, the Company has implemented price increases in certain of its managed care businesses. While these price increases are intended to improve profitability, there can be no assurance that this will occur. Subsequent unfavorable changes in the relative profitability between the Company's various products could have a material adverse effect on the Company's results of operations and on the continued merits of the Company's geographic expansion strategy.

Substantially all of the Company's investment assets are in interest−yielding debt securities of varying maturities or equity securities. The value of fixed income securities is highly sensitive to fluctuations in short− and long−term interest rates, with the value decreasing as such rates increase and increasing as such rates decrease. In addition, the value of equity securities can fluctuate significantly with changes in market conditions. Changes in the value of the Company's investment assets, as a result of interest rate fluctuations, can affect the Company's results of operations and stockholders' equity. There can be no assurances that interest rate fluctuations will not have a material adverse effect on the results of operations or financial condition of the Company.

The Company's operations are dependent on retaining existing employees, attracting additional qualified employees and achieving productivity gains from the Company's investment in technology. The Company faces intense competition for qualified information technology personnel and other skilled professionals. There can be no assurances that an inability to retain existing employees or attract additional employees will not have a material adverse effect on the Company's results of operations.

In December 2000, a wholly owned subsidiary of the Company completed its acquisition of certain mail order pharmaceutical service assets and conducts business as a mail order pharmacy. The pharmacy business is subject to extensive federal, state and local regulations which are in many instances different from those under which the Company's core health plan business currently operates.

The failure to properly adhere to these and other applicable regulations could result in the imposition of civil and criminal penalties, which could adversely affect the Company's results of operations or financial condition. In addition, pharmacies are exposed to risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Although the Company intends to maintain professional liability and errors and omissions liability insurance, there can be no assurances that the coverage limits under such insurance programs will be adequate to protect against future claims or that the Company will be able to maintain insurance on acceptable terms in the future.

Following the terrorist attacks of September 11, 2001, there have been various incidents of suspected bioterrorist activity in the United States. To date, these incidents have resulted in related isolated incidents of illness and death. However, federal and state law enforcement officials have issued public warnings about additional potential terrorist activity involving biological weapons. If the United States were to experience more widespread bioterrorist attacks, the Company's covered medical expenses could rise and the Company could experience a material adverse effect on its results of operations, financial condition and cash flow.

Item 7a. Quantitative and Qualitative Disclosures about Market Risk

The Company regularly evaluates its asset and liability interest rate risks as well as the appropriateness of investments relative to its internal investment guidelines. The Company operates within these guidelines by maintaining a well−diversified portfolio, both across and within asset classes. The Company has from time to time retained an independent consultant to advise the Company on the appropriateness of its investment policy and the compliance therewith.

Asset interest rate risk is managed within a duration band tied to the Company's liability interest rate risk. Credit risk is managed by maintaining high average quality ratings and a well−diversified portfolio.

The Company's use of derivative instruments is generally limited to hedging purposes and has principally consisted of forward exchange contracts and interest rate swaps. The foreign exchange contracts are intended to minimize the portfolio's exposure to currency volatility associated with certain foreign currency denominated bond holdings. The Company's investment policy prohibits the use of derivatives for leveraging purposes as well as the creation of risk exposures not otherwise allowed within the policy.

Since 1996, the Company has from time to time entered into interest rate swap agreements primarily by exchanging the floating debt payments due under its outstanding indebtedness for fixed rate payments. The Company believes that this allows it to better anticipate its interest payments while helping to manage the asset−liability relationship.

Interest Rate Risk

As of December 31, 2001, approximately 71% of the Company's investment portfolio consisted of fixed income securities (maturing in more than one year). Of the remainder, 10% was comprised of equities and 19% was comprised of cash, which is not subject to interest rate risk, the value of which generally varies inversely with changes in interest rates.

The Company has evaluated the net impact to the fair value of its fixed income investments from a hypothetical change in all interest rates of 100, 200 and 300 basis points ("bp"). In doing so, optionality was addressed through Monte Carlo simulation of the price behavior of securities with embedded options. In addressing prepayments on mortgage−backed securities, the model follows the normal market practice of estimating a non−interest rate sensitive component (primarily related to relocations) and an interest sensitive component (primarily related to refinancings) separately. The model is based on statistical techniques applied to historical prepayment and market data, and then incorporates

forward−looking mortgage market research and judgments about future prepayment behavior. Changes in the fair value of the investment portfolio are reflected in the balance sheet through stockholders' equity. Under the requirements of SFAS No. 133, effective January 1, 2001, all derivative financial instruments are reflected on the balance sheet at fair value. The results of this analysis as of December 31, 2001 are reflected in the table below. The table reflects the change in valuation of interest rate swap agreements for the year ended December 31, 2001 to the extent that the notional amount of interest rate swap agreements exceeded the principal balance of the Company's floating rate indebtedness.

	Increase (decrease) in fair value given an interest rate increase of:		
	100 bp	200 bp	300 bp
	(In millions)		
Fixed Income Portfolio	$ (120.0)	$ (236.3)	$ (346.8)
Valuation of Interest Rate Swap Agreements	4.8	9.4	13.8
	$ (115.2)	$ (226.9)	$ (333.0)

Results as of December 31, 2000 are reflected in the table below. The table reflects the change in valuation of interest rate swap agreements for the year ended December 31, 2000 to the extent that the notional amount of interest rate swap agreements exceeded the principal balance of the Company's floating rate indebtedness.

	Increase (decrease) in fair value given an interest rate increase of:		
	100 bp	200 bp	300 bp
	(In millions)		
Fixed Income Portfolio	$ (85.5)	$ (170.0)	$ (250.1)
Valuation of Interest Rate Swap Agreements	6.1	12.0	17.6
	$ (79.4)	$ (158.0)	$ (232.5)

The Company believes that an interest rate shift in a 12−month period of 100 bp represents a moderately adverse outcome, while a 200 bp shift is significantly adverse and a 300 bp shift is unlikely given historical precedents. Although the Company holds its bonds as "available for sale" for purposes of SFAS No. 115, the Company's cash flows and the short duration of its investment portfolio should allow it to hold securities to maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Interest Rate Swap Agreements

The Company has entered into interest rate swap agreements in order to reduce the volatility of interest expense resulting from changes in interest rates. As of December 31, 2001, the Company had entered into $200 million of floating to fixed rate swap agreements, which consisted of a $150 million notional amount swap agreement at 6.99% and a $50 million notional amount swap agreement at 7.06%. As of December 31, 2001, the Company also had $235 million of LIBOR−based floating rate debt outstanding. The Company also receives a LIBOR−based payment as a result of its swap arrangements, thereby eliminating the payment exposure to changes in interest rates on that $235 million of outstanding debt.

Equity Price Risk

The Company's equity securities are comprised primarily of domestic stocks as well as certain foreign holdings. Assuming an immediate decrease of 10% in market value, as of December 31, 2001

and 2000, the hypothetical loss in fair value of stockholders' equity was estimated to be approximately $47.8 million and $39.3 million, respectively.

Foreign Exchange Risk

The Company has generally hedged the foreign exchange risk associated with its fixed income portfolio. The Company uses short−term foreign exchange contracts to hedge the risk associated with certain fixed−income securities denominated in foreign currencies. Therefore, the Company believes that there is minimal risk to the fixed−income portfolio due to currency exchange rate fluctuations. The Company's hedging program related to its foreign currency denominated investments is described in Note 15 to the Consolidated Financial Statements. As of December 31, 2001, however, the Company had liquidated its non−dollar foreign bond holdings and entered into a hedge to offset the remaining currency hedge.

The Company does not hedge its foreign exchange risk arising from equity investments denominated in foreign currencies. Assuming a foreign exchange loss of 10% across all foreign equity investments, the net hypothetical pretax loss in fair value as of December 31, 2001 and 2000, was estimated to be $6.6 million and $8.1 million, respectively.

Item 8. Financial Statements and Supplementary Data

The location in this Annual Report on Form 10−K of the Company's Consolidated Financial Statements is set forth in the "Index" on Page F−1.

WellPoint Health Networks Inc.
Quarterly Selected Financial Information
(Unaudited)

	As of and for the Quarter Ended			
	March 31, 2001	June 30, 2001	September 30, 2001	December 31, 2001
	(In thousands, except per share data and membership data)			
Total revenues	$ 2,615,453	$ 3,145,406	$ 3,245,472	$ 3,422,316
Operating income	180,656	201,550	217,809	223,210
Income before provision for income taxes	159,151	169,381	183,820	186,230
Net income	$ 96,503	$ 99,929	$ 108,446	$ 109,868
Per Share Data(A):				
Earnings Per Share	$ 0.77	$ 0.79	$ 0.85	$ 0.86
Earnings Per Share Assuming Full Dilution	$ 0.74	$ 0.76	$ 0.82	$ 0.83
Medical membership	9,763,829	9,835,091	9,992,764	10,146,945

	As of and for the Quarter Ended			
	March 31, 2000	June 30, 2000	September 30, 2000	December 31, 2000
	(In thousands, except per share data and membership data)			
Total revenues	$ 2,145,246	$ 2,288,835	$ 2,353,324	$ 2,441,553
Operating income	143,946	157,692	165,133	167,417
Income before provision for income taxes	130,615	137,194	146,727	149,777
Net income	$ 79,644	$ 83,667	$ 89,504	$ 89,472
Per Share Data(A):				
Earnings Per Share	$ 0.63	$ 0.67	$ 0.72	$ 0.71
Earnings Per Share Assuming Full Dilution	$ 0.62	$ 0.65	$ 0.69	$ 0.69
Medical membership	7,541,027	7,617,773	7,742,973	7,869,119

(A) Per share data for each period presented has been restated to reflect the two−for−one stock split which occurred March 15, 2002.

Item 9. Changes And Disagreements With Accountants On Accounting And Financial Disclosure

None.

PART III

Item 10. Directors And Executive Officers Of The Registrant

The directors of the Company are as follows:

W. Toliver Besson, age 57, a Class III director, has been a director of the Company since May 1996, was an independent director of BCC from April 1994 until May 1996 and prior to that served as an advisory director of BCC from 1989. He has been a partner with the law firm of Paul, Hastings, Janofsky & Walker since 1978. He served on its national management committee from 1985 to 1990 and served on the Board of Governors of the California State Bar from 1979 to 1980. He currently serves as a member of the management committee of Cross Country Ventures (a venture capital limited partnership). Pursuant to an agreement with the DMHC, Mr. Besson has effectively agreed not to serve as a director beyond April 2003. Mr. Besson serves on the Audit Committee of the Board and as the chairperson of the Nominating & Governance Committee of the Board.

Roger E. Birk, age 71, a Class I director, has been a director of the Company since April 1993. He is retired. Mr. Birk served as President of the Federal National Mortgage Association ("Fannie Mae") from 1987 to 1992 and as Chairman and Chief Executive Officer of Merrill Lynch & Co., Inc. from 1982 to 1986. Mr. Birk serves as a director of Penske Corporation and Fannie Mae. Mr. Birk serves as the chairperson of the Audit Committee of the Board.

Sheila P. Burke, age 51, a Class I director, has been a director of the Company since April 1997. Since July 2000, Ms. Burke has been the Undersecretary for American Museums & National Programs of the Smithsonian Institution. From December 1996 until July 2000, Ms. Burke served as an Executive Dean of the John F. Kennedy School of Government, Harvard University. Previously in 1996, Ms. Burke was a senior advisor to the Dole for President Campaign. From 1986 until June 1996, Ms. Burke was the chief of staff for the Office of the Republican Leader of the United States Senate. Ms. Burke currently serves on the Board of Directors of Chubb Corp. Ms. Burke serves on the Audit Committee and the Compensation Committee of the Board.

William H. T. Bush, age 63, was elected a Class II director of the Company in January 2002, upon completion of the Company's merger with RightCHOICE Managed Care, Inc. ("RightCHOICE"). Mr. Bush served as a director of RightCHOICE from April 1994 to January 2002. He served on the Blue Cross and Blue Shield of Missouri board of directors from 1989 to 1994 and as Secretary of the Blue Cross and Blue Shield of Missouri board of directors from 1990 to 1994. Mr. Bush is the Chairman of Bush−O'Donnell & Company, Inc. of St. Louis, an investment management and financial advisory firm he founded in 1986. Prior to 1986, Mr. Bush served as President and as a director of The Boatmen's National Bank of St. Louis. Mr. Bush currently is a director of Mississippi Valley Bancshares, Inc., Maritz, Inc., D.T. Industries, Inc., the Lord−Abbett Family of Mutual Funds and Engineered Support Systems, Inc. Mr. Bush serves on the Audit Committee of the Board.

Stephen L. Davenport, age 69, a Class II director, has been a director of the Company since May 1996, was an independent director of BCC from 1991 until May 1996 and prior to that served as an advisory director of BCC from 1989. He is retired. From 1980 to 1995, he was president of D/A Financial Group. Prior to that he was Senior Vice President of Provident Mutual Life Insurance Company. Pursuant to an agreement with the DMHC, Mr. Davenport has effectively agreed not to serve as a director beyond April 2002. Mr. Davenport serves on the Compensation Committee and the Nominating and Governance Committee of the Board.

Julie A. Hill, age 55, a Class III director, has been a director of the Company since March 1994. Since December 1998, she has been the President and owner of Hiram−Hill Development Company, a residential real estate development firm. Ms. Hill was President and Chief Executive Officer of Costain Homes Inc. ("Costain") from January 1991 until November 1998. During 1998, Ms. Hill also served as Chairman of the Board of Costain. Costain was a division of London−based Costain Group PLC and built single−family detached residential communities. Ms. Hill serves as the chairperson of the Compensation Committee and on the Nominating & Governance Committee of the Board.

Warren Y. Jobe, age 61, was elected a Class II director of the Company in March 2001, upon completion of the Company's merger with Cerulean Companies, Inc. ("Cerulean"). Mr. Jobe served as a director of Cerulean and Blue Cross Blue Shield of Georgia, Inc. from April 1999 to March 2001. He is retired. Mr. Jobe was Senior Vice President of Southern Company responsible for Corporate Development from 1998 until 2001. During such time, Mr. Jobe also was Executive Vice President of Georgia Power Company. Mr. Jobe was Executive Vice President and Chief Financial Officer of Georgia Power Company from 1982 to 1998, during which time he was also a member of its Board of Directors. Mr. Jobe currently serves on the board of directors of UniSource Energy Corporation. He is a certified public accountant and a member of the American Institute of Certified Public Accountants. Mr. Jobe serves on the Audit Committee and the Nominating & Governance Committee of the Board.

Elizabeth A. Sanders, age 56, a Class I director, has been a director of the Company since May 1996. Ms. Sanders has been a consultant to executive management from 1990 to the present. She was employed by Nordstrom Inc. from 1971 to 1990 and served as Vice President and General Manager of Nordstrom, Inc. from 1981 to 1990. Ms. Sanders is a founder of the National Bank of Southern California and was on its board of directors from 1983 to 1990. She currently serves on the following boards of directors: Washington Mutual Inc., Wal−Mart Stores, Inc., Wolverine Worldwide, Inc. and the Advantica Restaurant Group, Inc. Ms. Sanders serves on the Nominating & Governance Committee and the Compensation Committee of the Board.

Leonard D. Schaeffer, age 56, a Class III director, has been Chairman of the Board of Directors and Chief Executive Officer of the Company since August 1992. Mr. Schaeffer has also been Chief Executive Officer of BCC since 1986 and Chairman of its Board of Directors since 1989. From 1982 to 1986, Mr. Schaeffer served as President of Group Health, Inc., an HMO in the midwestern United States. Prior to joining Group Health, Inc., Mr. Schaeffer was the Executive Vice President and Chief Operating Officer of the Student Loan Marketing Association, a financial institution that provides a secondary market for student loans, from 1980 to 1981. From 1978 to 1980, Mr. Schaeffer was the Administrator of the Health Care Financing Administration ("HCFA" now known as the Centers for Medicare and Medicaid Services ("CMS")). CMS administers the Federal Medicare and Medicaid programs. Mr. Schaeffer serves as a director of Allergan, Inc. and Providian Financial Corporation.

The WellPoint Restated Certificate of Incorporation provides that the Board of Directors is divided into three classes, currently with three directors in each class. Directors in each class serve for a three−year term and the current composition of the classes is as follows: Class I directors (whose terms expire in 2003) consist of Mr. Birk and Mesdames Burke and Sanders; Class II directors (whose terms expire in 2004) consist of Messrs. Bush, Davenport and Jobe; and Class III directors (whose terms expire in 2002) consist of Messrs. Besson and Schaeffer and Ms. Hill.

Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Securities Exchange Act of 1934 (the "Exchange Act") requires the Company's directors, executive officers and holders of more than 10 percent of the Company's Common Stock to file reports of ownership and changes in ownership with the Securities and Exchange Commission ("SEC"). Officers, directors and greater than 10 percent stockholders are required by SEC regulations to furnish the Company with copies of all Section 16(a) forms they file.

Based solely on a review of the copies of such forms received by it, or written representations from certain reporting persons, the Company believes that during the year ended December 31, 2001, the Company's officers, directors and greater than 10 percent beneficial owners complied with all applicable filing requirements, except D. Mark Weinberg, the Company's Executive Vice President and Chief Development Officer who reported late one gift transaction in 1998, one gift transaction in 1999 and seven gift transactions in 2000. All such gift transactions by Mr. Weinberg were made to unaffiliated third parties.

Information regarding the Company's executive officers is contained in Part I above under the caption "Item 1. Business."

Item 11. Executive Compensation

On March 15, 2002, the Company effected a two−for−one stock split in the form of a 100% stock dividend. Unless otherwise noted, the share amounts, share price and option exercise price information given in Items 11 and 12 have been adjusted to reflect such stock split.

Compensation of Directors

All non−employee directors of the Company are entitled to the following compensation: (i) $23,000 per year paid in quarterly installments (with the chairperson of each committee receiving an additional $5,000 annual retainer); and (ii) $1,500 per Board meeting and $1,000 per committee meeting. The meeting fee is $500 for any telephonic Board or committee meeting. Non−employee directors of the Company are also entitled to receive a Company−paid annual physical examination.

Non−employee directors may elect to defer the receipt of all or a portion of their fees. Under the Company's Board of Directors Deferred Compensation Plan (the "Directors' Deferred Compensation Plan"), amounts deferred may be credited with earnings at a rate equal to the actual rate of return of a range of investment vehicles authorized by the Compensation Committee. Alternatively, fees may be foregone in return for the grant of a non−statutory stock option. The number of shares of Common Stock subject to such option is equal to the dollar amount of cash compensation deferred divided by the product of the fair market value of the Company's Common Stock on the option grant date and 25%. The automatic stock awards discussed in the following paragraph may also be deferred under the Directors' Deferred Compensation Plan or may be foregone in exchange for stock options at a rate of four shares for each share foregone.

On each date on which annual grants are made to officers of the Company subject to the short−swing profit liability provisions of Section 16 of the Exchange Act, continuing non−employee directors who have served for at least six full calendar months automatically receive 1,600 shares of Common Stock and a 4,000−share stock option grant under the Company's 1999 Stock Incentive Plan. The 1,600−share grant is immediately vested and the 4,000−share stock option grant vests on the third anniversary of the grant date. Each newly elected non−employee director is also entitled to receive a 16,000−share stock option grant on the date of such director's election. This 16,000−share grant is immediately vested with respect to 4,000 shares, with the remaining shares vesting ratably on the first three anniversaries of the grant date.

In January 2002, the Board of Directors amended its non−employee director compensation program to provide that each non−employee director, on the date of his or her election to the Board, will receive a grant of 3,500 shares of Common Stock and a cash award equivalent to the fair market value of 1,500 shares of Common Stock as of such date. The stock grant is made under the Company's 1999 Stock Incentive Plan and is immediately vested. At the time of such amendment to the non−employee director compensation program, each then−current non−employee director also received such stock and cash awards.

In order to more closely align the interests of the directors with those of the Company's stockholders, the Board of Directors has adopted stock ownership guidelines for persons serving on the Board. This policy was last amended in January 2002. Each non−employee director is required to own Common Stock having a fair market value equal to 10 times the annual cash retainer paid to such director within five years of his or her election to the Board of Directors. At the time of the January 2002 stock grant to existing non−employee directors referenced in the immediately preceding paragraph, each of the directors agreed that such stock grant would not be transferred until such time as such director had met the stock ownership guidelines applicable to directors.

Compensation Committee Interlocks and Insider Participation

The Compensation Committee of the Board of Directors is composed of Sheila P. Burke, Stephen L. Davenport, Julie A. Hill and Elizabeth A. Sanders. The Company's Compensation Committee does not include any present or former officers or employees of the Company or any of its subsidiaries.

Summary of Certain Compensation

The following table provides certain summary information concerning compensation paid or accrued by the Company and its subsidiaries to or on behalf of the Company's Chief Executive Officer and each of the four other most highly compensated executive officers of the Company (determined for the year ended December 31, 2001) (colletively, with the Chief Executive Officer, the "Named Executive Officers") for the years ended December 31, 1999, 2000 and 2001:

Summary Compensation Table

		Annual Compensation			Long−Term Compensation Awards		
Name	Year	Salary ($)	Bonus ($)	Other Annual Compensation ($)(1)	Restricted Stock ($)	Securities Underlying Options (#)	All Other Compensation ($)(2)
Leonard D. Schaeffer	2001	$ 1,176,925	$ 4,437,500(3)	$ 135,559(4)	0	636,762	$ 169,688
Chairman and	2000	1,076,922	3,344,676(5)	141,868(6)	0	544,908	192,125
Chief Executive Officer	1999	999,992	2,200,700	129,849(7)	0	722,462	133,557
David C. Colby	2001	$ 502,239	$ 1,106,000(3)	$ 5,165(8)	0	140,400	$ 48,771
Executive Vice President	2000	459,846	642,110(5)	5,656(8)	0	90,000	41,969
and Chief Financial Officer	1999	423,154	374,800	3,900(8)	$ 316,750(9)	90,000	35,752
Thomas C. Geiser	2001	$ 473,770	$ 998,213(3)	$ 5,165(8)	0	140,400	$ 47,886
Executive Vice President,	2000	431,462	638,723(5)	5,105(8)	0	90,000	39,691
General Counsel and Secretary	1999	390,504	320,000	4,887(8)	$ 158,375(10)	78,000	32,911
Joan E. Herman	2001	$ 438,462	$ 945,163(3)	$ 5,165(8)	0	160,348	$ 42,926
Executive Vice President,	2000	401,000	710,730(5)	5,105(8)	0	95,644	37,683
Senior, Specialty and	1999	366,962	350,000	10,831(8)	0	60,348	27,416
State−Sponsored Program Division							
D. Mark Weinberg	2001	$ 589,231	$ 700,000	0	0	336,774	$ 63,022
Executive Vice President and	2000	561,923	776,201(5)	0	0	308,434	49,740
Chief Development Officer	1999	532,116	400,000	0	0	226,282	40,286

(1) Excludes perquisites and other personal benefits that do not exceed the lesser of $50,000 or 10% of the total annual salary and bonus for any Named Executive Officer.

(2)

For the year ended December 31, 2001, "All Other Compensation" includes the following:

- Contributions on behalf of Leonard D. Schaeffer, David C. Colby, Thomas C. Geiser, Joan E. Herman and D. Mark Weinberg in the amount of $9,691, $8,671, $7,618, $8,671 and $7,252, respectively, to the 401(k) plan to match pre−tax elective deferral contributions (included under Salary) made by each to such plan during 2001 and an award of 20 shares of Common Stock in the 401(k) Plan made to all eligible employees.

- Contributions on behalf of Leonard D. Schaeffer, David C. Colby, Thomas C. Geiser, Joan E. Herman and D. Mark Weinberg in the amount of $135,507, $35,559, $34,853, $30,073 and $49,468, respectively, to match pre−tax elective deferral contributions (included under Salary) made by each to WellPoint's deferred compensation plan during 2001; and

- Life insurance premiums paid on behalf of Leonard D. Schaeffer, David C. Colby, Thomas C. Geiser, Joan E. Herman and D. Mark Weinberg in the amount of $24,490, $4,541, $5,415, $4,182 and $6,302, respectively.

(3)

Includes restricted share right grants vesting in equal installments on March 15, 2003, 2004 and 2005 for Leonard D. Schaeffer, David C. Colby, Thomas C. Geiser and Joan E. Herman in the amount of $2,187,500, $530,000, $491,063, and $475,813, respectively. As of December 31, 2001, the shares underlying these grants (none of which were vested) had a fair market value of approximately $2,069,706, $501,403, $464,596 and $450,165, respectively, not accounting for vesting restrictions. The unvested shares underlying this grant are subject to forfeiture in certain instances and to accelerated vesting upon a change in control or involuntary termination. Dividends will not be paid on any shares prior to the lapsing of vesting restrictions.

(4)

Includes $105,677 of imputed interest income on a loan from the Company and $5,165 for reimbursement of tax obligations with respect to certain financial planning services provided by the Company.

(5)

Includes restricted share right grants vesting in equal installments on March 15, 2002, 2003 and 2004 for Leonard D. Schaeffer, David C. Colby, Thomas C. Geiser, Joan E. Herman and D. Mark Weinberg in the amount of $1,437,500, $184,152, $206,737, $310,980 and $134,195, respectively. As of December 31, 2001, the shares underlying these grants (none of which were vested) had a fair market value of approximately $1,776,821, $227,624, $255,551, $384,320 and $166,745, respectively, not accounting for vesting restrictions. The unvested shares underlying this grant are subject to forfeiture in certain instances and to accelerated vesting upon a change in control or involuntary termination. Dividends will not be paid on any shares prior to the lapsing of vesting restrictions.

(6)

Includes $105,677 of imputed interest income on a loan from the Company and $5,105 for reimbursement of tax obligations with respect to certain financial planning services provided by the Company.

(7)

Represents $93,779 of imputed interest income on a loan from the Company and $4,887 for reimbursement of tax obligations with respect to certain financial planning services provided by the Company.

(8)

Represents reimbursement of tax obligations with respect to financial and tax planning services provided by the Company.

(9)

Represents a restricted share right grant of 8,000 shares vesting in equal installments on August 18, 2000, 2001 and 2002. As of December 31, 2001, the shares underlying this grant (5,334 of which were vested) had a fair market value of approximately $467,400, not accounting for vesting restrictions. The unvested shares underlying this grant are subject to forfeiture in certain instances and to accelerated vesting upon a change in control. Dividends will not be paid on any shares prior to the lapsing of vesting restrictions.

(10)

Represents a restricted share right grant of 4,000 shares vesting in equal installments on August 18, 2000, 2001 and 2002. As of December 31, 2001, the shares underlying this grant (2,668 of which were vested) had a fair market value of approximately $233,700, not accounting for vesting restrictions. The unvested shares underlying this grant are subject to forfeiture in certain instances and to accelerated vesting upon a change in control. Dividends will not be paid on any shares prior to the lapsing of vesting restrictions.

Option/SAR Grants in Last Fiscal Year

The following table sets forth certain information with respect to stock options granted to the Named Executive Officers during 2001. No stock appreciation rights ("SARs") were granted in 2001.

	Individual Grants				
Name	Number of Shares Underlying Options Granted	Percentage of Total Options Granted to Employees	Exercise Price	Expiration Date	Grant Date Present Value(1)
Leonard D. Schaeffer	360,000	5.08%	$ 48.24	1/31/11	$ 6,017,886
	200,000	2.82	43.30	6/3/11	2,973,760
	16,442	0.23	49.43	3/3/06	279,845
	19,486	0.28	43.40	3/3/06	290,580
	14,498	0.20	53.24	3/3/06	257,784
	26,336	0.37	58.95	3/3/06	511,025
David C. Colby	92,400	1.31%	$ 48.24	1/31/11	$ 1,544,590
	48,000	0.68	43.30	6/3/11	713,702
Thomas C. Geiser	92,400	1.31%	$ 48.24	1/31/11	$ 1,544,590
	48,000	0.68	43.30	6/3/11	713,702
Joan E. Herman	92,400	1.31%	$ 48.24	1/31/11	$ 1,544,590
	48,000	0.68	43.30	6/3/11	713,702
	4	0.00	49.43	6/3/08	68
	2,838	0.04	49.43	2/10/09	48,303
	4,958	0.07	43.40	6/3/08	73,935
	3,074	0.05	53.24	6/3/08	54,658
	9,074	0.13	58.95	6/3/08	176,072
D. Mark Weinberg	120,000	1.70%	$ 48.24	1/31/11	$ 2,005,962
	60,000	0.85	43.30	6/3/11	892,128
	28,294	0.40	49.43	2/11/08	481,569
	16,384	0.23	49.43	2/10/09	278,858
	32,038	0.45	49.43	2/10/10	545,292
	34,232	0.48	53.24	2/9/07	608,667
	37,880	0.53	53.24	1/4/05	605,737
	7,946	0.11	53.24	2/10/09	141,285

(1)

Grant date present values were calculated using the Black−Scholes option valuation model with the following assumptions:

• Expected life of options	Four years
• Volatility	35%
• Dividend yield	0%
Risk−free interest rate:	
For grants made on February 1, 2001	4.83%
For grants made on March 1, 2001	4.69%
For grants made on June 1, 2001	4.64%
For grants made on June 4, 2001	4.63%
For grants made on September 1, 2001	4.02%
For grants made on December 1, 2001	3.71%

The actual value, if any, which a Named Executive Officer may realize will be based upon the difference between the market price of the Company's Common Stock on the date of exercise and the

exercise price. There is no assurance that the actual realized value, if any, will be at or near the value estimated by the Black−Scholes model. The Black−Scholes model is only one method of valuing options, and the Company's use of the model should not be construed as an endorsement of its accuracy.

The options shown for each individual may include annual grants of incentive stock options and nonqualified stock options as well as so−called "reload" grants of stock options resulting from a stock−for−stock option exercise. Reload options are granted when a stock option is exercised with the payment of the option price in the form of previously owned shares of the Company's Common Stock. The first grant shown for each individual in the table is the annual grant. Each annual grant made in 2001 vests in three equal annual installments beginning on the first anniversary of the grant date. The second grant shown for each individual in the table was a special grant. Each special grant vests in three equal annual installments beginning on August 1, 2002. Each grant contains provisions for earlier vesting in full upon a change in control. Any additional grants shown represent reload stock options. These reload options are immediately vested and retain the expiration date of the original annual stock option grant.

Aggregated Option/SAR Exercises in Last Fiscal Year and Year−End Option/SAR Values

The following table sets forth certain information with respect to exercises by the Named Executive Officers of stock options during 2001 and the value of all unexercised employee stock options as of December 31, 2001 held by the Named Executive Officers. No SARs were exercised or outstanding in 2001.

Name	Shares Acquired On Exercise	Value Realized	Number of Shares Underlying Unexercised Options at Fiscal Year−end		Value of Unexercised In−The−Money Options at Fiscal Year−end(1)	
			Exercisable	Unexercisable	Exercisable	Unexercisable
Leonard D. Schaeffer	127,634	$ 4,142,707	1,827,190	871,334	$ 46,581,170	$ 14,131,417
David C. Colby	0	0	407,346	230,400	11,927,038	3,814,236
Thomas C. Geiser	0	0	180,002	226,400	5,473,489	3,721,912
Joan E. Herman	27,518	597,814	118,460	220,400	2,473,916	3,583,426
D. Mark Weinberg	319,360	6,516,111	292,130	300,000	3,326,133	4,992,540

(1) In accordance with SEC rules, value at fiscal year−end is calculated as the difference between (i) the aggregate trading price as of December 31, 2001 of all shares subject to the options, and (ii) the aggregate option exercise price. The actual amount realized from unexercised options is dependent upon the price of the Company's Common Stock at the time shares obtained upon exercise of such options are sold and, as to unexercisable options, whether restrictions on exercise of such options lapse.

Pension Plans

Pension Plan

The Company sponsors the WellPoint Health Networks Inc. Pension Accumulation Plan (the "Pension Plan"), a cash balance plan that is designed to be a qualified defined benefit pension plan under the Internal Revenue Code of 1986. The benefit payable under the Pension Plan is generally equal to the amount of annual annuity that could be purchased at age 65 (based on certain actuarial assumptions) with the balance of an account that is credited with the following amounts for each calendar year after 1986: (i) 3% of the participant's compensation for that year, *plus* (ii) 1% of the participant's compensation for that year, if the participant has at least 10 years of service, *plus* (iii) 1% of the participant's compensation for that year if the participant has at least 20 years of service, *plus* (iv) interest on the balance of such account at a rate equal to the 5−year Treasury Bill average yield for the immediately preceding December (but not less than $2^{1}/_{2}$%). The Pension Plan became effective on January 1, 1987 as a successor plan to the Non−Contributory Retirement Program for Certain

Employees of Blue Cross of California (the "Prior Plan"). Certain participants in the Pension Plan are also eligible to receive retirement benefits under the Prior Plan.

The Company also sponsors the Supplemental Pension Plan (the "Supplemental Plan") of WellPoint Health Networks Inc., which provides additional benefits payable out of general corporate assets to certain employees equal to the benefits these employees cannot receive under the Pension Plan because of Internal Revenue Code limits on benefits and restrictions on participation by highly compensated employees.

The estimated annual benefit payable upon retirement at age 65 under the Pension Plan and the Supplemental Plan for the Named Executive Officers as of December 31, 2001 based on service and compensation to such date and as projected at age 65 was: Leonard D. Schaeffer, $32,896 and $46,694; David C. Colby, $22,606 and $78,942; Thomas C. Geiser, $24,380 and $85,246; Joan E. Herman, $19,175 and $58,243 and D. Mark Weinberg, $44,251 and $202,615. Mr. Schaeffer is also entitled to an additional annual annuity of $5,135 from the Prior Plan.

Special Executive Retirement Plan for Leonard D. Schaeffer

The Company maintains a Special Executive Retirement Plan (the "LDS SERP") with respect to Mr. Schaeffer. The LDS SERP, as amended May 24, 2000, provides that, within 30 days of his retirement, Mr. Schaeffer will begin receiving an annual benefit equal to 80% of his then−current "Target Annual Compensation," reduced by the benefits provided by the Pension Plan, the Prior Plan and Supplemental Plan described above. The percentage described in the immediately preceding sentence is reduced to $66^{2}/_{3}$% in the event that Mr. Schaeffer engages in or has any interest in any business competitive with the Company's business at the time of termination of his employment. Target Annual Compensation is defined as base salary plus target annual incentive compensation. For purposes of the LDS SERP, base salary for any calendar month beginning after December 31, 1997 will be computed in the following manner: (i) on each January 1 through January 1, 2003, Mr. Schaeffer's base salary, starting with his base salary as of December 31, 1997, will be increased by five percent (5%), (ii) on any date after December 31, 1997 and before January 2, 2003 that Mr. Schaeffer's actual base salary is increased so that the cumulative increase in his actual base salary since the most recent December 31 is more than five percent (5%), his base salary will be increased by the actual percentage increase in his base salary, but only to the extent that such increase, when added to earlier actual increases since the most recent December 31, exceeds five percent (5%), and (iii) on any date after January 1, 2003, his base salary will be increased in the same percentage amount that his actual base salary is increased. The benefit will be reduced by $6^{1}/_{4}$% per year for retirement before age 60. This retirement benefit is to be paid in monthly installments for the greater of Mr. Schaeffer's lifetime or a 10−year period, with payments, if any, made to Mr. Schaeffer's designated beneficiary after Mr. Schaeffer's death. On Mr. Schaeffer's death (or, if later, after retirement payments have been made for 10 years), the LDS SERP provides for a survivor benefit to be paid to his spouse for her lifetime equal to 50% of the benefit that he would receive. The Company's obligations under the LDS SERP are secured by a trust to which the Company makes periodic, irrevocable contributions. Based upon fiscal 2001 base salary and target annual incentive levels, the estimated annual benefit payable to Mr. Schaeffer under the LDS SERP upon retirement at age 65 is $2,212,976.

Supplemental Executive Retirement Plan

The Company maintains a Supplemental Executive Retirement Plan (the "SERP") with respect to Messrs. Colby, Geiser and Weinberg and Ms. Herman. The SERP provides that each participant will receive a retirement benefit if the participant terminates employment with the Company on or after reaching age 62 and completing five years of service with the Company. The retirement benefit is equal to either 50% or 60% (as determined by the Compensation Committee when selecting an individual for participation in the SERP) of the participant's final five−year average salary and target incentive

compensation. Each participant's benefit is reduced by 3.33% per year (4% per year for participants with a 60% benefit) for each year of service less than 15 that has been completed by the participant. Participants with five years of service but who are at least 55 years old may also elect to receive a reduced benefit. Amounts payable under the SERP are reduced by amounts provided by the Pension Plan, Prior Plan, Supplemental Plan, any other defined benefit pension plan maintained by the Company and, in the discretion of the Compensation Committee, any defined benefit pension plans of a participant's predecessor employers. Payments under the SERP will be made monthly, at each participant's election, in the form of (i) a single life annuity payable during the participant's lifetime, or (ii) a joint and survivor annuity payable during the participant's lifetime, with benefits continued at a rate equal to 50% or 100% during a surviving spouse's lifetime. If a participant with at least five years of service dies before beginning to receive retirement benefits under the SERP, the participant's surviving spouse will be entitled to receive a benefit equal to the benefit that such person would have received had his or her deceased spouse elected a 50% joint and survivor annuity. Any benefits being paid to a participant under the SERP will cease if the participant engages in or has an interest in any business competitive with the Company's business at the time of the participant's termination of employment. Based upon year 2001 base salary and target annual incentive levels, as of December 31, 2001, the estimated annual benefit payable under the SERP to each participant upon retirement at age 62 is: Mr. Colby, $346,453; Mr. Geiser, $383,034; Ms. Herman, $302,532; and Mr. Weinberg, $395,733.

Employment Contracts, Termination of Employment and Change in Control Arrangements

Employment Agreement with Leonard D. Schaeffer

In January 1997, Leonard D. Schaeffer entered into an employment agreement with the Company which covers a five−year period that originally expired in January 2002, but which is extended automatically on January 22 of each year for an additional year unless the Board of Directors elects to cease such automatic extension. This employment agreement was amended as of September 1, 1997 and as of February 10, 1999. Under Mr. Schaeffer's employment agreement, Mr. Schaeffer is entitled to receive an annual base salary of not less than $850,000, which can be adjusted upward as determined by the Board of Directors; provided, however, that the base salary in each successive year may not be less than the base salary in the preceding year. Mr. Schaeffer's annual base salary as of March 15, 2002 was $1,260,000.

The employment agreement with Mr. Schaeffer provides that the Company will provide long−term disability benefits equal to Mr. Schaeffer's then−current annual base salary until he reaches age 65 if he continues to be considered disabled during such period. In connection with the February 1999 amendment to Mr. Schaeffer's employment agreement, the Company also agreed to provide Mr. Schaeffer with certain additional benefits in the event that his employment is terminated for any reason other than cause after he has qualified for early or normal retirement from the Company. In such event, the Company has agreed to (i) transfer ownership to Mr. Schaeffer of any automobile then provided to him by the Company, (ii) provide financial counseling benefits for five calendar years following his termination, and (iii) provide office space and clerical support for a period of 60 months following his termination.

In addition, Mr. Schaeffer's employment agreement provides that, in the event that he is constructively terminated or the Company terminates his employment other than for cause, he will receive, in addition to payments under the SERP described above, a lump−sum payment equal to 2.99 times his then−annual base salary plus an amount equal to 2.99 times his then−current annual target incentive compensation. Mr. Schaeffer's annual target incentive compensation for 2002 is $1,701,000. To the extent that any such payment (alone or with other compensation payable to Mr. Schaeffer) would subject Mr. Schaeffer to an excise tax under Section 4999 of the Internal Revenue Code, the Company will make an additional cash payment to Mr. Schaeffer such that Mr. Schaeffer's net after−tax compensation is not reduced by such excise tax. In the event of such termination, he will continue to

receive certain fringe benefits for 48 months. In addition, Mr. Schaeffer will be entitled to a pro rata portion of any bonus pursuant to the Company's bonus programs, and any options granted to Mr. Schaeffer on or after January 22, 1997 will immediately become exercisable. If the Company agrees to a change of control, the employment agreement with Mr. Schaeffer provides that rights and privileges under the agreement may not be affected. Mr. Schaeffer may elect to terminate his employment with the Company upon 90 days' written notice to the Company. In such event, Mr. Schaeffer will continue to receive his salary during the 90−day notification period. In addition, Mr. Schaeffer will continue to receive health, dental and life insurance and disability benefits for a six−month period.

The current employment agreement with Mr. Schaeffer replaces previous employment agreements with BCC and the Company. At the time of the execution of Mr. Schaeffer's current employment agreement in January 1997, the Company also agreed that Mr. Schaeffer would receive 17,642 shares of the Company's Common Stock upon termination of Mr. Schaeffer's employment with the Company for any reason. At the time of the termination of certain cash−based performance units in May 1996, the Company granted Mr. Schaeffer deferred share rights with respect to an additional 110,732 shares of the Company's Common Stock. All of the 128,374 shares underlying these deferred share rights were issued to Mr. Schaeffer in February 1999 in connection with the execution of the most recent amendment to his employment agreement.

In connection with the issuance of such shares in February 1999, the Company made an interest−free loan to Mr. Schaeffer of $2,243,670, representing the Federal and state tax obligations associated with the value of such shares. Fifty percent of the principal balance of the loan will be forgiven provided that Mr. Schaeffer remains with the Company through February 10, 2003. An additional 25% of the principal balance will be forgiven if the fair market value (as defined) of the Company's Common Stock is equal to or greater than $51.75 per share on February 10, 2003; the entire remaining 50% of the loan will be forgiven if the fair market value of the Common Stock is equal to or greater than $61.82 per share on such date. The entire outstanding principal balance of the note will also be forgiven upon a change in control or if Mr. Schaeffer's employment with the Company is terminated prior to February 10, 2003 by reason of his death, disability, involuntary termination without cause or constructive termination.

In connection with the execution of the February 1999 amendment to Mr. Schaeffer's employment agreement, the Company issued to Mr. Schaeffer a stock option with respect to 256,748 shares. This option has an exercise price of $35.35 per share (the fair market value on the date of grant) with respect to 85,584 shares, $51.75 per share with respect to 85,582 shares and $61.82 per share with respect to 85,582 shares.

Officer Severance Plan

The Company maintains an Officer Severance Plan for the benefit of officers not otherwise covered by employment agreements or special officer severance agreements. Each of Messrs. Weinberg, Geiser and Colby and Ms. Herman participates in this plan or has a separate agreement with the Company regarding severance benefits. With respect to persons holding the title of Executive Vice President, the plan generally provides for a lump−sum payment, if an officer is involuntarily terminated (other than for cause), equal to 12 months salary and 100% of the previous fiscal year's target bonus, plus continuation for 12 months of health, dental, vision and life insurance paid by the Company. In the event of involuntary termination (other than for cause), Mr. Weinberg is entitled to receive 24 months salary and 200% of the previous fiscal year's target bonus plus benefits continuation for 24 months, and Mr. Geiser is entitled to receive 18 months salary and 150% of the previous fiscal year's target bonus plus benefits continuation for 18 months.

Relocation Loans

In connection with the purchase of a residence by Ms. Herman in 1998, the Company made an interest−free loan of $100,000 to Ms. Herman, forgivable in four annual installments of $25,000, so long as she remains employed by the Company. If Ms. Herman terminates employment voluntarily or if the Company terminates her employment for cause before the entire balance of the loan is forgiven, the remaining unpaid, unforgiven balance would become due. As of March 15, 2002, the outstanding principal balance of this loan was $25,000.

In connection with the purchase of a residence by Woodrow A. Myers, Jr., M.D., Executive Vice President and Chief Medical Officer, in 2000, the Company made an interest−free loan of $200,000 to Dr. Myers, forgivable in five annual installments of $40,000, so long as he remains employed by the Company. If Dr. Myers terminates employment voluntarily or if the Company terminates his employment for cause before the entire balance of the loan is forgiven, the remaining unpaid, unforgiven balance would become due. As of March 15, 2002, the outstanding principal balance of this loan was $160,000.

Change in Control Plan

The Company has adopted the WellPoint Health Networks Inc. Officer Change in Control Plan (the "Change in Control Plan") to provide officers of WellPoint and affiliates controlled by WellPoint with benefits in the event of a "Change in Control." The Change in Control Plan defines a Change in Control as:

- the acquisition, directly or indirectly by any person or related group of persons (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), but other than the Company or a person that directly or indirectly controls, is controlled by, or is under, control with the Company, of beneficial ownership (as defined in Rule 13d−3 of the Exchange Act) of securities of the Company that results in such person or related group of persons beneficially owning securities representing 40% or more of the combined voting power of the Company's then−outstanding securities;

- a merger, recapitalization, consolidation or similar transaction to which the Company is a party or the sale, transfer or other disposition of all or substantially all of the Company's assets if, in either case, the beneficial owners of the Company's securities immediately before the transaction do not have, immediately after the transaction, beneficial ownership of securities representing at least 60% of the combined voting power of the then−outstanding securities of the surviving entity or the entity acquiring the Company's assets, as the case may be, or a parent thereof;

- a merger, recapitalization, consolidation or similar transaction to which the Company is a party or the sale, transfer or other disposition of all or substantially all of the Company's assets if, in either case, the directors of the Company immediately prior to consummation of the transaction do not, upon consummation of the transaction, constitute at least a majority of the board of directors of the surviving entity or the entity acquiring the Company's assets, as the case may be, or a parent thereof (for this purpose, any change in director composition that is anticipated or pursuant to an understanding or agreement in connection with a transaction will be deemed to have occurred at the time of the transaction); or

- a change in the composition of the Board of Directors of the Company (the "Board") over a period of thirty−six (36) consecutive months or less such that a majority of the Board members ceases by reason of one or more contested elections for Board membership, to be comprised of individuals who either (a) have been Board members since the beginning of such period or (b) have been elected or nominated for election as Board members during such period by at

least a majority of the Board members described in clause (a) who were still in office at the time the Board approved such election or nomination.

If a Change in Control occurs, an officer will receive any bonus or other incentive compensation for any prior period that has been earned but is still unpaid, a guaranteed annual bonus and a completion bonus. The guaranteed annual bonus will be equal to the greater of (i) an officer's target bonus for the fiscal year in which the Change in Control occurs, (ii) the average of the annual bonus paid to such officer for the preceding two fiscal years or (iii) the bonus that is determined in the ordinary course under the Company bonus plan for officers for the fiscal year in which the Change in Control occurs. This guaranteed bonus is prorated if the Company or any Affiliate (as defined in the Change in Control Plan) involuntarily terminates (other than for cause) or constructively discharges the officer after the announcement of, or the execution of a definitive agreement to effect, a Change in Control and before the end of the fiscal year in which the Change in Control occurs. An officer is deemed constructively discharged for purposes of the Change in Control Plan if (i) the Company significantly reduces the officer's duties, responsibilities, status, reporting responsibilities, titles or offices, (ii) reduces the officer's aggregate salary and target bonus, (iii) changes the officer's principal place of employment such that his or her one−way commute is increased by more than 35 miles, (iv) requires the officer to spend an average of two or more days per week at a place of employment other than his or her principal of employment if the average ground commute to such additional place of employment from the officer's primary residence is longer than two hours or (v) the successor company fails to assume the Company's obligations under the Plan.

The change in control completion bonus will be equal to 100% of the officer's Base Salary and Plan Bonus. "Base Salary" is defined under the Change in Control Plan to be the highest annualized base salary payable at any time to an officer during the period beginning five years before the announcement of the relevant Change in Control and ending immediately preceding the officer's termination date. "Plan Bonus" is defined under the Change in Control Plan to mean an amount equal to (i) an officer's Base Salary multiplied by (ii) the highest percentage target bonus for the officer during the period beginning five years before the announcement of the relevant Change in Control and ending immediately before the officer's termination date, multiplied by (iii) the greater of (A) 100% or (B) the average percentage, for the two consecutive fiscal years within the period beginning five years before the announcement of the relevant Change of Control and ending immediately before the officer's termination date for which such average percentage is the highest, that the officer's actual annual bonus for a fiscal year represented as a percentage of the officer's annual base salary.

Officers will be eligible to receive additional Change in Control Plan severance benefits if the Company or any Affiliate (as defined in the Change in Control Plan) involuntarily terminates (other than for cause) or constructively discharges the officer within 36 months after a Change in Control or if the officer experiences an involuntary termination after execution of a definitive agreement to effect, but before consummation of, a Change in Control. The basic severance benefit is 3.00 times Base Salary plus 3.00 times Plan Bonus in effect for an Executive Vice President. Officers also receive various additional benefits including, in the case of Executive Vice Presidents, contributions to the Company's Pension Accumulation Plan and 401(k) Plan and deferred compensation plan as if such officer had remained employed by the Company for an additional three years and made the maximum salary deferrals and supplementary salary deferrals eligible for matching and supplemental matching contributions under such plans.

Officers at the level of Executive Vice President participating in the SERP described above will also become vested in the benefits under such plan and will be credited with an additional three years of service for purposes of benefits under such plan. Finally, officers receive financial planning services, outplacement services and, in the case of Executive Vice Presidents, continuation of health and welfare benefits for a period of up to three years. Each of Messrs. Weinberg, Colby and Geiser and Ms. Herman currently participates in the Change in Control Plan.

The Change in Control Plan also provides that, if any person holding a title of Senior Vice President or above receives compensation from the Company that subjects such person to an excise tax under Section 4999 of the Internal Revenue Code, the Company will make an additional payment to such person that, net of all such taxes, fully reimburses the employee for the amount of such excise tax.

An officer who is to receive other severance benefits from an Affiliate will not receive benefits under the Change in Control Plan unless the other severance benefit plan so provides or the officer waives benefits under the other severance benefit plan. The Compensation Committee may amend or terminate the Change in Control Plan at any time; provided, that termination of the Change in Control Plan or any amendment that adversely affects the rights of participants will be effective no sooner than one year after the approval of such amendment or termination by the Committee.

In addition to the benefits under the Change in Control Plan, options and restricted share right awards granted under the Company's stock incentive plans, including grants to the Named Executive Officers under the Company's 1999 Stock Incentive Plan, contain provisions for immediate acceleration of vesting upon a change in control.

Item 12. Security Ownership Of Certain Beneficial Owners And Management

The following table sets forth the beneficial ownership of Common Stock of the Company as of April 15, 2002 (or such other date as indicated) by (a) each person known by the Company to own beneficially more than five percent of the outstanding Common Stock; (b) the Chief Executive Officer of the Company; (c) each of the four other Named Executive Officers; (d) each director of the Company; and (e) all directors and executive officers as a group:

Name and Address	Number of Shares Beneficially Owned(1)	Percent of Class(2)	Number of Shares Supplementally Owned	Total Shares Beneficially and Supplementally Owned	Percent of Class
AXA Financial, Inc.(3) 1290 Avenue of the Americas New York, NY 10104	15,292,322	10.6%	—	15,292,322	10.6%
Leonard D. Schaeffer	2,393,376(4)	1.6	68,637(5)	2,462,013	1.7
David C. Colby	583,556(6)	*	43,967(7)	627,523	*
Thomas A. Geiser	308,200(8)	*	13,513(9)	321,713	*
Joan E. Herman	210,338(10)	*	15,660(11)	225,998	*
D. Mark Weinberg	487,730(12)	*	65,090(13)	552,820	*
W. Toliver Besson	31,300(14)	*	3,200(15)	34,500	*
Roger E. Birk	59,704(16)	*	—	59,704	*
Sheila P. Burke	25,700(17)	*	—	25,700	*
William H. T. Bush	18,220(18)	*	—	18,220	*
Stephen L. Davenport	31,420(19)	*	1,600(20)	33,020	*
Julie A. Hill	30,144(21)	*	1,600(22)	31,744	*
Warren Y. Jobe	13,100(23)	*	—	13,100	*
Elizabeth A. Sanders	35,100(24)	*	1,600(25)	36,700	*
All executive officers and directors as a group (19 persons)	4,996,906(26)	3.4	263,451(27)	5,260,357	3.5

*
Less than one percent.

(1)
Except as indicated in footnotes to this table, the stockholders named in this table are known to the Company to have sole voting and investment power with respect to all shares of Common Stock shown as beneficially owned by them, subject to community property laws where applicable. Shares shown as beneficially owned by any person have been determined in accordance with the requirements of Rule 13d−3 promulgated under the Exchange Act.

(2)

Calculation based on approximately 144,270,886 shares of Common Stock outstanding as of April 15, 2002.

(3)

Based solely on a Schedule 13G report filed with the SEC prepared as of December 31, 2001, and an amendment prepared as of February 28, 2002. The shares are also reported as beneficially owned by the following affiliates of AXA Financial, Inc.: AXA Conseil Vie Assurance Mutuelle, AXA Assurances I.A.R.D. Mutuelle and AXA Assurances Vie Mutuelle, each with an address at 370, rue Saint Honore, 75001 Paris, France; AXA Courtage Assurance Mutuelle, with an address at 26, rue Louis le Grand, 75002 Paris, France; and AXA, with an address at 25, avenue Matignon, 75008 Paris, France (collectively, the "AXA Group"). Of the reported shares, the AXA Group reports that it has sole voting power with respect to 5,644,864 shares, that it shares voting power with respect to 6,092,296 shares, that it has sole dispositive power with respect to 15,216,322 shares and shared dispositive power with respect to 76,000 shares. The AXA Group reports that its shares are deemed to be beneficially owned by the following subsidiaries of AXA: AXA Konzern AG (Germany) (64,600 shares) and AXA Rosenberg Investment Management LLC (76,000 shares) and by the following subsidiaries of AXA Financial, Inc.: Alliance Capital Management L.P. (14,920,522 shares) and The Equitable Life Assurance Society of the United States (231,200 shares).

(4)

Includes 230 shares held in a 401(k) account for the benefit of Mr. Schaeffer. Includes 2,119,524 shares subject to presently exercisable options, options that become exercisable within 60 days and restricted share right grants that vest within 60 days.

(5)

Includes a restricted share right grant with respect to 20,274 shares that vests in equal installments on March 15, 2003 and March 15, 2004, all of which are in a deferred compensation plan. Includes a restricted share right grant with respect to 35,425 shares that vests in equal installments on March 15, 2003, March 15, 2004 and March 15, 2005, all of which are in a deferred compensation plan. Includes deferred rights to 12,938 shares held in a deferred compensation account for the benefit of Mr. Schaeffer.

(6)

Includes 804 shares held in a 401(k) account for the benefit of Mr. Colby and 498,146 shares subject to presently exercisable options, options that become exercisable within 60 days and restricted share right grants that vest within 60 days.

(7)

Includes a restricted share right grant with respect to 25,000 shares that vests on September 1, 2002. Includes a restricted share right grant with respect to 2,666 shares that vests on August 18, 2002. Includes a restricted share right grant with respect to 2,597 shares that vests in equal installments on March 15, 2003 and 2004, all of which are in a deferred compensation account. Includes a restricted share right grant with respect to 8,582 shares that vests in equal installments on March 15, 2003, March 15, 2004 and March 15, 2005, all of which are in a deferred compensation account. Includes deferred rights to 5,122 shares held in a deferred compensation account for the benefit of Mr. Colby.

(8)

Includes 966 shares held in a 401(k) account for the benefit of Mr. Geiser and 266,802 shares subject to presently exercisable options, options that become exercisable within 60 days and restricted share right grants that vest within 60 days.

(9)

Includes a restricted share right grant with respect to 1,333 shares that vests on August 18, 2002. Includes a restricted share right grant with respect to 2,915 shares that vests in equal installments on March 15, 2003 and March 15, 2004, of which 437 shares are in a deferred compensation account. Includes a restricted share right grant with respect to 7,952 shares that vests in equal installments on March 15, 2003, March 15, 2004 and March 15, 2005, of which 1,192 shares are in a deferred compensation account. Includes deferred rights to 1,313 shares held in a deferred compensation account for the benefit of Mr. Geiser.

(10)

Includes 146 shares held in a 401(k) account for the benefit of Ms. Herman and 195,824 shares subject to presently exercisable options, options that become exercisable within 60 days and restricted share right grants that vest within 60 days.

(11)

Includes a restricted share right grant with respect to 1,250 shares that vests on June 1, 2002. Includes a restricted share right grant with respect to 4,385 shares that vests in equal installments on March 15, 2003 and March 15, 2004, all of which are in a deferred compensation account. Includes a restricted share right grant with respect to 7,705 shares that vests in equal installments on March 15, 2003, March 15, 2004 and March 15, 2005, of which 3,852 shares are in a deferred compensation account. Includes deferred rights to 2,320 shares held in a deferred compensation account for the benefit of Ms. Herman.

(12)

Includes 11,188 shares held in a 401(k) account for the benefit of Mr. Weinberg and 387,746 shares subject to presently exercisable options or options that become exercisable within 60 days.

(13)

Includes a restricted share right grant with respect to 1,902 shares that vests in equal installments on March 15, 2003 and March 15, 2004, all of which are in a deferred compensation account. Includes deferred rights to 63,188 shares held in a deferred compensation account for the benefit of Mr. Weinberg.

(14)

Includes 1,800 shares owned by the W. Toliver Besson Retirement Plan, of which Mr. Besson is trustee, and 200 shares owned by Mr. Besson's wife. Includes 19,200 shares subject to presently exercisable options.

(15)

Includes deferred rights to 3,200 shares under the Company's Board of Directors Deferred Compensation Plan. See "Item 11. Executive Compensation—Compensation of Directors."

(16)

Includes 22,034 shares subject to presently exercisable options.

(17)

Includes 16,000 shares subject to presently exercisable options.

(18)

Includes 13,856 shares subject to presently exercisable options.

(19)

Includes 2,000 shares held in an IRA for the benefit of Mr. Davenport and 13,902 shares owned by the Davenport Family Trust, of which Mr. Davenport is trustee. Includes 15,518 shares subject to presently exercisable options.

(20)

Includes deferred rights to 1,600 shares under the Company's Board of Directors Deferred Compensation Plan. See "Item 11. Executive Compensation—Compensation of Directors."

(21)

Includes 10,556 shares subject to presently exercisable options.

(22)

Includes deferred rights to 1,600 shares under the Company's Board of Directors Deferred Compensation Plan. See "Item 11. Executive Compensation—Compensation of Directors."

(23)

Includes 8,000 shares subject to presently exercisable options.

(24)

Includes 28,360 shares subject to presently exercisable options.

(25)

Includes deferred rights to 1,600 shares under the Company's Board of Directors Deferred Compensation Plan. See "Item 11. Executive Compensation—Compensation of Directors."

(26)

Includes 4,216,524 shares subject to presently exercisable options, options that become exercisable within 60 days or restricted share right grants that vest within 60 days.

(27)

Includes deferred rights to 13,138 shares. Includes restricted share right grants with respect to 4,122 shares that vest in equal installments on March 15, 2003 and March 15, 2004, all of which are in deferred compensation accounts. Includes restricted share right grants with respect to 10,828 shares that vest in equal installments on March 15, 2003, March 15, 2004 and March 15, 2005, all of which are in deferred compensation accounts. Includes restricted share right grants with respect to 20,496 shares.

Item 13. Certain Relationships And Related Transactions

Mr. Besson is a partner in the law firm of Paul, Hastings, Janofsky & Walker, which has been retained by the Company to advise it on a variety of matters. During 2001, approximately $532,000 was paid by WellPoint to such firm for legal fees and disbursements.

Fredrick Davenport, CLU, ChFC, the son of Stephen L. Davenport, serves as an insurance broker for Company−provided insurance and provides financial counseling services to officers of the Company. In connection with such services, Fredrick Davenport serves as the originating agent for certain life insurance policies provided to officers by the Company. For life insurance policies in force during 2001, a company in which Fredrick Davenport had an ownership interest received commissions, expense reimbursements and other amounts of approximately $42,000. Stephen L. Davenport has no equity or other ownership interest in this entity.

PART IV

Item 14. Exhibits, Financial Statements Schedules And Reports On Form 8−K.

a. 1) Financial Statements

The consolidated financial statements are contained herein as listed on the "Index" on page F−1 hereof.

2) Financial Statement Schedules

All of the financial statement schedules for which provision is made in the applicable accounting regulations of the Commission are not required under the applicable instructions or are not applicable and therefore have been omitted.

b. Reports on Form 8−K

On December 7, 2001, the Company filed a Current Report on Form 8−K which reported that the Company had signed the Agreement and Plan of Merger dated as of November 20, 2001 among the Company, CareFirst, Inc. ("CareFirst") and Congress Acquisition Corp., a wholly owned subsidiary of the Company, pursuant to which CareFirst would merge with Congress Acquisition Corp.

c. Exhibits

Exhibit Number	Exhibit
2.01	Amended and Restated Recapitalization Agreement dated as of March 31, 1995, by and among the Registrant, Blue Cross of California, Western Health Partnerships and Western Foundation for Health Improvement, incorporated by reference to Exhibit 2.1 of Registrant's Registration Statement on Form S−4 dated April 8, 1996
2.02	Amended and Restated Agreement and Plan of Merger dated as of November 29, 2000, by and among Cerulean Companies, Inc., the Registrant and Water Polo Acquisition Corp, incorporated by reference to Exhibit 2.01 of the Registrant's Current Report on Form 8−K dated March 15, 2001.
2.03	Agreement and Plan of Merger dated as of October 17, 2001 by and among the Registrant, RightCHOICE Managed Care, Inc. ("RightCHOICE") and RWP Acquisition Corp., incorporated by reference to Exhibit 2.01 to the Registrant's Registration Statement on Form S−4 (registration no. 333−73382)

2.04	Agreement and Plan of Merger dated as of November 20, 2001 by and among WellPoint Health Networks Inc., CareFirst, Inc. and Congress Acquisition Corp., incorporated by reference to Exhibit 99.1 to the Registrant's Current Report on Form 8−K dated November 20, 2001
3.01	Restated Certificate of Incorporation of the Registrant, incorporated by reference to Exhibit 3.1 of the Registrant's Current Report on Form 8−K filed on August 5, 1997.
3.02	Bylaws of the Registrant, incorporated by reference to Exhibit 4.2 of the Registrant's Registration Statement on Form S−8 (Registration No. 333−90791)
4.01	Specimen of Common Stock certificate of WellPoint Health Networks Inc., incorporated by reference to Exhibit 4.4 of the Registrant's Registration Statement on Form 8−B, Registration No. 001−13083
4.02	Restated Certificate of Incorporation of the Registrant (included in Exhibit 3.01)
4.03	Bylaws of the Registrant (included in Exhibit 3.02)
4.04	Indenture dated as of July 2, 1999 by and between Registrant and the Bank of New York, as trustee (including the Form of Debenture attached as Exhibit A thereto), incorporated by reference to Exhibit 4.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 1999.
4.05	Amended and Restated Senior Indenture dated as of June 8, 2001 by and between the Registrant and the Bank of New York, as trustee, incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8−K dated June 7, 2001.
4.06	Form of Note evidencing the Registrant's $6^{3}/_{8}$% Notes due 2006, incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8−K dated June 12, 2001.
4.07	Form of Note evidencing the Registrant's $6^{3}/_{8}$% Notes due 2012, incorporated by reference to Exhibit 4.1 of the Registrant's Current Report on Form 8−K dated January 12, 2002.
9.01	Voting Trust Agreement dated as of January 31, 2002 by and among the Registrant, the Missouri Foundation for Health and Wilmington Trust Company, incorporated by reference to Exhibit 9.01 to the Registrant's Current Report on Form 8−K dated January 31, 2002
10.01	Undertakings dated January 7, 1993, by the Registrant, Blue Cross of California and certain subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 10.24 of the Registrant's Form S−1 Registration Statement No. 33−54898
10.02*	Supplemental Pension Plan of Blue Cross of California, incorporated by reference to Exhibit 10.15 of the Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1992
10.03*	Form of Indemnification Agreement between the Registrant and its Directors and Officers, incorporated by reference to Exhibit 10.17 of the Registrant's Form S−1 Registration Statement No. 33−54898
10.04*	Officer Severance Agreement, dated as of July 1, 1993, between the Registrant and Thomas C. Geiser, incorporated by reference to Exhibit 10.24 of the Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1993
10.05	Orders Approving Notice of Material Modification and Undertakings dated September 7, 1995, by BCC, the Registrant and the Registrant's subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 10.47 of Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 1995

10.06	Lease Agreement, dated as of January 1, 1996, by and between TA/Warner Center Associates II, L.P., and the Registrant, incorporated by reference to Exhibit 10.46 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995
10.07*	Letter, dated November 13, 1995, from the Registrant to D. Mark Weinberg regarding severance benefits, together with underlying Officer Severance Agreement, incorporated by reference to Exhibit 10.48 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995
10.08*	Letter, dated November 13, 1995, from the Registrant to Thomas C. Geiser regarding severance benefits, incorporated by reference to Exhibit 10.49 of Registrant's Annual Report on Form 10−K for the fiscal year ended December 31, 1995
10.09	Amended and Restated Undertakings dated March 5, 1996, by BCC, the Registrant and the Registrant's subsidiaries to the California Department of Corporations, incorporated by reference to Exhibit 99.1 of the Registrant's Current Report on Form 8−K dated March 5, 1996
10.10	Indemnification Agreement dated as of May 17, 1996, by and among the Registrant, WellPoint Health Networks Inc., a Delaware corporation, and Western Health Partnerships, incorporated by reference to Exhibit 99.9 of the Registrant's Current Report on Form 8−K dated May 20, 1996
10.11	Amended and Restated Share Escrow Agent Agreement dated as of August 4, 1997 by and between the Registrant and U.S. Trust Company of California, N.A., incorporated by reference to Exhibit 99.4 of the Registrant's Current Report on Form 8−K filed on August 5, 1997
10.12†	Blue Cross License Agreement effective as of January 31, 2002 by and among the Registrant and the Blue Cross Blue Shield Association (the "BCBSA")
10.13	Blue Cross Controlled Affiliate License Agreement effective as of August 4, 1997 by and between the BCBSA and Blue Cross of California, incorporated by reference to Exhibit 99.8 of Registrant's Current Report on Form 8−K filed on August 5, 1997
10.14	Blue Cross Affiliate License Agreement effective as of August 4, 1997 by and between the BCBSA and BC Life & Health Insurance Company, incorporated by reference to Exhibit 99.9 of Registrant's Current Report on Form 8−K filed on August 5, 1997
10.15	Blue Cross Controlled Affiliate License Agreement Applicable to Life Insurance Companies effective as of August 4, 1997 by and between the BCBSA and BC Life & Health Insurance Company, incorporated by reference to Exhibit 99.10 of Registrant's Current Report on Form 8−K filed on August 5, 1997
10.16	Undertakings dated July 31, 1997 by the Registrant, WellPoint California and WellPoint California Services, Inc. to the California Department of Corporations, incorporated by reference to Exhibit 99.12 to the Registrant's Current Report on Form 8−K filed on August 5, 1997
10.17*	401(k) Retirement Savings Program of WellPoint Health Networks Inc., as amended through January 1, 2001, incorporated by reference to Exhibit 10.23 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.18*†	WellPoint Officer Benefit Enrollment Guide Brochure

10.19*	Office Lease dated as of December 2, 1997 by and among the Registrant and Westlake Business Park, Ltd., incorporated by reference to Exhibit 10.48 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 1997
10.20	Amendment No. 1 dated as of June 12, 1998 to the Amended and Restated Share Escrow Agent Agreement by and between the Registrant and U.S. Trust Company of California, N.A., incorporated by reference to Exhibit 99.3 to the Registrant's Current Report on Form 8−K filed on June 15, 1998
10.21*	Promissory Note dated as of June 23, 1998 made by Joan E. Herman in favor of the Registrant, incorporated by reference to Exhibit 10.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 1998
10.22*†	WellPoint Health Networks Inc. Officer Change−in−Control Plan (as amended and restated through December 4, 2001)
10.23*†	WellPoint Health Networks Inc. Officer Severance Plan (as amended and restated through December 4, 2001)
10.24*	WellPoint Health Networks Inc. Management Bonus Plan, incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.25*	Board of Directors Deferred Compensation Plan of WellPoint Health Networks Inc., incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10−K for the year ended December 31, 1998.
10.26*	Employment Agreement dated as of February 10, 1999 by and between the Registrant and Leonard D. Schaeffer, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999.
10.27*	Promissory Note dated as of February 10, 1999 made by Leonard D. Schaeffer in favor of the Registrant, incorporated by reference to Exhibit 10.02 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999
10.28*	Special Executive Retirement Plan dated as of February 10, 1999 by and between the Registrant and Leonard D. Schaeffer, incorporated by reference to Exhibit 10.03 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 31, 1999
10.29*	1999 Stock Incentive Plan, as amended through December 6, 2000, incorporated by reference to Exhibit 10.37 of the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.30*	1999 Executive Officer Annual Incentive Plan, incorporated by reference to Annex II to the Registrant's Proxy Statement on Schedule 14A dated March 28, 2001
10.31*	WellPoint Health Networks Inc. Comprehensive Executive Non−Qualified Retirement Plan (as amended through February 1, 2001), incorporated by reference to Exhibit 10.39 of the Registrant's Annual Report on Form 10−K for the year ended December 31, 2000
10.32*	WellPoint Health Networks Inc. Employee Stock Purchase Plan (as amended and restated effective April 1, 2000), incorporated by reference to Annex I to the Registrant's definitive Proxy Statement on Schedule 14A dated March 23, 2000
10.33*†	WellPoint Health Networks Inc. 2000 Employee Stock Option Plan (as amended through October 19, 2001)

10.34*	Amendment No. 1 to the Special Executive Retirement Plan for Leonard D. Schaeffer, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 2000
10.35*†	WellPoint Health Networks Inc. Supplemental Executive Retirement Plan (as restated effective December 4, 2001)
10.36*	Promissory Note made by Woodrow A. Myers, Jr., M.D. in favor of the Registrant, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended September 30, 2000
10.37	Credit Agreement ($750,000,000 Five−Year Revolving Credit and Competitive Advance Facility) dated as of March 30, 2001 by and among the Registrant, the lenders from time to time party thereto, Bank of America, N.A., as administrative agent, and Banc of America Securities LLC and JPMorgan, as joint arrangers and joint book managers, incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.38	Credit Agreement ($250,000,000 364−Day Revolving Credit and Competitive Advance Facility) dated as of March 30, 2001 by and among the Registrant, the lenders from time to time party thereto, Bank of America, N.A., as administrative agent, and Banc of America Securities LLC and JPMorgan, as joint arrangers and joint book managers, incorporated by reference to Exhibit 10.02 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.39	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Blue Cross and Blue Shield of Georgia, Inc. ("Georgia Blue") and the Registrant, incorporated by reference to Exhibit 10.03 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.40	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Georgia Blue and the Registrant, incorporated by reference to Exhibit 10.04 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.41	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Blue Cross Blue Shield Health Care Plan of Georgia, Inc. ("Georgia Blue HMO") and Registrant, incorporated by reference to Exhibit 10.05 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.42	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Georgia Blue HMO and the Registrant, incorporated by reference to Exhibit 10.06 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.43	Blue Cross Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, Greater Georgia Life Insurance Company ("GGL") and the Registrant, incorporated by reference to Exhibit 10.07 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001
10.44	Blue Shield Controlled Affiliate License Agreement dated as of March 15, 2001 by and among the BCBSA, and GGL and the Registrant, incorporated by reference to Exhibit 10.08 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended March 30, 2001

10.45*	Amendment No. 1 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001), incorporated by reference to Exhibit 10.01 to the Registrant's Quarterly Report on Form 10−Q for the quarter ended June 30, 2001
10.46†	California Blue Cross License Addendum dated as of January 31, 2002 by and among the Registrant and the BCBSA
10.47†	California Blue Shield License Addendum dated as of January 31, 2002 by and among the Registrant and the BCBSA
10.48†	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, RightCHOICE Managed Care, Inc. ("RightCHOICE") and the Registrant
10.49†	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, RightCHOICE and the Registrant
10.50†	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, Healthy Alliance Life Insurance Company ("HALIC") and the Registrant
10.51†	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HALIC and the Registrant
10.52†	Blue Cross Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HMO Missouri, Inc. ("HMO Missouri") and the Registrant
10.53†	Blue Shield Controlled Affiliate License Agreement dated as of January 31, 2002 by and among the BCBSA, HMO Missouri and the Registrant
10.54	Registration Rights Agreement dated as of October 17, 2001 by and between the Registrant and the Missouri Foundation for Health, incorporated by reference to Exhibit 10.01 to the Registrant's Current Report on Form 8−K dated January 31, 2002
10.55*†	Amendment No. 2 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.56*†	Amendment No. 3 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.57*†	Amendment No. 4 to the WellPoint 401(k) Retirement Savings Plan (as amended through January 1, 2001)
10.58†	Blue Shield License Agreement effective as of January 31, 2002 by and between the Registrant and the BCBSA
21†	List of Subsidiaries of the Registrant
23.1	Consent of Independent Accountants
24†	Power of Attorney (included on Signature Page).

* Management contract or compensatory plan or arrangement

† Previously filed with the Registrant's Annual Report on Form 10−K for the year ended December 31, 2001.

SIGNATURES

Pursuant to the requirement of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Amendment to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: April 26, 2002

WELLPOINT HEALTH NETWORKS INC.

By: /s/ LEONARD D. SCHAEFFER*

Leonard D. Schaeffer
Chairman of the Board of Directors and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, the Amendment has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ LEONARD D. SCHAEFFER* Leonard D. Schaeffer	Chairman of the Board of Directors and Chief Executive Officer (Principal Executive Officer)	April 26, 2002
/s/ DAVID C. COLBY* David C. Colby	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	April 26, 2002
/s/ KENNETH C. ZUREK* Kenneth C. Zurek	Senior Vice President, Controller and Taxation (Principal Accounting Officer)	April 26, 2002
/s/ W. TOLIVER BESSON* W. Toliver Besson	Director	April 26, 2002
/s/ ROGER E. BIRK* Roger E. Birk	Director	April 26, 2002
/s/ SHEILA P. BURKE* Sheila P. Burke	Director	April 26, 2002

/s/ WILLIAM H.T. BUSH*	Director	
William H.T. Bush		April 26, 2002
/s/ STEPHEN L. DAVENPORT*	Director	
Stephen L. Davenport		April 26, 2002
/s/ JULIE A. HILL*	Director	
Julie A. Hill		April 26, 2002
/s/ WARREN Y. JOBE*	Director	
Warren Y. Jobe		April 26, 2002
/s/ ELIZABETH A. SANDERS*	Director	
Elizabeth A. Sanders		April 26, 2002

*By: /s/ THOMAS C. GEISER

Thomas C. Geiser, Attorney−in−Fact

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WELLPOINT HEALTH NETWORKS INC.

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Report of Independent Accountants

To the Stockholders and Board of Directors
WellPoint Health Networks Inc.

In our opinion, the accompanying consolidated balance sheets and the related consolidated income statements and consolidated statements of changes in stockholders' equity and cash flows present fairly, in all material respects, the financial position of WellPoint Health Networks Inc. and its subsidiaries (the "Company") at December 31, 2001 and 2000, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2001, in conformity with accounting principles generally accepted in the United States of America. 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 of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 3 to the Consolidated Financial Statements, effective January 1, 1999, the Company changed its method of accounting for start−up costs.

PricewaterhouseCoopers LLP
Los Angeles, California
January 31, 2002,
except Note 3 as to which the date is March 15, 2002, and
Note 22 as to which the date is March 18, 2002

WellPoint Health Networks Inc.

Consolidated Balance Sheets

	2001	2000
	(In thousands, except share data)	
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 1,028,476	$ 566,889
Investment securities, at market value	3,832,982	3,096,350
Receivables, net	841,722	699,868
Deferred tax assets, net	79,063	77,757
Other current assets	90,398	59,545
Total Current Assets	5,872,641	4,500,409
Property and equipment, net	222,080	151,031
Intangible assets, net	430,488	165,164
Goodwill, net	661,346	418,120
Long−term investments, at market value	124,611	116,811
Deferred tax assets, net	54,486	92,982
Other non−current assets	106,481	60,189
Total Assets	$ 7,472,133	$ 5,504,706
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Medical claims payable	$ 1,934,620	$ 1,566,569
Reserves for future policy benefits	62,739	58,085
Unearned premiums	332,813	232,132
Accounts payable and accrued expenses	783,026	513,637
Experience rated and other refunds	255,570	249,725
Income taxes payable	64,654	53,898
Other current liabilities	632,383	398,867
Total Current Liabilities	4,065,805	3,072,913
Accrued postretirement benefits	94,124	71,510
Reserves for future policy benefits, non−current	222,406	267,552
Long−term debt	837,957	400,855
Other non−current liabilities	119,262	47,459
Total Liabilities	5,339,554	3,860,289
Stockholders' Equity:		
Preferred Stock—$0.01 par value, 50,000,000 shares authorized, none issued and outstanding	—	—
Common Stock—$0.01 par value, 300,000,000 shares authorized, 71,390,971 issued at December 31, 2001 and 2000	714	714
Treasury stock, at cost, 7,474,305 and 8,566,399 shares at December 31, 2001 and 2000, respectively	(465,805)	(536,524)
Additional paid−in capital	1,002,193	983,028
Retained earnings	1,548,941	1,145,464
Accumulated other comprehensive income	46,536	51,735
Total Stockholders' Equity	2,132,579	1,644,417
Total Liabilities and Stockholders' Equity	$ 7,472,133	$ 5,504,706

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.

Consolidated Income Statements

	Year Ended December 31,		
	2001	**2000**	**1999**
	(In thousands, except earnings per share)		
Revenues:			
Premium revenue	$ 11,577,170	$ 8,583,663	$ 6,896,857
Management services and other revenue	609,693	451,847	429,336
Investment income	241,784	193,448	159,234
	12,428,647	9,228,958	7,485,427
Operating Expenses:			
Health care services and other benefits	9,436,264	6,935,398	5,533,068
Selling expense	502,571	394,217	328,619
General and administrative expense	1,666,587	1,265,155	1,075,449
	11,605,422	8,594,770	6,937,136
Operating Income	823,225	634,188	548,291
Interest expense	49,929	23,978	20,178
Other expense, net	74,714	45,897	40,792
Income before Provision for Income Taxes, Extraordinary Gain and Cumulative Effect of Accounting Change	698,582	564,313	487,321
Provision for income taxes	283,836	222,026	190,110
Income before Extraordinary Gain and Cumulative Effect of Accounting Change	414,746	342,287	297,211
Extraordinary Gain from Early Extinguishment of Debt, net of tax	—	—	1,891
Cumulative Effect of Accounting Change, net of tax	—	—	(20,558)
Net Income	$ 414,746	$ 342,287	$ 278,544
Earnings Per Share(A):			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.27	$ 2.74	$ 2.25
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.02
Cumulative effect of accounting change, net of tax	—	—	(0.16)
Net income	$ 3.27	$ 2.74	$ 2.11
Earnings Per Share Assuming Full Dilution(A):			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.15	$ 2.64	$ 2.19
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.01
Cumulative effect of accounting change, net of tax	—	—	(0.15)
Net income	$ 3.15	$ 2.64	$ 2.05

(A) Per share data for each period presented has been calculated to reflect the two−for−one stock split which occurred March 15, 2002.

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.
Consolidated Statements of Changes in Stockholders' Equity

	Preferred Stock	Common Stock Issued Shares	Common Stock Issued Amount	Common Stock In Treasury Shares	Common Stock In Treasury Amount	Additional Paid−in Capital	Retained Earnings	Accumulated Other Comprehensive Income	Total
				(in thousands)					
Balance as of January 1, 1999	$ —	70,621	$ 706	3,502	$ (193,435)	$ 921,747	$ 576,598	$ 9,607	$ 1,315,223
Stock grants to employees and directors		75	1	(4)	172	3,051			3,224
Stock issued for employee stock option and stock purchase plans		695	7	(66)	3,616	30,218			33,841
Stock repurchased, at cost				4,333	(291,684)				(291,684)
Net losses from treasury stock reissued							(500)		(500)
Comprehensive income (loss)									
Net income							278,544		278,544
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								(26,179)	(26,179)
Foreign currency adjustments, net of tax								231	231
Total comprehensive income (loss)							278,544	(25,948)	252,596
Balance as of December 31, 1999	—	71,391	714	7,765	(481,331)	955,016	854,642	(16,341)	1,312,700
Stock grants to employees and directors				(15)	1,013				1,013
Stock issued for employee stock option and stock purchase plans				(1,668)	118,396	28,012			146,408
Stock repurchased, at cost				2,484	(174,602)				(174,602)
Net losses from treasury stock reissued							(51,465)		(51,465)
Comprehensive income									
Net income							342,287		342,287
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								68,045	68,045
Foreign currency adjustments, net of tax								31	31
Total comprehensive income							342,287	68,076	410,363
Balance as of December 31, 2000	—	71,391	714	8,566	(536,524)	983,028	1,145,464	51,735	1,644,417
Stock grants to employees and directors				(14)	886				886
Stock issued for employee stock option and stock purchase plans				(1,153)	77,266	19,165			96,431
Stock repurchased, at cost				75	(7,433)				(7,433)
Net losses from treasury stock reissued							(11,269)		(11,269)
Comprehensive income (loss)									
Net income							414,746		414,746
Other comprehensive income, net of tax									
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment								17,569	17,569
Foreign currency adjustments, net of tax								(262)	(262)
Minimum pension liability adjustment, net of tax								(22,506)	(22,506)
Total comprehensive income (loss)							414,746	(5,199)	409,547
Balance as of December 31, 2001	$ —	71,391	$ 714	7,474	$ (465,805)	$ 1,002,193	$ 1,548,941	$ 46,536	$ 2,132,579

See the accompanying notes to the consolidated financial statements.

WellPoint Health Networks Inc.

Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Cash flows from operating activities:			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Adjustments to reconcile income before extraordinary gain and cumulative effect of accounting change to net cash provided by operating activities:			
Depreciation and amortization, net of accretion	110,157	75,402	68,767
Loss on sales of assets, net	13,283	24,170	31,898
Provision (benefit) for deferred income taxes	15,915	(61,188)	41,087
Amortization of deferred gain on sale of building	(4,426)	(4,426)	(4,426)
Accretion of interest on zero coupon convertible subordinated debentures and 6 3/8% Notes	3,128	2,971	1,465
(Increase) decrease in certain assets:			
Receivables, net	18,365	(162,375)	(29,263)
Income taxes recoverable	—	—	191,079
Other current assets	(20,892)	1,829	(26,169)
Other non−current assets	(9,126)	(5,324)	(8,451)
Increase (decrease) in certain liabilities:			
Medical claims payable	109,676	367,189	195,681
Reserves for future policy benefits	(48,307)	(23,424)	(25,019)
Unearned premiums	66,812	1,460	15,349
Accounts payable and accrued expenses	94,663	61,856	107,086
Experience rated and other refunds	2,315	26,659	(26,619)
Income taxes payable	(32,256)	(30,070)	—
Other current liabilities	81,199	20,692	(5,227)
Accrued postretirement benefits	3,047	2,607	1,845
Other non−current liabilities	(12,135)	7,634	3,064
Net cash provided by operating activities	806,164	647,949	829,358
Cash flows from investing activities:			
Investments purchased	(4,914,118)	(3,427,465)	(3,456,317)
Proceeds from investments sold	4,628,088	2,979,906	2,892,802
Proceeds from investments matured	74,972	86,412	83,404
Property and equipment purchased	(92,937)	(46,891)	(38,516)
Proceeds from property and equipment sold	8,481	2,358	1,925
Settlement of sales price for sale of Workers' Compensation business	—	—	(6,733)
Acquisition of new businesses, net of cash acquired	(561,652)	(151,748)	(7,700)
Net cash used in investing activities	(857,166)	(557,428)	(531,135)
Cash flows from financing activities:			
Proceeds from issuance of zero coupon convertible subordinated debentures	—	—	200,823
Net borrowing (repayment) of long−term debt under the revolving credit facility	(15,000)	50,000	(149,788)
Net borrowing of long−term debt under 6 3/8% Notes due 2006	448,974	—	—
Proceeds from issuance of common stock	86,048	95,956	36,565
Common stock repurchased	(7,433)	(174,602)	(291,684)
Net cash provided by (used in) financing activities	512,589	(28,646)	(204,084)
Net increase in cash and cash equivalents	461,587	61,875	94,139
Cash and cash equivalents at beginning of period	566,889	505,014	410,875
Cash and cash equivalents at end of period	1,028,476	$ 566,889	$ 505,014

See the accompanying notes to the consolidated financial statements.

1. ORGANIZATION

WellPoint Health Networks Inc. (the "Company" or "WellPoint") is one of the nation's largest publicly traded managed health care companies. As of December 31, 2001, WellPoint had approximately 10.1 million medical members and approximately 45.1 million specialty members. The Company offers a broad spectrum of network−based managed care plans. WellPoint provides these plans to the large and small employer, individual and senior markets. The Company's managed care plans include preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), point−of−service ("POS") plans, other hybrid medical plans and traditional indemnity plans. In addition, the Company offers managed care services, including underwriting, actuarial service, network access, medical cost management and claims processing. The Company offers a continuum of managed health care plans while providing incentives to members and employers to select more intensively managed plans. The Company also provides a broad array of specialty and other products and services including pharmacy, dental, utilization management, vision, life insurance, preventive care, disability, behavioral health, medicare supplements, COBRA and flexible benefits account administration.

2. ACQUISITIONS

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean"), the parent company of Blue Cross Blue Shield of Georgia, Inc., which served approximately 1.9 million medical members in the state of Georgia as of March 31, 2001. This acquisition was accounted for under the purchase method of accounting and, accordingly, the consolidated results of operations of the Company include the results of Cerulean from the date of acquisition. The cash purchase price was $700.0 million. As a result of the acquisition of Cerulean, the Company estimates that it will incur up to $140.6 million in expenses primarily related to change in control payments to Cerulean management and transaction costs. Generally accepted accounting principles require that these expenses, which are not associated with the generation of future revenues and have no future economic benefit, be reflected as assumed liabilities in the allocation of the purchase price to the net assets acquired. Cash of $200.0 million and debt of $500.0 million were used to purchase net assets with a fair value of approximately $334.8 million. Goodwill and other intangibles totaling $572.7 million includes $66.9 million of deferred and current tax liabilities relating to identified intangibles. The estimated purchase price allocation between goodwill and identifiable intangible assets is $282.7 million and $290.0 million, respectively.

On March 1, 2000, the Company completed its acquisition of Rush Prudential Health Plans ("Rush Prudential"). Rush Prudential offers a broad array of products and services ranging from HMO products to traditional PPO products. The acquisition significantly increased the Company's Illinois medical membership to nearly 600,000 members as of March 31, 2000. Subsequent to the acquisition, the acquired business has been operated as UNICARE Health Plans. The transaction, which was financed with both cash from operations and debt from the Company's existing revolving credit facility, is valued at approximately $202.6 million. This acquisition was accounted for under the purchase method of accounting. Cash of $102.6 million and debt totaling $100.0 million were used to purchase net assets with a fair value of approximately $19.4 million, resulting in goodwill and other intangibles totaling $215.5 million. The resulting goodwill includes $32.3 million of deferred tax liabilities relating to identified intangibles. The purchase price allocation between goodwill and identifiable intangible assets is $135.8 million and $79.7 million, respectively.

On December 5, 2000, the Company completed its acquisition of a mail order pharmacy fulfillment facility from RxAmerica LLC ("RxAmerica"). RxAmerica is a pharmacy benefits management joint

venture between Albertson's, Inc. and Longs Drugs Stores California, Inc. Subsequent to the acquisition, the business was re−named PrecisionRx. This acquisition was accounted for under the purchase method of accounting.

In accordance with the requirements of APB Opinion No. 16, "Business Combinations," the following unaudited pro forma summary presents revenues, net income and per share data of WellPoint as if the acquisitions of Cerulean, Rush Prudential and PrecisionRx had occurred on January 1, 2000. The pro forma information includes the results of operations for the period prior to the acquisition, adjusted for interest expense on long−term debt incurred to fund the acquisition of Cerulean and Rush Prudential, amortization of goodwill and intangible assets and the related income tax effects. The pro forma financial information is presented for informational purposes only and may not be indicative of the results of operations had the Company been a single entity during the years ended December 31, 2001 and 2000, nor is it necessarily indicative of future results of operations. Pro forma earnings per share is based on 126.9 million and 125.1 million weighted average shares for the years ended December 31, 2001 and 2000, respectively. Pro forma earnings per share assuming full dilution is based on 132.4 million and 130.2 million weighted average shares for the years ended December 31, 2001 and 2000, respectively.

	Year Ended December 31,	
	2001	2000
	(In millions, except earnings per share)	
Revenues	$ 12,915.3	$ 11,473.9
Net Income	$ 424.1	$ 342.3
Earnings Per Share	$ 3.34	$ 2.74
Earnings Per Share Assuming Full Dilution	$ 3.22	$ 2.64

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

As a managed health care organization, the Company derives the majority of its revenues from premiums received for providing prepaid health services and prepares its financial statements in accordance with the AICPA Audit and Accounting Guide for "Health Care Organizations." The following is a summary of significant accounting policies used in the preparation of the accompanying consolidated financial statements. Such policies are in accordance with accounting principles generally accepted in the United States of America and have been consistently applied. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses for each reporting period. The significant estimates made in the preparation of the Company's consolidated financial statements relate to the assessment of the carrying value of the goodwill and intangible assets, medical claims payable, reserves for future policy benefits, experience rated refunds and contingent liabilities. While management believes that the carrying value of such assets and liabilities is adequate as of December 31, 2001 and 2000, actual results could differ from the estimates upon which the carrying values were based.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its subsidiaries. All significant intercompany transactions and accounts have been eliminated in consolidation.

Cash Equivalents

The Company considers cash equivalents to include highly liquid debt instruments purchased with an original remaining maturity of three months or less.

Concentration of Credit Risk

Financial instruments that potentially subject the Company to significant concentrations of credit risk consist principally of cash investments, bonds, foreign currency denominated forward exchange contracts and interest rate swap agreements. The Company invests its excess cash primarily in commercial paper and money market funds. Although a majority of the cash accounts exceed the federally insured deposit amount, management does not anticipate nonperformance by financial institutions and reviews the financial viability of these institutions. The Company attempts to limit its risk in investment securities by maintaining a diversified portfolio. The components of investment securities are shown in Note 4.

Investments

Investment securities consist primarily of U.S. Treasury and agency securities, foreign currency denominated bonds, mortgage−backed securities, investment grade and non−investment grade corporate bonds, equity securities and venture capital. The Company has determined that its investment securities are available for use in current operations and, accordingly, has classified such investment securities as current without regard to contractual maturity dates.

Long−term investments consist primarily of restricted assets, equity and other investments. Restricted assets, at market value, included in long−term investments at December 31, 2001 and 2000 were $106.6 million and $104.1 million, respectively, and consisted of investments on deposit with the California Department of Managed Health Care ("DMHC"). These deposits consisted primarily of U.S. Treasury and agency securities. Due to their restricted nature, such investments are classified as long−term without regard to contractual maturity.

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. Unrealized gains and losses are computed on the basis of specific identification and are included in other comprehensive income, net of applicable deferred income taxes. Realized gains and losses on the disposition of investments are included in investment income. The specific identification method is used in determining the cost of debt and equity securities sold.

The Company evaluates all of its investments based on current economic conditions, declining market valuation and financial condition of the issuer. Investments that have declines in fair value below cost, which are judged to be other than temporary, are written down to estimated fair value.

The Company participates in a securities lending program whereby marketable securities in the Company's portfolio are transferred to an independent broker or dealer in exchange for collateral equal to at least 101% of the market value of securities on loan.

In June 1998, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). SFAS No. 133, as amended by SFAS Nos. 137 and 138, establishes the accounting and reporting standards for derivative instruments and for hedging activities. Upon adoption of SFAS No. 133, all derivatives must be recognized on the balance sheet at their then fair value. Any deferred gains and losses remaining on the balance sheet under previous hedge−accounting rules must be removed from the balance sheet and all hedging relationships must be designated anew and documented pursuant to the new accounting. The new standard was adopted in the first quarter of 2001.

The adoption of SFAS No. 133 on January 1, 2001, resulted in a pre−tax increase to other income of $0.1 million and an after−tax decrease to other comprehensive income of $4.2 million.

The Company utilizes derivative instruments, specifically forward exchange contracts, to mitigate foreign currency risk associated with its foreign currency denominated investment portfolio. Forward exchange contracts are used to hedge the foreign currency risk between trade date and settlement date of foreign currency investment transactions. Gains and losses from such instruments are recognized in the Company's income statement at the settlement date.

Forward exchange contracts are also used to hedge asset positions in foreign denominated securities. The unrealized gains and losses, net of deferred taxes, from such forward contracts and related hedging investments are reflected in other comprehensive income at the balance sheet dates. As of December 31, 2001, the Company no longer invested in foreign government securities.

Premiums Receivable

Premiums receivable are shown net of an allowance based on historical collection trends and management's judgment on the collectibility of these accounts. These collection trends, as well as prevailing and anticipated economic conditions, are routinely monitored by management, and any adjustments required are reflected in current operations.

Property and Equipment, net

Property and equipment are stated at cost, net of depreciation, and are depreciated on the straight−line method over the estimated useful lives of the assets. Leasehold improvements are stated net of amortization and are amortized over a period not exceeding the term of the lease. Upon disposal of property and equipment, the cost of the asset and the related accumulated depreciation are removed from the accounts while the resulting gain or loss is reflected in current operations.

Computer software costs that are incurred in the preliminary project stage are expensed as incurred. Direct consulting costs, payroll and payroll related cost for employees, incurred during the development stage, who are directly associated with each project are capitalized and amortized over a five−year period when placed into production.

Intangible Assets and Goodwill, net

Intangible assets and goodwill represent the cost in excess of fair value of the net assets, net of the related tax impact, acquired in purchase transactions. Intangible assets and goodwill are being amortized on a straight−line basis over periods ranging from 1.5 to 40 years. For acquisitions

consummated prior to 1998, intangible assets and goodwill are being amortized utilizing a composite useful life. For acquisitions consummated after 1997, the specific identified useful life method is utilized. (See Note 7 for a more complete discussion of the Company's intangible assets and goodwill.)

The Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, such potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity.

Effective January 1, 2002, intangible assets and goodwill will be accounted for under SFAS No. 142, "Goodwill and Other Intangible Assets." The new rules eliminate amortization of goodwill and other intangibles with indefinite lives, but these assets will be subject to the impairment tests. (See "New Accounting Pronouncements" and Note 7 for a more complete discussion of the Company's intangible assets and goodwill).

Medical Claims Payable

The liability for medical claims payable includes claims in process and a provision for incurred but not reported claims, which is actuarially determined based on historical claims payment experience and other statistics. Claim processing expenses are also accrued based on an estimate of expenses necessary to process such claims. Such reserves are continually monitored and reviewed with any adjustments reflected in current operations. Capitation costs represent monthly fees paid one month in advance to physicians, certain other medical service providers and hospitals in the Company's HMO networks as retainers for providing continuing medical care. The Company maintains various programs that provide incentives to physicians, certain other medical service providers and hospitals participating in its HMO networks through the use of risk−sharing agreements and other programs. Payments under such agreements are made based on the providers' performance in controlling health care costs while providing quality health care. Expenses related to these programs, which are based in part on estimates, are recorded in the period in which the related services are rendered. Management believes that its reserves for medical claims payable are adequate to satisfy its ultimate claim liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

The Company's future results of operations will depend in part on its ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. WellPoint's ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high−cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above−listed or other factors may adversely affect the Company's future profitability.

Reserves for Future Policy Benefits

The estimated reserves for future policy benefits relate to life and disability policies written in connection with health care contracts. Reserves for future extended benefit coverage are based on projections of past experience. Reserves for future policy and contract benefits for certain long−term disability products and group paid−up life products are based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon the Company's experience. Reserves are continually monitored and reviewed, and as settlements are made or reserves adjusted, differences are reflected in current operations. The current portion of reserves for future policy benefits relates to the portion of such reserves which management expects to pay within one year. Management believes that its reserves for future policy benefits are adequate to satisfy its ultimate benefit liability. However, these estimates are inherently subject to a number of highly variable circumstances. Consequently, the actual results could differ materially from the amount recorded in the consolidated financial statements.

Postretirement Benefits

The Company currently provides certain health care and life insurance benefits to eligible retirees and their dependents under plans administered by the Company. The Company accrues the estimated costs of retiree health and other postretirement benefits during the periods in which eligible employees render service to earn the benefits.

Interest Rate Swap Agreements

The Company uses interest rate swap agreements to manage interest rate exposures. The principal objective of such contracts is to minimize the risks and costs associated with financial activities. The counterparties to these contractual arrangements are major financial institutions with which the Company also has other financial relationships. These counterparties expose the Company to credit loss in the event of nonperformance. However, the Company does not anticipate nonperformance by the counterparties.

The Company entered into interest rate swap agreements to reduce the impact of changes in interest rates on its floating rate debt under its revolving credit facility. The swap agreements are contracts to exchange floating interest rate payments for fixed interest rate payments periodically over the life of the agreements without the exchange of the underlying notional amounts. The notional amounts of the interest rate swap agreements are used to measure interest to be paid. For interest rate instruments that effectively hedge interest rate exposures, the net cash amounts paid on the agreements are accrued and recognized as an adjustment to interest expense. If an agreement no longer qualifies as a hedge instrument, then it is marked to market and carried on the balance sheet at fair value. The change in fair value of these instruments is included in investment income.

Income Taxes

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

Recognition of Premium Revenue and Management Services and Other Revenue

For most health care and life insurance contracts, premiums are billed in advance of coverage periods and are recognized as revenue over the period in which services or benefits are obligated to be provided. Premiums include revenue from other contracts, which principally relate to minimum premium contracts, where revenue is recognized based upon the ultimate loss experience of the contract. These contracts obligate the Company to arrange for the provision of health care for the members covered by the related contract and exposes the Company to financial risk based upon its ability to manage health care costs below a contractual fixed attachment point. Premium revenue includes an adjustment for experience rated refunds based on an estimate of incurred claims. Experience rated refunds are paid based on contractual requirements.

The Company's group life and disability insurance contracts are traditional insurance contracts, which are typically issued only in conjunction with a health care contract. Additionally, WellPoint has a limited number of indemnity health insurance contracts. All of these contracts provide insurance protection for a fixed period ranging from one month to a year.

The Company has the ability at a minimum to cancel the contract or adjust the provisions of the contract at the end of the contract period. As a result, the Company's insurance contracts are considered short−duration contracts.

Premiums applicable to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheet as unearned premiums.

Management services revenue is earned as services are performed and consists of administrative fees for services provided to third parties, including management of medical services, claims processing and access to provider networks. Under administrative service contracts, self−funded employers retain the full risk of financing benefits. Funds received from employers are equal to amounts required to fund benefit expenses and pay earned administrative fees. Because benefit expenses are not the obligation of the Company, premium revenue and benefit expenses for these contracts are not included in the Company's financial statements. Administrative service fees received from employer groups are included in the Company's revenues. Revenues from PrecisionRx, a mail order pharmacy acquired in December 2000, are shown net of pharmaceutical costs. Gross pharmaceutical sales for the years ended December 31, 2001 and 2000 were $200.3 million and $11.0 million, respectively. The pharmaceutical costs for the years ended December 31, 2001 and 2000 were $186.8 million and $10.3 million, respectively.

Loss Contracts

The Company monitors its contracts for the provision of medical care and recognizes losses on those contracts when it is probable that expected future health care and maintenance costs, under a group of existing contracts, will exceed anticipated future premiums on those contracts. The estimation of future health care medical costs includes all costs related to the provision of health care to members covered by the related group of contracts. In determining whether a loss has been incurred, the Company reviews contracts either individually or collectively, depending upon the Company's method of establishing premium rates for such contracts.

The Company further monitors its life insurance contracts and recognizes losses on those contracts for which estimated future claims costs and maintenance costs exceed the related unearned premium.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Health Care Services and Other Benefits

Health care services and other benefits expense includes the costs of health care services, capitation expenses and expenses related to risk sharing agreements with participating physicians, medical groups and hospitals and incurred losses on the disability and life products. The costs of health care services are accrued as services are rendered, including an estimate for claims incurred but not yet reported.

Advertising Costs

The Company uses print and broadcast advertising to promote its products. The cost of advertising is expensed as incurred and totaled approximately $59.6 million, $61.8 million and $40.8 million for the years ended December 31, 2001, 2000 and 1999, respectively.

Earnings per Share

Basic earnings per share is computed excluding the impact of potential common stock and earnings per share assuming full dilution is computed including the impact of potential common stock.

Stock Split

On March 15, 2002, WellPoint effected a two−for−one split of the Company's Common Stock. The stock split was in the form of a stock dividend of one additional share of WellPoint stock for each share held. Share and per share data for all periods presented herein have been adjusted to give effect to the stock split. Except for the Consolidated Balance Sheets, Consolidated Statements of Changes in Stockholders' Equity and as noted otherwise, all per share, weighted average share amounts and other share related numbers have been restated retroactively to reflect this stock split.

Stock−Based Compensation

The Company accounts for stock−based compensation using the intrinsic method. Accordingly, compensation cost for stock options under existing plans is measured as the excess, if any, of the quoted market price of the Company's stock at the date of the grant over the amount an employee must pay to acquire the stock.

Comprehensive Income

Comprehensive income encompasses all changes in stockholders' equity (except those arising from transactions with stockholders) and includes net income and net unrealized gains or losses on available−for−sale securities, foreign currency adjustments and adjustments to minimum pension liabilities. Comprehensive income is net of reclassification adjustments to adjust for items currently included in net income, such as realized gains on investment securities.

Start−Up Costs

Effective January 1, 1999, the Company changed its method of accounting for start−up costs related to the Company's provider and sales network development to comply with the AICPA Statement of Position No. 98−5, "Reporting on the Costs of Start−Up Activities." The change involves expensing

these costs as incurred, rather than capitalizing and subsequently amortizing such costs. The total amount of deferred start−up costs reported as a cumulative effect of a change in accounting principle was $20.6 million, net of a tax benefit of $14.3 million, for the year ended December 31, 1999.

Reclassifications

Certain amounts in the prior years consolidated financial statements have been reclassified to conform to the 2001 presentation.

New Accounting Pronouncements

In June 2001, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 141, "Business Combinations" ("SFAS No. 141"). SFAS No. 141 addresses financial accounting and reporting for business combinations and supersedes APB Opinion No. 16, "Business Combinations," and FASB Statement No. 38, "Accounting for Preacquisition Contingencies of Purchased Enterprises." Upon adoption of SFAS No. 141, all business combinations must be accounted for using the purchase method. The use of the pooling of interests method is now prohibited. The provisions of the new standard apply to all business combinations initiated after June 30, 2001. The adoption of SFAS No. 141 did not have a material effect on the financial statements of the Company.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 142 addresses financial accounting and reporting for acquired goodwill and other intangible assets and supersedes APB Opinion No. 17, "Intangible Assets." The new rules change the accounting methodology for goodwill from a model that amortizes goodwill to one which evaluates it for impairment. Amortization of goodwill, including previously recorded goodwill, will end upon adoption of the new rules. The new rules also eliminate amortization of other intangibles with indefinite useful lives, but these assets also will be subject to the impairment tests. SFAS No. 142 is effective for fiscal years beginning after December 15, 2001. Based upon the Company's review of its operations conducted thus far, the accounting impact of SFAS No. 142 related to goodwill amortization would increase the Company's net income by approximately $31.7 million on an annualized basis. The Company is in the process of completing the impairment tests for goodwill and other intangible assets and based on current information, does not anticipate transitional impairment losses.

In June 2001, the FASB issued Statement of Financial Accounting Standards No. 143, "Accounting for Asset Retirement Obligations" ("SFAS No. 143"). SFAS No. 143 is effective for financial statements issued for fiscal years beginning after June 15, 2002. The Company will adopt SFAS No. 143 on January 1, 2003. The provisions of SFAS No. 143 require companies to record an asset and related liability for the costs associated with the retirement of a long−lived tangible asset if a legal liability to retire the asset exists. The Company is in the process of analyzing the provisions of SFAS No. 143; however, the effect of adoption is not expected to have a significant impact on the Company's financial condition and results of operations.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long−Lived Assets" ("SFAS No. 144"). SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001. This statement addresses financial accounting and reporting for the impairment or disposal of long−lived

assets and supersedes SFAS No. 121, "Accounting for the Impairment of Long−Lived Assets and for Long−Lived Assets to be Disposed of" and the accounting and reporting provisions of APB 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," for the disposal of a segment of business (as previously defined in that opinion). SFAS No. 144 retains the basic principles of SFAS No. 121 for long−lived assets to be disposed of by sale or held and used and broadens discontinued operations presentation to include a component of an entity that is held for sale or that has been disposed. Components must have operations and cash flows that can be clearly distinguished from the rest of the entity. The Company is in the process of analyzing the provisions of this statement. All provisions of this statement will be effective in the first quarter of 2002. The adoption of this standard is not expected to have a significant impact on the Company's financial results.

4. INVESTMENTS

Investment Securities

The Company's investment securities consist of the following:

	December 31, 2001			
		Gross Unrealized		
	Cost or Amortized Cost	Gains	Losses	Estimated Fair Value
	(in thousands)			
U.S. Treasury and agency securities	$ 427,013	$ 12,901	$ 421	$ 439,493
Municipal securities	730	21	—	751
Mortgage−backed securities	906,022	15,413	1,459	919,976
Corporate and other securities	1,964,773	42,106	12,572	1,994,307
Total debt securities	3,298,538	70,441	14,452	3,354,527
Equity and other investments	408,450	88,863	18,858	478,455
Total investment securities	$ 3,706,988	$ 159,304	$ 33,310	$ 3,832,982

	December 31, 2000			
		Gross Unrealized		
	Cost or Amortized Cost	Gains	Losses	Estimated Fair Value
	(in thousands)			
U.S. Treasury and agency securities	$ 136,051	$ 3,852	$ 42	$ 139,861
Foreign government securities	128,367	2,065	122	130,310
Mortgage−backed securities	886,972	14,136	3,552	897,556
Corporate and other securities	1,546,369	18,999	29,445	1,535,923
Total debt securities	2,697,759	39,052	33,161	2,703,650
Equity and other investments	312,225	102,192	21,717	392,700
Total investment securities	$ 3,009,984	$ 141,244	$ 54,878	$ 3,096,350

The amortized cost and estimated fair value of debt securities as of December 31, 2001, based on contractual maturity dates are summarized below (in thousands). Expected maturities for mortgage−backed securities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Estimated Fair Value
	(in thousands)	
Due in one year or less	$ 80,050	$ 82,000
Due after one year through five years	1,374,080	1,405,415
Due after five years through ten years	867,976	877,677
Due after ten years	976,432	989,435
Total debt securities	$ 3,298,538	$ 3,354,527

For the years ended December 31, 2001, 2000 and 1999, proceeds from the sales and maturities of debt securities were $4,534.7 million, $2,760.8 million and $2,713.8 million, respectively. For 2001, gross realized gains and gross realized losses from sales of debt securities were $54.2 million and $41.6 million, respectively. Gross gains of $12.0 million and gross losses of $28.8 million were realized on the sales of debt securities for the year ended December 31, 2000. In 1999, gross realized gains and gross realized losses from sales of debt securities were $16.2 million and $52.6 million, respectively.

For the years ended December 31, 2001, 2000 and 1999, proceeds from the sales of equity securities were $168.4 million, $310.3 million and $262.4 million, respectively. In 2001, gross realized gains and gross realized losses on the sales of equity securities were $6.4 million and $23.3 million, respectively. Gross gains of $11.0 million and gross losses of $15.3 million were realized on the sales of equity securities in 2000. For 1999, gross realized gains and gross realized losses on the sales of equity securities were $30.9 million and $26.5 million, respectively.

Securities on loan under the Company's securities lending program are included in its cash and investment portfolio shown on the accompanying consolidated balance sheets. Under this program, broker/dealers are required to deliver substantially the same security to the Company upon completion of the transaction. The balance of securities on loan as of December 31, 2001 and 2000 was $110.8 million and $101.9 million, respectively, and income earned on security lending transactions for the years ended December 31, 2001, 2000 and 1999 was $0.3 million, $0.3 million and $0.6 million, respectively.

Long−term Investments

The Company's long−term investments consist of the following:

	December 31, 2001			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(in thousands)			
Mortgage−backed securities	$ 97,365	$ 2,779	$ —	$ 100,144
Equity and other investments	24,467	—	—	24,467
Total long−term investments	$ 121,832	$ 2,779	$ —	$ 124,611

	December 31, 2000			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(in thousands)			
Mortgage−backed securities	$ 95,950	$ 632	$ —	$ 96,582
Equity and other investments	20,229	—	—	20,229
Total long−term investments	$ 116,179	$ 632	$ —	$ 116,811

At December 31, 2001 the Company's debt securities had contractual maturity dates: due in one through five years, amortized cost of $97.4 million and market value of $100.1 million. Expected maturities for mortgage−backed securities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

5. RECEIVABLES, NET

Receivables consist of the following:

	December 31,	
	2001	2000
	(In thousands)	
Premiums receivable	$ 442,503	$ 373,616
Investment income and other receivables	487,745	385,175
	930,248	758,791
Less: allowance for doubtful accounts	88,526	58,923
Receivables, net	$ 841,722	$ 699,868

6. PROPERTY AND EQUIPMENT, NET

Property and equipment, at cost, consist of the following:

		December 31,	
	Useful Life	2001	2000
		(in thousands)	
Equipment	5 years	$ 135,863	$ 123,994
Software	5 years	186,158	94,371
Leasehold improvements	Term of Lease	75,630	67,931
Furniture and fixtures	8 years	81,658	58,338
Building	30 years	14,427	3,373
Land		1,429	382
		495,165	348,389
Less: accumulated depreciation and amortization		273,085	197,358
Property and equipment, net		$ 222,080	$ 151,031

Depreciation and amortization expense for the years ended December 31, 2001, 2000 and 1999 was $45.4 million, $38.5 million and $39.3 million, respectively.

7. INTANGIBLE ASSETS AND GOODWILL

The intangible asset balance consists of the following components:

	December 31,	
	2001	2000
	(in thousands)	
Employer group relationships	$ 282,148	$ 160,609
Tradenames and trademarks	135,000	—
Self−developed software	27,280	7,280
Provider contracts	23,378	13,247
Miscellaneous intangible assets	10,495	11,197
	478,301	192,333
Less: accumulated amortization	47,813	27,169
Intangible assets, net	$ 430,488	$ 165,164

The goodwill balance consists of the following components:

	December 31,	
	2001	2000
	(in thousands)	
Goodwill	$ 778,407	$ 492,804
Less: accumulated amortization	117,061	74,684
Goodwill, net	$ 661,346	$ 418,120

In May 1999, the Company entered into an agreement with Omni Healthcare ("Omni"), a Sacramento, California−based health plan to transition Omni members to the Company's Blue Cross of California subsidiary. The Company paid $7.7 million, subject to adjustment, in exchange for Omni's cooperation in transferring its approximately 124,000 members. The entire amount has been allocated to intangible assets and was originally being amortized over 3 years. During the second quarter of 2000, the Company re−evaluated the useful life of intangible assets related to its acquisition of Omni and reduced its related useful life to 1.5 years.

On March 1, 2000, the Company completed its acquisition of Rush Prudential Health Plans ("Rush Prudential"), which was valued at approximately $202.6 million, subject to certain post−closing adjustments. This acquisition generated goodwill and other intangibles of $135.8 million and $79.7 million, respectively. (See Note 2 for a more complete discussion of this acquisition).

On March 15, 2001, the Company completed its acquisition of Cerulean Companies, Inc. ("Cerulean") for $700.0 million. This estimated purchase price allocation between goodwill and other intangibles was $282.7 million and $290.0 million, respectively. (See Note 2 for a more complete discussion of this acquisition). Goodwill and other intangibles are being amortized on a straight−line basis ranging from 15 to 25 years for goodwill and ranging from three to 40 years for other intangible assets.

Amortization charged to operations was $63.1 million, $38.1 million and $25.5 million for the years ended December 31, 2001, 2000 and 1999, respectively.

8. LONG−TERM DEBT

$6\frac{3}{8}$% Notes due 2006

On June 15, 2001, the Company issued $450.0 million aggregate principal amount at maturity of $6\frac{3}{8}$% Notes due June 15, 2006 (the "2001 Notes"). The net proceeds of this offering totaled approximately $449.0 million. The net proceeds from the sale of the 2001 Notes were used for repayment of indebtedness under the Company's revolving credit facilities. The 2001 Notes bear interest at a rate of $6\frac{3}{8}$% per annum, payable semi−annually in arrears on June 15 and December 15 of each year commencing December 15, 2001. Interest is computed on the basis of a 360−day year of twelve 30−day months. At December 31, 2001, the Company had $449.1 million (based upon the principal amount of $450.0 million less discount) of 2001 Notes outstanding and the related interest expense for 2001 totaled $16.4 million.

The 2001 Notes may be redeemed, in whole or in part, at the Company's option at any time. The redemption price for any 2001 Notes redeemed will be equal to the greater of the following amounts: 1) 100% of the principal amount of the 2001 Notes being redeemed on the redemption date; and 2) the sum of the present values of the remaining scheduled payments of principal and interest on the 2001 Notes being redeemed on that redemption date (not including any portion of any payments of interest accrued to the redemption date) discounted to the redemption date on a semiannual basis at the Treasury rate as determined by the designated Reference Treasury Dealer (Salomon Smith Barney Inc. or UBS Warburg LLC or their respective successors), plus 25 basis points. In each case, the redemption price will also include accrued and unpaid interest on the 2001 Notes to the redemption date.

The 2001 Notes are unsecured obligations and rank equally with all of the Company's existing and future senior unsecured indebtedness. All existing and future liabilities of the Company's subsidiaries are and will be effectively senior to the 2001 Notes. The indenture governing the 2001 Notes contains a covenant that limits the Company's ability and that of the Company's subsidiaries to create liens on Company property or assets to secure certain indebtedness without also securing the 2001 Notes.

Revolving Credit Facility

Effective as of March 30, 2001, the Company entered into two new unsecured revolving credit facilities allowing aggregate indebtedness of $1.0 billion. Upon execution of these facilities, the Company terminated its prior $1.0 billion unsecured revolving facility. Borrowings under these facilities, which are generally referred to collectively in this Annual Report on Form 10−K as the Company's "revolving credit facility," bear interest at rates determined by reference to the bank's base rate or to the London Inter Bank Offered Rate ("LIBOR") plus a margin determined by reference to the then−current rating of the Company's unsecured long−term debt by specified rating agencies. One facility, which provides for borrowings of up to $750.0 million, expires as of March 30, 2006, although it may be extended for up to two additional one−year periods under certain circumstances. The other facility, which provides for borrowings of up to $250.0 million, expires as of March 30, 2002. Any amount outstanding under this facility as of March 29, 2002 may be converted into a one−year term loan at the option of the Company. In March 2002, the Company amended this facility to provide for a one year extension with an expiration date of March 28, 2003. Borrowings under the facilities are made on a committed basis or, in the case of the $750.0 million facility, pursuant to an auction bid process. The $750.0 million facility also contains sublimits for letters of credit and "swingline" loans. Each credit agreement requires the Company to maintain certain financial ratios and contains restrictive

convenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control. The total amount outstanding under these facilities was $235.0 million as of December 31, 2001. The total amount outstanding under the Company's prior revolving credit facility was $250.0 million as of December 31, 2000.

The agreement provides for interest on committed advances at rates determined by reference to the bank's base rate or to the London Interbank Offered Rate ("LIBOR") plus a margin determined by reference to the Company's leverage ratio (as defined in the credit agreement) or the then−current rating of the Company's unsecured long−term debt by specified rating agencies. Interest is determined using whichever of these methods is the most favorable to the Company. The effective interest rates were 2.76% and 6.87% at December 31, 2001 and 2000, respectively. Borrowings under the credit facility are made on a committed basis or pursuant to an auction−bid process. A facility fee based on the facility amount, regardless of utilization, is payable quarterly. The facility fee rate is also determined by the unsecured debt ratings or the leverage ratio of the Company.

Zero Coupon Convertible Subordinated Debentures

On July 2, 1999, the Company issued $299.0 million aggregate principal amount at maturity of zero coupon convertible subordinated debentures due 2019 (the "Debentures"). The proceeds totaled approximately $200.8 million. The Debentures accrue interest at a yield to maturity of 2.0% per year compounded semi−annually. Holders have the option to convert the Debentures into the Company's Common Stock at any time prior to maturity at a rate of 13.594 shares per $1,000 principal amount at maturity. In lieu of delivering shares of common stock upon conversion of any Debentures, the Company may elect to pay cash for the Debentures in an amount equal to the last reported sales price of its Common Stock on the trading day preceding the conversion date. The Debentures are subordinate in right of payment to all existing and future senior indebtedness.

On October 6, 1999, the Board of Directors authorized the repurchase of some or all of the Company's Debentures for cash. The Company did not repurchase any Debentures during the years ended December 31, 2001 and 2000. During the year ended December 31, 1999, the Company repurchased $81.0 million in aggregate principal amount at maturity of the Debentures at a total purchase price of $49.8 million. The gain on such repurchase is shown on the Company's income statement as an extraordinary gain, net of applicable tax.

As of December 31, 2001 and 2000, the Company had $153.9 million and $150.9 million (based upon the original issue price plus accreted interest), respectively, of Debentures outstanding. For the years ended December 31, 2001 and 2000, the Company accrued $3.0 million and $3.1 million, respectively, of interest related to the Debentures.

Maturities

At December 31, 2001, the Company's long−term debt maturities were as follows: 2002—zero; 2003—$35 million; 2004—zero; 2005—zero; 2006—$650 million; 2019—$218 million.

Debt Covenants

The Company's revolving credit facility requires the maintenance of certain financial ratios and contains other restrictive covenants, including restrictions on the occurrence of additional indebtedness and the granting of certain liens, limitations on acquisitions and investments and limitations on changes in control. As of December 31, 2001, the Company was in compliance with the requirements in these agreements.

Interest Rate Swaps

As described in Note 15, as of December 31, 2001, the Company was a party to two separate interest rate swap agreements, which convert underlying variable−rate debt into fixed−rate debt.

Interest Paid

Interest paid on long−term debt for the years ended December 31, 2001, 2000 and 1999 was $43.0 million, $21.5 million and $22.1 million, respectively.

9. INCOME TAXES

The components of the provision (benefit) for income taxes are as follows:

	Year Ended December 31,		
	2001	2000	1999
	(in thousands)		
Current:			
Federal	$ 224,380	$ 226,606	$ 106,036
State	43,541	56,608	42,987
	267,921	283,214	149,023
Deferred:			
Federal	13,180	(54,552)	43,968
State	2,735	(8,383)	(2,881)
	15,915	(62,935)	41,087
Valuation allowance	—	1,747	—
Provision for income taxes	$ 283,836	$ 222,026	$ 190,110

The overall effective tax rate differs from the statutory federal tax rate as follows (percent of pretax income from continuing operations):

	Year Ended December 31,		
	2001	2000	1999
Tax provision based on the federal statutory rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	4.3	5.6	5.3
Non−deductible expenses/non−taxable items	1.2	(0.1)	(0.4)
Change in valuation allowance	—	0.3	—
Other, net	0.1	(1.5)	(0.9)
Effective tax rate	40.6%	39.3%	39.0%

Net deferred tax assets are comprised of the following:

	December 31,	
	2001	2000
	(in thousands)	
Gross deferred tax assets:		
Net operating loss	$ 6,028	$ 4,420
Investment basis difference	39,696	—
Vacation and holiday accruals	9,322	6,224
Incurred claim reserve discounting	19,587	23,038
Provision for doubtful accounts	33,530	22,472
Unearned premium reserve	24,424	18,644
State income taxes	15,942	21,068
Postretirement benefits	37,161	29,138
Deferred gain on building	1,653	3,456
Deferred compensation	30,909	25,114
Expenses not currently deductible	95,699	73,774
Intangible asset impairment	5,689	6,439
Capital loss carryover	5,676	26,708
Start−up costs	2,540	4,327
Deferred acquisition costs	9,321	8,904
Other, net	10,282	4,733
Total gross deferred tax assets	347,459	278,459
Gross deferred tax liabilities:		
Market valuation on investment securities	(35,736)	(35,687)
Depreciation and amortization	(2,827)	(5,582)
Investment basis difference	—	(6,947)
Internally developed software	(25,216)	(13,119)
Purchased intangibles	(138,272)	(32,330)
Lease expense	(6,221)	(6,239)
Other, net	(1,935)	(1,728)
Total gross deferred tax liabilities	(210,207)	(101,632)
Valuation allowance:		
Net operating loss carryover	(1,337)	(4,341)
Capital loss carryover	(2,366)	(1,747)
	(3,703)	(6,088)
Net deferred tax assets	$ 133,549	$ 170,739

In connection with the acquisition of Cerulean, the Company acquired $112.8 million deferred tax liabilities and $72.0 million net deferred tax assets. The net result was an increase to goodwill of $40.8 million. In connection with the acquisition of Rush Prudential, the Company acquired $32.3 million deferred tax liabilities and $7.4 million net deferred tax assets. The net result was an

increase to goodwill of approximately $24.9 million, which included a valuation allowance for certain operating loss carryforwards acquired in such transaction.

As of December 31, 2001, the Company had $5.5 million of federal net operating loss carryforwards acquired from Cerulean and $9.6 million of federal net operating loss carryforwards acquired from Rush Prudential. In addition, the Company's $16.6 million of Illinois net operating loss carryforward acquired from Rush Prudential was completely utilized during the year ended December 31, 2001. As a result, management reduced the valuation allowance from $4.3 million to $1.3 million and recorded the change as a reduction to goodwill. The federal carryforward begins to expire in 2014.

As of December 31, 2001, the Company has a state capital loss carryforward of $98.0 million. The Company established a valuation allowance of $2.4 million related to this carryforward. Management believes it is more likely than not that the recorded deferred tax assets, net of the valuation allowance, will be realized. The state carryforward begins to expire in 2003. As of December 31, 2001, the Company utilized its entire federal capital loss carryforward.

During 2001, the Internal Revenue Service ("IRS") completed its examination of the Company's consolidated federal income tax returns for 1992 through 1994. The settlement of the audit had no material impact on the financial position or results of operations. The IRS has begun its audit of tax years 1995 through 1998. The results of this audit are not expected to have a material impact on the Company's financial position or results of operations.

Income taxes paid (refunded) for the years ended December 31, 2001, 2000 and 1999 were $222.5 million, $283.8 million and ($57.0) million, respectively.

10. PENSION AND POSTRETIREMENT BENEFITS

Pension Benefits

The Company covers substantially all employees through two non−contributory defined benefit pension plans. The Restated Employees' Retirement Plan of Blue Cross of California covers employees of a bargaining unit. The WellPoint Pension Accumulation Plan, which was established on January 1, 1987, covers all eligible employees (employees covered under a collective bargaining agreement participate if the terms of the collective bargaining agreement permits) meeting certain age and service requirements. Plan assets are invested primarily in pooled income funds. The Company's policy is to fund its plans according to the applicable Employee Retirement Income Security Act of 1974 and income tax regulations. The Company uses the projected unit credit method of cost determination.

In conjunction with the acquisition of Cerulean on March 15, 2001, the Company's Board of Directors approved the merger of Cerulean's Non−Contributory Retirement Program for Certain Employees of Blue Cross and Blue Shield of Georgia, Inc. into the WellPoint Pension Accumulation Plan.

The funded status of the plans is as follows:

	December 31,	
	2001	2000
	(In thousands)	
Change in Benefit Obligation		
Benefit obligation at beginning of year	$ 86,680	$ 77,656
Service cost	10,987	8,008
Interest cost	10,353	6,456
Actuarial (gain) loss	13,699	(59)
Acquisitions	65,814	—
Benefits paid	(12,178)	(5,381)
Benefit obligation at end of year	$ 175,355	$ 86,680
Change in Plan Assets		
Fair value at beginning of year	$ 72,180	$ 72,128
Actual return on fair value	(5,028)	(3,206)
Employer contributions	24,455	8,639
Acquisitions	65,770	—
Benefits paid	(12,178)	(5,381)
Fair value at end of year	$ 145,199	$ 72,180
Funded status	$ (30,156)	$ (14,500)
Unrecognized prior service cost	377	424
Unrecognized actuarial loss	48,037	20,252
Net amount recognized	$ 18,258	$ 6,176

Amounts recognized in the Consolidated Balance Sheets consists of:

	December 31,	
	2001	2000
	(In thousands)	
Prepaid benefit cost	$ 18,258	$ 6,176
Additional minimum liability	(38,523)	—
Intangible asset	377	—
Accumulated other comprehensive income	38,146	—
Net amount recognized	$ 18,258	$ 6,176

As of December 31, 2001 and December 31, 2000 the Company's Pension Accumulation Plan had accumulated benefits in excess of plan assets as follows:

	December 31,	
	2001	2000
	(In thousands)	
Projected benefit obligation	$ 163,386	$ 78,771
Accumulated benefit obligation	156,510	73,350
Fair value of assets	133,758	61,870
Weighted Average Assumptions		
Discount rate	7.25%	7.75%
Expected return on plan assets	9.50%	9.50%
Rate of compensation increases	4.50%	5.00%

Net periodic pension expense for the Company's defined benefit pension plans includes the following components:

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Service cost—benefits earned during the year	$ 10,987	$ 8,008	$ 8,117
Interest cost on projected benefits obligations	10,353	6,456	5,583
Expected return on plan assets	(10,736)	(6,946)	(6,603)
Amortization of prior service cost	47	15	14
Recognized net actuarial loss	1,677	286	81
Net periodic pension expense	$ 12,328	$ 7,819	$ 7,192

The Company sponsors the WellPoint 401(k) Retirement Savings Plan (the "401(k) Plan"). Generally, employees (excluding temporary employees working less than 1,000 hours and leased employees) over 18 years of age are eligible to participate in the 401(k) Plan if they meet certain length of service requirements. Under this plan, employees may contribute a percentage of their pre−tax earnings to the 401(k) Plan. After one year of service, employee contributions up to 6% of eligible compensation are matched by an employer contribution equal to 75% on the employee's contribution. Matching contributions are immediately vested. One third of the employer contribution is in the Company's Common Stock. As of December 31, 2001, employees were prohibited from transferring the Company's match received in the form of Common Stock until the calendar year following receipt of such Company match. Effective March 1, 2002, the 401(k) Plan was amended to remove this restriction. The 401(k) Plan includes a grandfather match provision whereby the employer contribution is 85% for those employees with 10 to 19 years of service as of January 1, 1997 and 100% for those employees with 20 years or more of service as of such date. Company expense related to the 401(k) Plan totaled $20.2 million, $16.5 million and $15.9 million for the years ended December 31, 2001, 2000 and 1999, respectively. In conjunction with the acquisition of Cerulean on March 15, 2001, the Company's Board of Directors approved the merger of Cerulean's Blue Cross and Blue Shield of Georgia, Inc. Savings Program into the Company's 401(k) Plan.

Postretirement Benefits

The Company currently provides certain health care and life insurance benefits to eligible retirees and their dependents. Employees outside of California and certain employees in California acquired as a result of the acquisitions and all employees hired, rehired or reinstated after January 1, 1997 are not covered under the Company's postretirement benefit plan. All eligible employees in Georgia acquired as a result of the Cerulean acquisition will continue to be covered under the Cerulean Defined Dollar Benefit Plan ("DDB Plan"). Blue Cross Blue Shield of Georgia employees hired, rehired or reinstated after March 15, 2001 are not eligible to be covered under the Cerulean DDB Plan or any WellPoint retiree plan. All other Company employees are fully eligible for retiree benefits upon attaining 10 years of service and a minimum age of 55. The plan, in effect for those retiring prior to September 1, 1994, provides for Company−paid life insurance for all retirees based on age and a percent of salary. In addition, the majority of retirees from age 62 or greater currently receive fully paid health benefit coverage for themselves and their dependents. For employees retiring on or after September 1, 1994, the Company currently subsidizes health benefit coverage based on the retiree's years of service at retirement and date of hire. Life insurance benefits for retirees hired on or after May 1, 1992 are set at $10,000 upon retirement and are reduced to $5,000 at age 70.

The accumulated postretirement benefit obligation ("APBO") and the accrued postretirement benefits as of December 31, 2001 and 2000 are as follows:

	December 31,	
	2001	2000
	(in thousands)	
Benefit obligation at the beginning of the year	$ 59,291	$ 54,932
Service cost	2,312	1,520
Interest cost	5,950	4,234
Actuarial (gain) loss	9,711	1,063
Acquisitions	19,568	—
Benefits paid	(3,564)	(2,458)
Accumulated postretirement benefits obligation	93,268	59,291
Unrecognized net gain from accrued postretirement benefit cost	856	12,219
Accrued postretirement benefits	$ 94,124	$ 71,510

The Company currently pays for its postretirement benefit obligations as they are incurred. As such, there are no plan assets.

The above actuarially determined APBO was calculated using a discount rate of 7.25% and 7.75% for 2001 and 2000, respectively. The original medical trend rate assumed a decline from 7.0% (under age 65) and 6.5% (age 65 and over) for 2001 to 6.0% by the year 2002. This medical trend rate was re−evaluated and modified to 10.0% for the year 2002 with a gradual decline to 5.0% by the year 2007. These estimated trend rates are subject to change in the future. The medical trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care trend rate of one percent in each year would increase the APBO as of December 31, 2001 by $8.5 million and would increase service and interest costs by $1.0 million. Conversely, a decrease in the assumed health care trend rate of one percent in each year would decrease the APBO as of December 31, 2001 by $7.6 million and would decrease service and interest costs by $0.9 million. For life insurance benefit calculations, a compensation increase of 4.5% was assumed.

10. PENSION AND POSTRETIREMENT BENEFITS (Continued)

Net periodic postretirement benefit cost includes the following components (in thousands):

	Year Ended December 31,		
	2001	2000	1999
Service cost	$ 2,312	$ 1,520	$ 1,650
Interest cost	5,950	4,234	3,933
Net amortization and deferral	(213)	(689)	(418)
Net periodic postretirement benefit cost	$ 8,049	$ 5,065	$ 5,165

11. COMMON STOCK

Stock Option Plans

In 1996, the Company adopted an Employee Stock Option Plan (the "Employee Option Plan"). In May 1996, all eligible employees were granted options to purchase common stock under the Employee Option Plan. The exercise price of options granted under the Employee Option Plan is the fair market value of the Common Stock on the date of the grant. Each option granted has a maximum term of 10 years. Options granted under the Employee Option Plan vest in accordance with the terms of the applicable grant.

In 1996, the Company also implemented a Stock Option/Award Plan (the "Stock Option/Award Plan") for key employees, officers and directors. The exercise price per share is fixed by a committee appointed by the Board of Directors to administer the Stock Option/Award Plan, but for any incentive stock option, the exercise price will not be less than the fair market value on the date of grant. The maximum term for an option is ten years. Options granted will vest in accordance with the terms of each grant. The Stock Option/Award Plan also allows the grant or award of restricted stock, performance units and phantom stock.

On May 11, 1999, the stockholders of the Company approved a new Stock Incentive Plan (the "Plan") for key employees, officers and directors. This new plan serves as the successor to the Company's Stock Option/Award Plan and Employer Stock Option Plan (the "Predecessor Plans"). All options granted under the Predecessor Plans and outstanding on the Plan's effective date were incorporated into the Plan and treated as outstanding awards under the Plan. The exercise price is determined by the plan administrator; however, it will generally not be less than the fair market value on the date of grant. The maximum term for an option is ten years. Options granted will vest in accordance with the terms of each grant. The Plan also allows the grant or award of restricted stock, performance units and phantom stock. As of December 31, 2001 the maximum number of shares issuable under the Plan, subject to subsequent adjustments for certain changes in the Company's capital structure, was 14.6 million.

Effective as of February 17, 2000, the Company adopted the 2000 Employee Stock Option Plan (the "2000 Employee Plan") for employees and non−executive officers of the Company. The exercise price and maximum term of any stock option granted under the 2000 Employee Plan are determined by the plan administrator. Options granted will vest in accordance with the terms of each grant. As of December 31, 2001, the maximum number of shares issuable under the 2000 Employee Plan, subject to subsequent adjustments for certain changes in the Company's capital structure, was 9.0 million shares.

The following summarizes activity in the Company's stock option plans for the years ended December 31, 2001, 2000 and 1999:

	Shares	Weighted Average Exercise Price Per Share
Outstanding at January 1, 1999	8,998,476	22.12
Granted	3,915,210	36.93
Canceled	(283,208)	26.29
Exercised	(2,028,958)	19.54
Outstanding at December 31, 1999	10,601,520	27.97
Granted	4,370,190	36.11
Canceled	(497,882)	33.73
Exercised	(3,821,630)	23.21
Outstanding at December 31, 2000	10,652,198	32.73
Granted	7,293,674	47.25
Canceled	(835,604)	42.41
Exercised	(2,402,460)	31.97
Outstanding at December 31, 2001	14,707,808	39.45
Exercisable at:		
December 31, 1999	4,928,650	23.96
December 31, 2000	4,924,224	30.99
December 31, 2001	5,993,936	34.02

The options outstanding at December 31, 2001 had exercise prices ranging from $13.43 to $61.82 per share.

	Options Outstanding			Options Exercisable	
Actual Range of Exercise Prices	Number Outstanding at 12/31/01	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number Outstanding at 12/31/01	Weighted Average Exercise Price
$13.43 − 19.84	1,175,998	4.3	$ 19.12	1,175,998	$ 19.12
$22.78 − 33.82	1,366,140	6.1	$ 28.43	1,356,952	$ 28.40
$34.19 − 51.25	11,375,568	8.3	$ 41.78	2,810,052	$ 37.96
$51.51 − 61.82	790,102	7.0	$ 55.29	650,934	$ 55.62
	14,707,808	7.7	$ 39.45	5,993,936	$ 34.02

Stock Purchase Plan

On May 18, 1996, the Company's stockholders approved the Company's Employee Stock Purchase Plan (the "ESPP"). The stockholders approved an amendment and restatement of the ESPP on May 9, 2000. The ESPP allows eligible employees to purchase Common Stock at the lower of 85% of the market price of the stock at the beginning or end of each offering period. The aggregate amount of Common Stock that may be issued pursuant to the ESPP shall not exceed 2,800,000 shares, subject to adjustment pursuant to the terms of the ESPP. During the years ended December 31, 2001, 2000 and 1999, approximately 218,000, 222,800, and 186,800 shares of Common Stock were purchased under the ESPP. There are offering periods for the first half and second half of the year and accordingly, two

purchase prices. For the year ended December 31, 2001, the purchase prices were $40.05 and $39.74 per share. For the year ended December 31, 2000, the purchase prices were $28.05 and $30.84 per share. For the year ended December 31, 1999, the purchase prices were $36.07 and $28.03 per share.

SFAS No. 123 Disclosure

In accordance with the provisions of SFAS No. 123, the Company applies APB Opinion No. 25 and related interpretations in accounting for its stock option plans and, accordingly, does not recognize compensation cost. If the Company had elected to recognize the compensation cost based on the fair value of the options granted at grant date as prescribed by SFAS No. 123, net income and earnings per share for the years ended December 31, 2001, 2000 and 1999 would have been reduced to the pro forma amounts indicated in the table which follows:

	2001	2000	1999
		(In millions, except per share amounts)	
Net income—as reported	$ 414.7	$ 342.3	$ 278.5
Net income—pro forma	$ 381.7	$ 315.7	$ 256.3
Earnings per share—as reported	$ 3.27	$ 2.74	$ 2.11
Earnings per share—pro forma	$ 3.01	$ 2.52	$ 1.94
Earnings per share assuming full dilution—as reported	$ 3.15	$ 2.64	$ 2.05
Earnings per share assuming full dilution—pro forma	$ 2.90	$ 2.44	$ 1.88

2001	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	4.66%	4.53%
Expected stock price volatility	35.00%	35.00%
Expected life of options	four years	three years

2000	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	6.38%	6.37%
Expected stock price volatility	40.00%	40.00%
Expected life of options	four years	three years

1999	Officers	Employees
Assumptions		
Expected dividend yield	—	—
Risk−free interest rate	5.02%	4.86%
Expected stock price volatility	38.00%	38.00%
Expected life of options	four years	three years

The above pro forma disclosures may not be representative of the effects on reported pro forma net income for future years. The weighted average fair value of options granted during 2001, 2000 and 1999 is $14.46, $13.09, and $11.88 per share, respectively.

Treasury Stock

As of December 31, 2001, the Company was authorized to repurchase approximately 25.4 million shares of its Common Stock. As of December 31, 2001, 20.8 million shares of Common Stock had been repurchased pursuant to this authorization.

12. EARNINGS PER SHARE

The following is an illustration of the dilutive effect of the Company's potential Common Stock on earnings per share ("EPS"). There were no antidilutive securities in any of the three periods presented.

	Year Ended December 31,		
	2001	2000	1999
		(In thousands, except earnings per share)	
Basic Earnings Per Share Calculation:			
Numerator			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891
Cumulative effect of accounting change, net of tax	—	—	(20,558)
Net Income	$ 414,746	$ 342,287	$ 278,544
Denominator			
Weighted average shares outstanding	126,851	125,061	132,141
Earnings Per Share			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.27	$ 2.74	$ 2.25
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.02
Cumulative effect of accounting change, net of tax	—	—	(0.16)
Net Income	$ 3.27	$ 2.74	$ 2.11
Earnings Per Share Assuming Full Dilution Calculation:			
Numerator			
Income before extraordinary gain and cumulative effect of accounting change	$ 414,746	$ 342,287	$ 297,211
Interest expense on zero coupon convertible subordinated debentures, net of tax	1,880	1,890	930
Adjusted income before extraordinary gain and cumulative effect of accounting change	416,626	344,177	298,141
Extraordinary gain from early extinguishment of debt, net of tax	—	—	1,891
Cumulative effect of accounting change, net of tax	—	—	(20,558)
Adjusted Net Income	$ 416,626	$ 344,177	$ 279,474
Denominator			
Weighted average shares outstanding	126,851	125,061	132,141
Net effect of dilutive stock options	2,608	2,195	2,154
Assumed conversion of zero coupon convertible subordinated debentures	2,963	2,963	1,898
Diluted weighted average shares outstanding	132,422	130,219	136,193
Earnings Per Share Assuming Full Dilution			
Income before extraordinary gain and cumulative effect of accounting change	$ 3.15	$ 2.64	$ 2.19
Extraordinary gain from early extinguishment of debt, net of tax	—	—	0.01
Cumulative effect of accounting change, net of tax	—	—	(0.15)
Net Income	$ 3.15	$ 2.64	$ 2.05

13. LEASES

Effective January 1, 1996, the Company entered into a new lease agreement for a 24−year period for its former corporate headquarters, expiring in December 2019, with two options to extend the term for up to two additional five−year terms. In addition to base rent, beginning in January 1997, the Company must pay a contingent amount based upon annual changes in the consumer price index. The Company paid $30 million to the owner of the building in connection with this lease agreement which is being amortized on a straight−line basis over the life of the new lease.

The Company's other lease terms range from one to 19 years with certain options to renew. Certain lease agreements provide for escalation of payments which are based on fluctuations in certain published cost−of−living indices.

Future minimum rental payments under operating leases utilized by the Company having initial or remaining noncancellable lease terms in excess of one year at December 31, 2001 are as follows:

Year Ending December 31, (In thousands)	Operating Leases
2002	$ 89,635
2003	71,475
2004	49,001
2005	37,737
2006	29,640
Thereafter	245,610
Total minimum payments required	$ 523,098

Rental expense for the years ended December 31, 2001, 2000 and 1999 for all operating leases was $66.3 million, $47.5 million and $41.8 million, respectively. Contingent rentals included in the above rental expense for the years ended December 31, 2001, 2000 and 1999 were $1.5 million, $1.2 million and $0.9 million, respectively.

14. FAIR VALUE OF FINANCIAL INSTRUMENTS

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Cash and Cash Equivalents. The carrying amount approximates fair value, based on the short−term maturities of these instruments.

Investment Securities. The carrying amount approximates fair value, based on quoted market prices for the same or similar instruments.

Long−term Investments. The carrying amount approximates fair value, based on quoted market prices for the same or similar instruments.

Revolving Credit Facility. The carrying amount for the revolving credit facility approximates fair value as the underlying instruments have variable interest rates at market value.

Zero Coupon Convertible Subordinated Debentures. The fair value for the convertible debt is based upon quoted market prices. The carrying value is based on the face value adjusted for accretion of original issue discount.

6 3/8% Notes Due 2006. The fair value of the notes payable is based on quoted market prices. The carrying value is based on face value adjusted for the discount.

Interest Rate Swaps. The fair value of the interest rate swaps is based on its quoted market prices by the financial institutions which are the counterparties to the swaps.

Forward Exchange Contracts. The carrying value for forward exchange contracts represents the fair value of such contracts that exceed the fair value of the related foreign denominated bond position. The fair value of such contracts is determined by the counterparties to the contracts.

The carrying amounts and estimated fair values of the Company's financial instruments as of December 31, 2001 are summarized below:

	Carrying Amount	Estimated Fair Value
	(In thousands)	
Cash and cash equivalents	$ 1,028,476	$ 1,028,476
Investment securities	3,832,982	3,832,982
Long−term investments	124,611	124,611
Revolving credit facility	235,000	235,000
Zero Coupon Convertible Subordinated Debentures	153,887	185,280
6 3/8% Notes Due 2006	449,070	458,955
Interest rate swaps	(14,085)	(14,558)
Forward exchange contracts	775	775

15. HEDGING ACTIVITIES

In June 1998, the Financial Accounting Standards Board (the "FASB") issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). SFAS No. 133, as amended by SFAS Nos. 137 and 138, establishes the accounting and reporting standards for derivative instruments and for hedging activities. Upon adoption of SFAS No. 133, all derivatives must be recognized on the balance sheet at their then fair value. Any deferred gains and losses remaining on the balance sheet under previous hedge−accounting rules must be removed from the balance sheet and all hedging relationships must be designated anew and documented pursuant to the new accounting. The Company adopted SFAS No. 133 on January 1, 2001.

The Company maintains an interest rate risk management strategy that uses derivative instruments to minimize significant, unanticipated earnings fluctuations caused by interest rate volatility. The Company's goal is to maintain a balance between fixed and floating interest rates on its long−term debt.

By using derivative financial instruments to hedge exposures to changes in exchange rates and interest rates, the Company exposes itself to credit risk and market risk. Market risk is the adverse effect on the value of a financial instrument that results from a change in currency exchange rates or interest rates. The Company manages exposure to market risk associated with interest rate and foreign exchange contracts by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

15. HEDGING ACTIVITIES (Continued)

The Company uses interest rate swap agreements and foreign currency contracts to manage interest rate and foreign currency exposures. The principal objective of such contracts is to minimize the risks and/or costs associated with financial and investing activities. The Company does not use derivative financial instruments for speculative purposes. The counterparties to these contractual arrangements are major financial institutions with which the Company also has other financial relationships. These counterparties expose the Company to credit loss in the event of non performance. However, the Company does not anticipate non performance by the other parties.

Fair Value Hedges

As part of the Company's investment strategy to diversify its investment portfolio, the Company has invested in certain fixed maturity securities denominated in foreign currencies. In order to mitigate the foreign currency risk, the Company has entered into foreign currency derivative instruments. Gains and losses related to such instruments are recognized in the Company's income statement. The Company recognized a gain of $0.5 million and losses of $0.5 million and $1.9 million from such hedging activities for the years ended December 31, 2001, 2000 and 1999, respectively. As of December 31, 2001, the Company had liquidated its non−dollar foreign bond holdings and, as a result, entered into a hedge to offset the remaining currency hedge.

The transition provisions of SFAS No. 133 state that any gain or loss previously reported in accumulated other comprehensive income on a derivative that hedged an available−for−sale security, together with the gain or loss on the related security shall be reclassified to earnings as a cumulative effect type adjustment of both net income and accumulated other comprehensive income. On January 1, 2001, the Company recorded a transition adjustment as a charge to other income of approximately $0.3 million, net of tax, which represented a gain of $2.0 million on the available−for−sale bonds related to the Company's foreign exchange contracts partially offset by a loss of $1.7 million on the related hedges.

For the year ended December 31, 2001, the Company recognized a net loss of $1.2 million, included in other income on the consolidated income statement, which represented the ineffective portion of all the Company's fair value hedges. All components of each derivative's gain or loss were included in the assessment of hedge effectiveness.

Cash Flow Hedges

The Company uses interest rate swap agreements to reduce the impact of changes in interest rates on its floating rate debt under its revolving credit facility. The swap agreements are contracts to exchange variable−rate for fixed−rate interest payments without the exchange of the underlying notional amounts. During the year ended December 31, 2001, the Company recognized a net gain of $0.1 million reported in other income in the consolidated income statement, which represented the total ineffectiveness of all cash flow hedges.

The adoption of SFAS No. 133 resulted in an after−tax reduction in accumulated other comprehensive income of $4.2 million to recognize at fair value all derivatives that were designated as cash flow hedges as of January 1, 2001.

Events that are expected to occur over the next 12 months and will necessitate reclassifying the derivative losses into earnings relate primarily to the repricing of variable rate debt. The Company does

not expect that the amounts that will be reclassified will be material to the Company's financial condition or results of operations.

As of December 31, 2001 the Company had the following interest rate swap agreements in effect (notional amount in thousands):

Notional Amount	Strike Rate	Expiration Date
$150,000	6.99 %	October 17, 2003
$50,000	7.06 %	October 17, 2006

As of December 31, 2001, the Company had recognized net derivative liabilities related to such interest rate swap agreements and foreign currency contracts of $13.3 million.

16. CONTINGENCIES

From time to time in the ordinary course of business, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In June 2000, the California Medical Association filed a lawsuit in U.S. district court in San Francisco against BCC. The lawsuit alleges that BCC violated the RICO Act through various misrepresentations to and inappropriate actions against health care providers. In late 1999, a number of class−action lawsuits were brought against several of the Company's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, the Company was added as a party to Shane v. Humana, et al., a class−action lawsuit brought on behalf of health care providers nationwide. In addition to the RICO claims brought in the California Medical Association lawsuit, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the California Medical Association lawsuit, the Shane lawsuit and various other pending managed care class−action lawsuits against other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of the pretrial proceedings. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refile their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the California Medical Association filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. On May 9, 2001, Judge Moreno issued an order requiring that all discovery in the litigation be completed by December 2001, with the exception of discovery related to expert witnesses, which must be completed by March 15, 2002. In June 2001, the federal Court of Appeals for the 11th Circuit issued a stay of Judge Moreno's discovery order, pending a hearing before the Court of Appeals on the Company's appeal of its motion to compel arbitration (which had earlier been granted in part

and denied in part by Judge Moreno). The panel for the hearing was selected in December 2001. The hearing was held in January 2002 and, in March 2002, the Court of Appeals issued an opinion affirming Judge Moreno's earlier action with respect to the motion to compel arbitration.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against the Company and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class−action status.

In July 2001, two individual physicians seeking to represent a class of physicians, hospitals and other providers brought suit in the Circuit Court of Madison County, Illinois against HealthLink, Inc., which is now a subsidiary of the Company as a result of the RightCHOICE transaction. The physicians allege that HealthLink breached the contracts with these physicians by engaging in the practices of "bundling" and "down−coding" in its processing and payment of provider claims. The relief sought includes an injunction against these practices and damages in an unspecified amount. In March 2002, HealthLink was notified that the court intends to hold a hearing on class certification, although no formal date for such a hearing has been set. A similar lawsuit was brought by physicians (including one of the physicians in the case described above) in the same court in Madison County, Illinois, on behalf of a nationwide class of providers who contract with Blue Cross and Blue Shield plans against the Blue Cross and Blue Shield Association and another Blue Cross Blue Shield plan. The complaint recites that it is brought against those entities and their "unnamed subsidiaries, licensees, and affiliates," listing a large number of Blue Cross and Blue Shield plans, including "Alliance Blue Cross Blue Shield of Missouri." The plaintiffs also allege that the plans have systematically engaged in practices known as "short paying," "bundling," and "down−coding" in their processing and payment of subscriber claims. Blue Cross Blue Shield of Missouri has not been formally named or served as a defendant in this suit.

The financial and operational impact that these and other evolving theories of recovery will have on the managed care industry generally, or the Company in particular, is at present unknown.

Certain of such legal proceedings are or may be covered under insurance policies or indemnification agreements. Based upon information presently available, management of the Company believes that the final outcome of all such proceedings should not have a material adverse effect on the Company's results of operations, cash flows or financial condition.

17. REGULATORY REQUIREMENTS

Certain of the Company's regulated subsidiaries must comply with certain minimum capital or tangible net equity requirements in each of the states in which they operate. As of December 31, 2001, the Company and its regulated subsidiaries were in compliance with these requirements.

The ability of the Company's licensed insurance company subsidiaries to pay dividends is limited by the Departments of Insurance in their respective states of domicile. Generally, dividends in any 12−month period are limited to the greater of the prior year's statutory net income or 10% of statutory surplus. Larger dividends, classified as extraordinary, require a special request of the applicable Departments of Insurance. The maximum dividend payable in 2002 without prior approval by WellPoint's licensed insurance company subsidiaries (which do not include the Company's Blue Cross of California subsidiary) is estimated to be $220.6 million.

18. FISCAL INTERMEDIARY FUNCTION

Under an agreement with the BCBSA, the Company's wholly−owned subsidiary Blue Cross of California ("BCC") was previously contracted to administer Part A of Title XVIII of the Social Security Act (Medicare) in certain regions or for certain health care providers. The agreement was renewable annually unless terminated by the parties involved. As fiscal intermediary under the agreement, BCC made disbursements to providers for medical care from funds provided by the Federal Government and was reimbursed for these expenses incurred under the agreement. Effective December 1, 2000, BCC ceased to participate as a Medicare fiscal intermediary. BCC disbursed approximately $7.6 billion and $8.8 billion and received administrative fees of approximately $39.1 million and $40.7 million for the years ended December 31, 2000 and 1999, respectively. The reimbursement was treated as a direct recovery of general and administrative expenses.

With the acquisition of Cerulean, the Company is currently a participant in the aforementioned Medicare plan through its wholly−owned subsidiary Blue Cross and Blue Shield of Georgia, Inc. ("BCBSGA"). BCBSGA disbursed approximately $2.9 billion and received administrative fees of approximately $8.5 million from March 15, 2001, the acquisition date, to December 31, 2001.

19. BUSINESS SEGMENT INFORMATION

The Company has two reportable segments: the Large Employer Group business segment and the Individual and Small Employer Group business segment. The Large Employer Group and Individual and Small Employer Group segments provide a broad spectrum of network−based health plans, including HMOs, PPOs, POS plans, other hybrid plans and traditional indemnity products to large and small employers and individuals. The Company's senior and specialty businesses are included in the Corporate and Other segment.

The Company's management identified its reportable segments based upon the following factors: (1) the Company's organizational structure contains a Division President that oversees each of these segments, (2) the Company's Chief Operating Decision Maker (Chief Executive Officer) reviews the results of operations for each of the following segments and holds each Division President accountable for results, and (3) a Division President's overall compensation is based upon the related segment's results.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies and are consistent with generally accepted accounting principles with the exception of the exclusion of allocated corporate overhead to the reportable segments.

The following tables present segment information for the Large Employer Group and Individual and Small Employer Group for the years ended December 31, 2001, 2000 and 1999:

2001

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
		(In thousands)		
Premium revenue	$ 7,188,430	$ 3,583,839	$ 804,901	$ 11,577,170
Management services and other revenue	500,290	268	109,135	609,693
Total revenue from external customers	7,688,720	3,584,107	914,036	12,186,863
Intersegment revenues	19,724	—	(19,724)	—
Investment income	139,701	82,119	19,964	241,784
Interest expense	36,358	10,140	3,431	49,929
Depreciation and amortization expense	62,500	23,503	24,154	110,157
Income tax expense (benefit)	244,257	93,500	(53,921)	283,836
Segment net income (loss)	$ 347,495	$ 135,817	$ (68,566)	$ 414,746
Segment Assets	$ 3,714,081	$ 1,416,361	$ 2,341,691	$ 7,472,133

2000

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
		(In thousands)		
Premium revenue	$ 5,011,562	$ 3,030,503	$ 541,598	$ 8,583,663
Management services and other revenue	379,142	2,865	69,840	451,847
Total revenue from external customers	5,390,704	3,033,368	611,438	9,035,510
Intersegment revenues	12,375	(583)	(11,792)	—
Investment income	102,037	77,886	13,525	193,448
Interest expense	23,244	310	424	23,978
Depreciation and amortization expense	38,167	17,014	20,221	75,402
Income tax expense (benefit)	176,342	131,027	(85,343)	222,026
Segment net income (loss)	$ 210,221	$ 172,051	$ (39,985)	$ 342,287
Segment Assets	$ 2,323,129	$ 1,067,692	$ 2,113,885	$ 5,504,706

19. BUSINESS SEGMENT INFORMATION (Continued)

1999

	Large Employer Group	Individual & Small Employer Group	Corporate & Other	Consolidated
	(In thousands)			
Premium revenue	$ 3,889,032	$ 2,551,961	$ 455,864	$ 6,896,857
Management services and other revenue	367,060	4,579	57,697	429,336
Total revenue from external customers	4,256,092	2,556,540	513,561	7,326,193
Intersegment revenues	19,941	2,500	(22,441)	—
Investment income	98,410	53,627	7,197	159,234
Interest expense	20,949	278	(1,049)	20,178
Depreciation and amortization expense	36,829	14,641	13,328	64,798
Income tax expense (benefit)	145,973	105,347	(61,210)	190,110
Extraordinary gain / cumulative effect	(12,328)	(7,685)	1,346	(18,667)
Segment net income (loss)	$ 167,435	$ 134,828	$ (23,719)	$ 278,544
Segment Assets	$ 2,300,056	$ 998,060	$ 1,295,118	$ 4,593,234

As a result of the January 31, 2002 acquisition of RightCHOICE, the organizational structure of the Company has changed effective February 1, 2002. As a result of these changes, the Company currently anticipates that its Quarterly Report on Form 10−Q for the quarterly period ending March 31, 2002 (and subsequent filings under the Securities Exchange Act of 1934) will reflect the following two reportable segments: Health Care business and Specialty business.

20. COMPREHENSIVE INCOME

The following summarizes comprehensive income reclassification adjustments included in the statements of changes in stockholders' equity:

	Year Ended December 31,		
	2001	2000	1999
	(In thousands)		
Holding gain (loss) on investment securities arising during the period (net of tax expense of $12,485, $53,624 and tax benefit of $6,295, respectively)	$ 21,051	$ 83,691	$ (9,847)
Holding gain (loss) related to foreign exchange transactions (net of tax expense of $222 and tax benefit of $1,013, respectively)	—	350	(1,584)
Net change in pension liability (net of tax benefit of $15,640)	(22,506)	—	—
Add: Reclassification adjustment for realized losses on investment securities (net of tax benefit of $2,420, $10,004 and $10,442, respectively)	(3,482)	(15,646)	(16,332)
Reclassification adjustment related to foreign exchange gains (losses) on investment securities (net of tax benefit of $163, tax benefit of $204 and tax expense of $1,160, respectively)	(262)	(319)	1,815
Net gain (loss) recognized in other comprehensive income (net of tax benefit of $5,738, tax expense of $43,638 and tax benefit of $16,590, respectively)	$ (5,199)	$ 68,076	$ (25,948)

21. EXTRAORDINARY GAIN

On October 6, 1999, the Board of Directors authorized the repurchase of some or all of the Company's Debentures for cash. During the year ended December 31, 1999, the Company repurchased $81.0 million aggregate principal amount at maturity of the Company's Debentures at a total purchase price of $49.8 million. This repurchase resulted in an extraordinary gain of $1.9 million, or $0.01 per share assuming full dilution (per share amount reflects the two−for−one stock split which occurred on March 15, 2002), net of tax expense totaling $1.2 million.

22. SUBSEQUENT EVENTS

6 3/8% Notes due 2012

On January 16, 2002, the Company issued $350.0 million aggregate principal amount at maturity of 6 3/8% Notes due January 15, 2012 (the "2002 Notes"). Interest on the 2002 Notes will accrue from January 16, 2002, and will be payable on January 15 and July 15 of each year, beginning on July 15, 2002. The net proceeds of this offering totaled approximately $348.9 million. The net proceeds from the sale of the 2002 Notes were used for the financing of the RightCHOICE merger discussed below.

RightCHOICE Acquisition

On January 31, 2002 WellPoint completed its merger, through its wholly owned subsidiary, RWP Acquisition Corp., with RightCHOICE Managed Care, Inc. ("RightCHOICE"), the parent company of Blue Cross and Blue Shield of Missouri, Inc., which serves approximately 2.2 million medical members. Under the terms of the transaction, total consideration paid to all holders of RightCHOICE common stock and holders of employee stock options in the merger was $379.0 million in cash and 8.3 million shares (on a pre−stock split basis) of WellPoint Common Stock. The Company currently expects that approximately 6.1 million shares (on a pre−stock split basis) will be issued from treasury stock and the remaining 2.2 million shares (on a pre−stock split basis) will be newly issued shares of WellPoint Common Stock. The total purchase price was approximately $1.4 billion.

Open Tax Issue relating to the WellPoint Recapitalization

During the quarter ended September 30, 1998 the Company received a private letter ruling from the IRS with respect to the treatment of certain payments made at the time of the Recapitalization and the acquisition of the commercial operations of BCC. The ruling allowed the Company to deduct as an ordinary and necessary business expense the $800 million cash payment made by BCC in May 1996 to one of two newly formed charitable foundations. As a result of and in reliance on the ruling, the Company experienced a reduction in its income tax expense of $85.5 million and the Company reduced its goodwill resulting from the Recapitalization by $194.5 million during the year ended December 31, 1998. The Company filed for refund claims of approximately $198.6 million of previous year income tax payments and reduced income tax payments during 1998 and 1999 by approximately $81.4 million. In August 1999, the Company received a cash refund (including applicable accrued interest) of approximately $183.0 million, which was reflected in the statement of cash flows for such year. The Company has refund claims pending of approximately $39.3 million.

In March 2002, the Company received a letter from the IRS notifying the Company that the IRS was considering revoking the September 1998 private letter ruling. The letter stated that the IRS was considering, in essence, reversing its earlier position and concluding that the $800 million payment was not an ordinary and necessary business expense. The letter further stated that the IRS was withdrawing

the private letter ruling and that the Company could no longer rely on the private letter ruling. Under Section 7805(b) of the Code, the IRS has discretionary authority to limit the retroactive effect of any revocation of a letter ruling. The Company has submitted a written request for such relief under Section 7805(b). According to regulations promulgated by the United States Treasury, such relief will be granted whenever a taxpayer meets all of five specified criteria, including that the taxpayer has relied in good faith on an earlier ruling and that the revocation of the ruling would be to the detriment of the taxpayer. The Company believes that it meets substantially all of these criteria. Therefore, although no assurances can be given, the Company currently expects that such relief will be granted. The Company's request for relief under Section 7805(b) is being made without prejudice to the Company's right to subsequently argue that the $800 million cash payment should continue to be treated as an ordinary and necessary business expense under the Code.

23. PENDING ACQUISITION

On November 20, 2001, WellPoint entered into a definitive agreement to acquire CareFirst, Inc. ("CareFirst"). CareFirst is a not−for−profit health care company which, along with its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products, direct health care and administrative services to more than three million people in Maryland, Delaware, the District of Columbia and Northern Virginia. CareFirst operates through three wholly owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., doing business under the name CareFirst BlueCross BlueShield, and Blue Cross Blue Shield of Delaware. Under the terms of the acquisition agreement, a wholly owned subsidiary of the Company will merge with and into CareFirst. As a result of the merger, the outstanding shares of common stock of CareFirst will be converted into the right to receive an aggregate purchase price of $1.3 billion. Before the CareFirst acquisition is completed, CareFirst and its subsidiaries will convert from their current status as not−for−profit corporations into for−profit, stock corporations. As part of this conversion, CareFirst will issue 100% of its outstanding common stock to charitable foundations established according to applicable law. The conversion will require the approval of insurance regulators and the transaction is subject to the receipt of a private letter ruling from the IRS that the conversion of CareFirst will constitute a tax−free reorganization and that gain or loss recognized by the holders of CareFirst stock in the merger will not be subject to unrelated business income tax. The conversion and regulatory approval process is currently expected to take 18 to 24 months from the date of signing of the definitive agreement. The acquisition is expected to close in 2003.

24. RESOLUTION OF OPEN TAX ISSUE RELATING TO THE WELLPOINT RECAPITALIZATION (UNAUDITED) SUBSEQUENT TO THE DATE OF THE INDEPENDENT AUDITOR'S REPORT

On April 9, 2002, the Company received a letter from the IRS notifying the Company that its request for relief under Section 7805(b) of the Code had been granted and that the September 1998 private letter ruling would not be revoked on a retroactive basis. Based on this April 9, 2002 letter, the Company intends to continue to rely on the September 1998 private letter ruling in its treatment of the $800 million cash payment made in May 1996. (See Note 22 for further discussion)

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SIGNATURES
WellPoint Health Networks Inc. Notes to Consolidated Financial Statements

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Exhibit 23.1

CONSENT OF INDEPENDENT ACCOUNTANTS

We hereby consent to the incorporation by reference in the Registration Statements on Form S−8 (File Nos. 333−05111, 333−33013, 333−42073, 333−81687, 333−90791, 333−37958, 333−55314, 333−81872 and 333−83462), Form S−3 (File No. 333−08519) and Form S−4 (File No. 333−73382) of WellPoint Health Networks Inc. of our report dated January 31, 2002, except Note 3 as to which the date is March 15, 2002, and Note 22 as to which the date is March 18, 2002, relating to the financial statements, which appears in this Form 10−K/A.

PricewaterhouseCoopers LLP

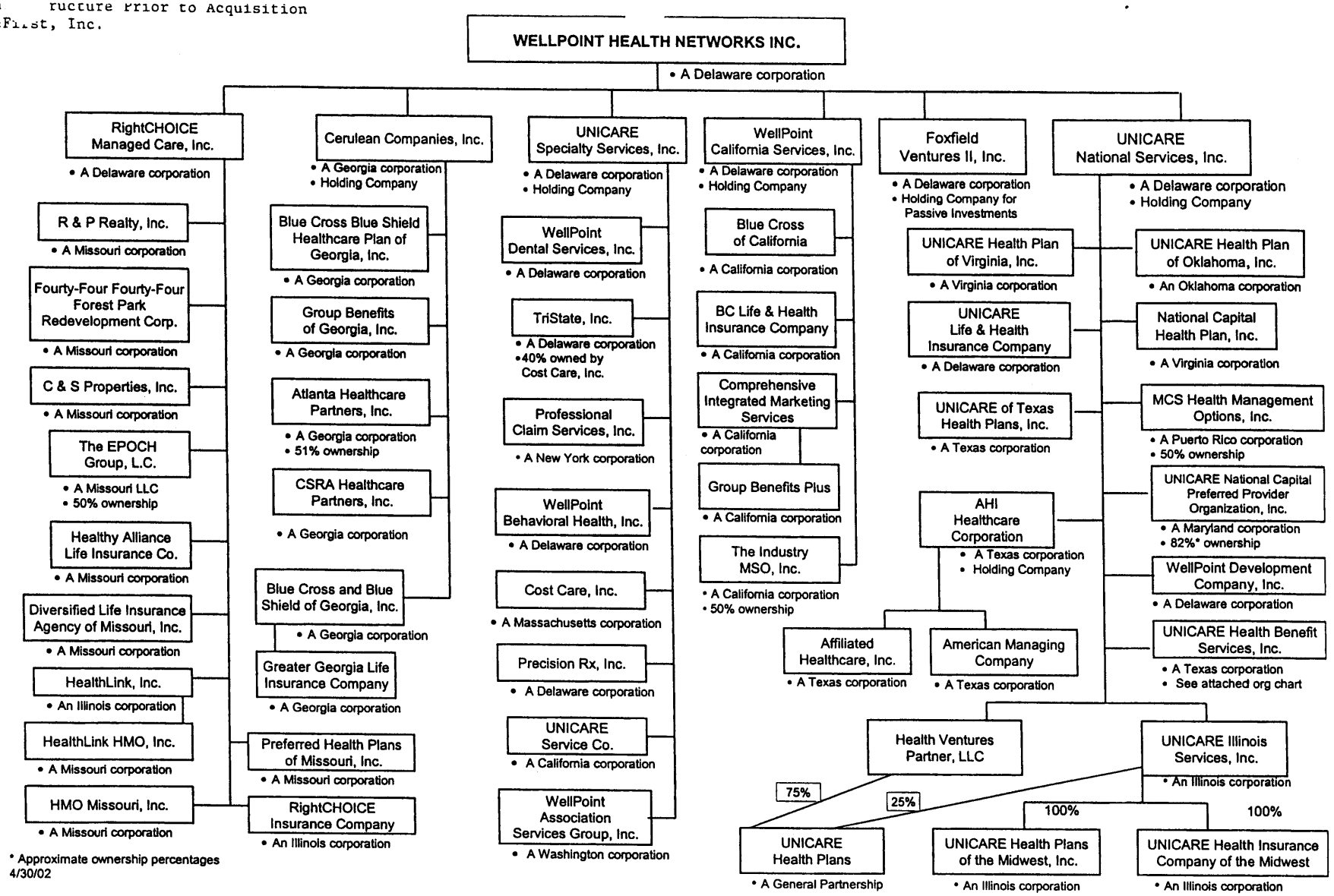
Los Angeles, California
April 29, 2002

QuickLinks

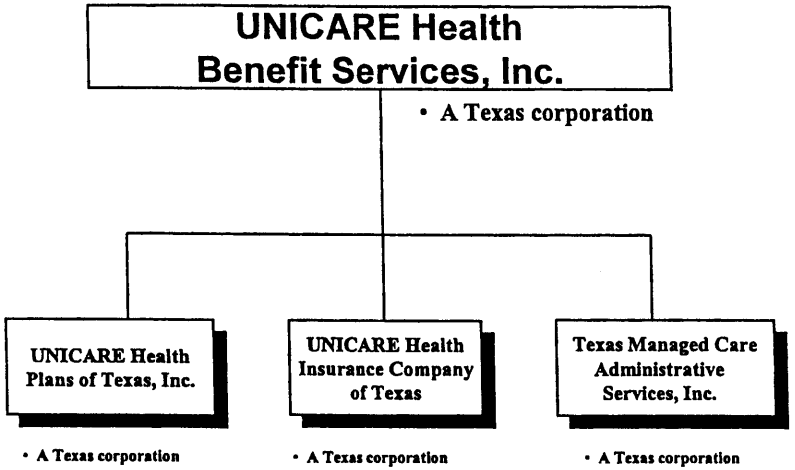
CONSENT OF INDEPENDENT ACCOUNTANTS

Created by 10KWizard Technology www.10KWizard.com

Corpora ructure Prior to Acquisition
of CareFirst, Inc.



* Approximate ownership percentages 4/30/02



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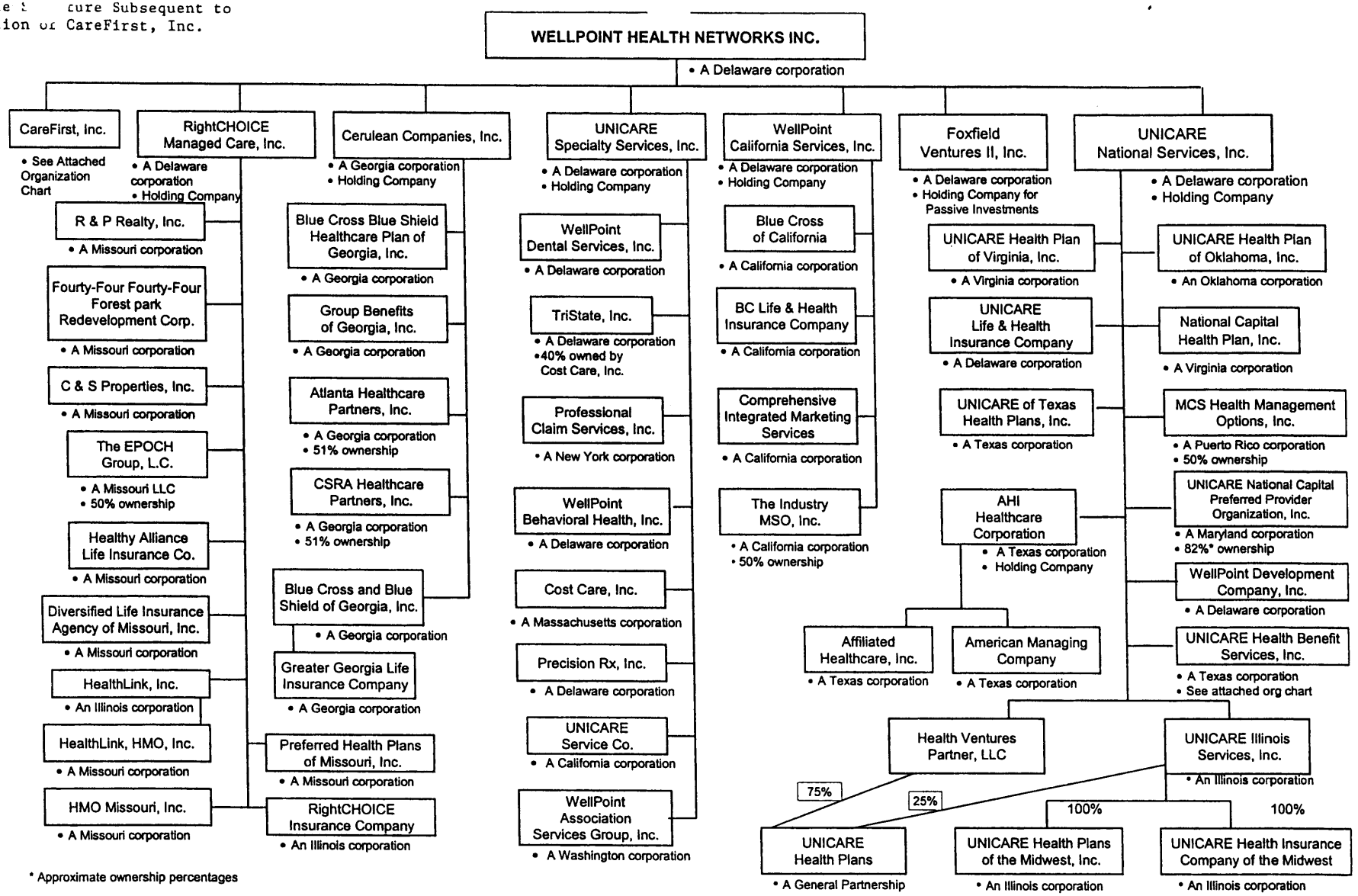
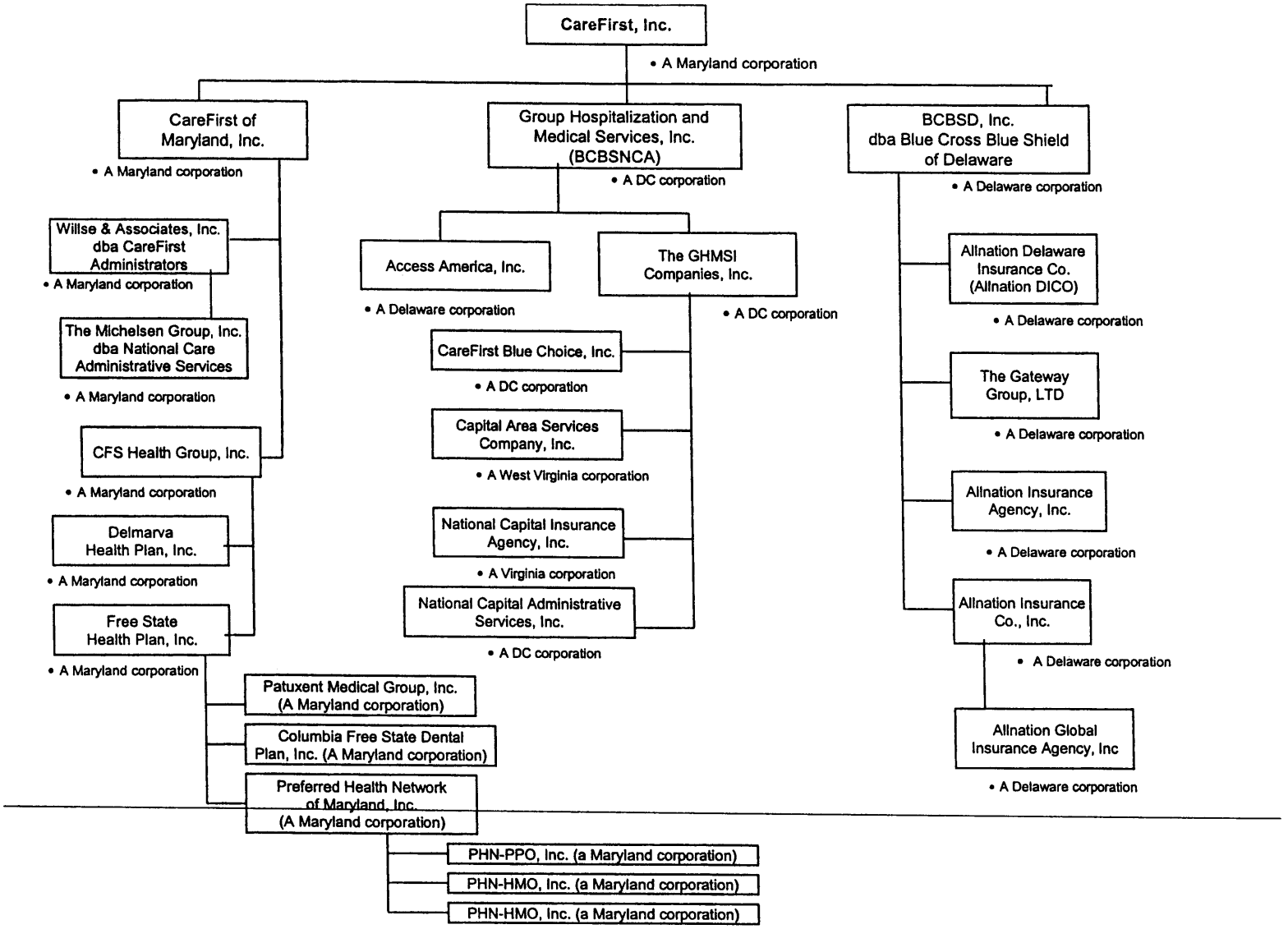
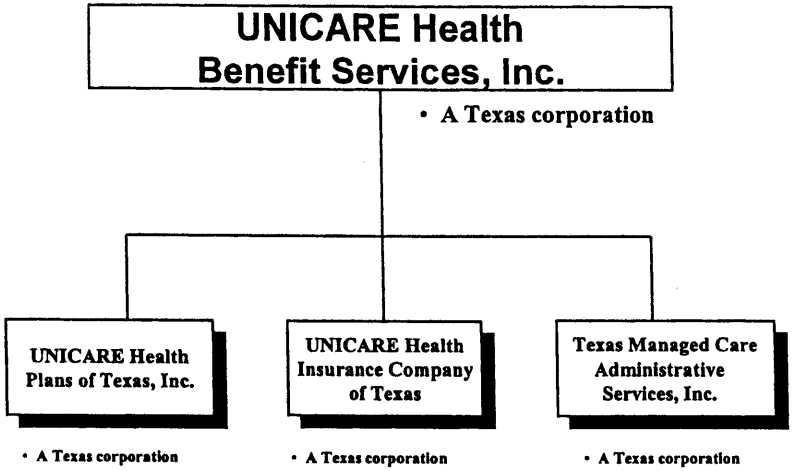
Corporate Structure Subsequent to Acquisition of CareFirst, Inc.



* Approximate ownership percentages


CareFirst, Inc.
• A Maryland corporation
CareFirst of Maryland, Inc.
• A Maryland corporation
Group Hospitalization and Medical Services, Inc. (BCBSNCA)
• A DC corporation
BCBSD, Inc. dba Blue Cross Blue Shield of Delaware
• A Delaware corporation
Willse & Associates, Inc. dba CareFirst Administrators
• A Maryland corporation
The Michelsen Group, Inc. dba National Care Administrative Services
• A Maryland corporation
CFS Health Group, Inc.
• A Maryland corporation
Delmarva Health Plan, Inc.
• A Maryland corporation
Free State Health Plan, Inc.
• A Maryland corporation
Access America, Inc.
• A Delaware corporation
The GHMSI Companies, Inc.
• A DC corporation
CareFirst Blue Choice, Inc.
• A DC corporation
Capital Area Services Company, Inc.
• A West Virginia corporation
National Capital Insurance Agency, Inc.
• A Virginia corporation
National Capital Administrative Services, Inc.
• A DC corporation
Allnation Delaware Insurance Co. (Allnation DICO)
• A Delaware corporation
The Gateway Group, LTD
• A Delaware corporation
Allnation Insurance Agency, Inc.
• A Delaware corporation
Allnation Insurance Co., Inc.
• A Delaware corporation
Allnation Global Insurance Agency, Inc
• A Delaware corporation
Patuxent Medical Group, Inc. (A Maryland corporation)
Columbia Free State Dental Plan, Inc. (A Maryland corporation)
Preferred Health Network of Maryland, Inc. (A Maryland corporation)
PHN-PPO, Inc. (a Maryland corporation)
PHN-HMO, Inc. (a Maryland corporation)
PHN-HMO, Inc. (a Maryland corporation)



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FIRST AMENDMENT TO 364-DAY CREDIT AGREEMENT

THIS FIRST AMENDMENT TO 364-DAY CREDIT AGREEMENT (this "Amendment"), dated as of March 29, 2002, is entered into among **WELLPOINT HEALTH NETWORKS INC.**, a Delaware corporation (the "Borrower"), the Lenders identified on the signature pages hereto (the "Lenders"), **BANK OF AMERICA, N.A.**, as administrative agent for the Lenders (in such capacity, the "Administrative Agent") and **JPMORGAN**, a division of Chase Securities Inc., as syndication agent (in such capacity, the "Syndication Agent"). Terms used but not otherwise defined herein shall have the meanings provided in the Credit Agreement described below.

W I T N E S S E T H

WHEREAS, the Borrower, the Lenders, the Administrative Agent and the Syndication Agent entered into that certain Credit Agreement dated as of March 30, 2001 (the "Existing Credit Agreement"); and

WHEREAS, the Borrower has requested to extend the Commitment Termination Date for an additional 364 day period, and certain Lenders party to the Existing Credit Agreement have agreed to extend their respective Commitments and amend the Existing Credit Agreement in accordance with such request and as provided herein.

NOW, THEREFORE, in consideration of the agreements hereinafter set forth, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

PART 1
DEFINITIONS

SUBPART 1.1 Certain Definitions. Unless otherwise defined herein or the context otherwise requires, the following terms used in this Amendment, including its preamble and recitals, have the following meanings:

"Amended Credit Agreement" means the Existing Credit Agreement as amended hereby.

"Amendment No. 1 Effective Date" is defined in Subpart 3.1.

SUBPART 1.2 Other Definitions. Unless otherwise defined herein or the context otherwise requires, terms used in this Amendment, including its preamble and recitals, have the meanings provided in the Existing Credit Agreement.

PART 2
AMENDMENTS TO EXISTING CREDIT AGREEMENT

Effective on (and subject to the occurrence of) the Amendment No. 1 Effective Date, the Existing Credit Agreement is hereby amended in accordance with this Part 2.

SUBPART 2.1 Amendments to Section 1.01. Section 1.01 of the Credit Agreement is hereby amended in the following respects:

(a) The definition of "Commitment Termination Date" is hereby amended in its entirety to read as follows:

"Commitment Termination Date" shall mean the date 364 days following March 29, 2002.

(b) The definition of "Maturity Date" is hereby amended in its entirety to read as follows:

"Maturity Date" shall mean the date 364 days following the Commitment Termination Date.

SUBPART 2.2 Amendments to Schedule 2.01. Schedule 2.01 of the Existing Credit Agreement is hereby replaced with Schedule 2.01 attached hereto.

PART 3
CONDITIONS TO EFFECTIVENESS

SUBPART 3.1 Amendment No. 1 Effective Date. This Amendment shall be and become effective as of the date hereof (the "Amendment No. 1 Effective Date") when all of the conditions set forth in this Part III shall have been satisfied, and thereafter this Amendment shall be known, and may be referred to, as the "Amendment".

SUBPART 3.2 Execution of Counterparts of Amendment. The Administrative Agent shall have received counterparts (or other evidence of execution, including telephonic message, satisfactory to the Administrative Agent) of this Amendment, which collectively shall have been duly executed on behalf of each of the Borrower, the Lenders, the Administrative Agent and the Syndication Agent.

SUBPART 3.4 Fees and Expenses. The Borrower has paid all fees and expenses incurred in connection with the negotiation, preparation, execution and delivery of this Amendment and the other transactions contemplated herein including, without limitation, the legal fees and expenses of Moore & Van Allen, counsel to the Administrative Agent.

SUBPART 3.5 Other Items. The Administrative Agent shall have received such other documents, agreements or information which may be reasonably requested by the Administrative Agent.

PART 4
MISCELLANEOUS

SUBPART 4.1 Representations and Warranties. Each of the Borrower and the Guarantors hereby represents and warrants to the Administrative Agent and the Lenders that, after giving effect to this Amendment, (a) no Default or Event of Default exists under the Credit Agreement and (b) the representations and warranties set forth in Section 3 of the Existing Credit Agreement are, subject to the limitations set forth therein, true and correct in all material respects as of the date hereof (except for those which expressly relate to an earlier date).

SUBPART 4.2 Reaffirmation of obligations. The Borrower hereby ratifies the Credit Agreement and acknowledges and reaffirms (a) that it is bound by all terms of the Credit Agreement applicable to it and (b) that it is responsible for the observance and full performance of its respective obligations under the Credit Agreement.

SUBPART 4.3 Cross-References. References in this Amendment to any Part or Subpart are, unless otherwise specified, to such Part or Subpart of this Amendment.

SUBPART 4.4 Instrument Pursuant to Existing Credit Agreement. This Amendment is executed pursuant to the Existing Credit Agreement and shall (unless otherwise expressly indicated therein) be construed, administered and applied in accordance with the terms and provisions of the Existing Credit Agreement.

SUBPART 4.5 References in Other Credit Documents. At such time as this Amendment shall become effective pursuant to the terms of Subpart 3.1, all references to the "Credit Agreement" shall be deemed to refer to the Credit Agreement as amended by this Amendment.

SUBPART 4.6 Counterparts/Telecopy. This Amendment may be executed by the parties hereto in several counterparts, each of which shall be deemed to be an original and all of which shall constitute together but one and the same agreement. Delivery of executed counterparts of the Amendment by telecopy shall be effective as an original and shall constitute a representation that an original shall be delivered.

SUBPART 4.7 Governing Law. THIS AMENDMENT SHALL BE DEEMED TO BE A CONTRACT MADE UNDER AND GOVERNED BY THE INTERNAL LAWS OF THE STATE OF NEW YORK (INCLUDING SECTIONS 5-1401 AND 5-1402 OF THE NEW YORK GENERAL OBLIGATIONS LAW, BUT EXCLUDING ALL OTHER CHOICE OF LAW AND CONFLICTS OF LAW RULES).

SUBPART 4.8 Successors and Assigns. This Amendment shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

SUBPART 4.9 General. Except as amended hereby, the Existing Credit Agreement and all other Credit Documents shall continue in full force and effect.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment to Credit Agreement as of the date first above written.

BORROWER:

WELLPOINT HEALTH NETWORKS INC.,
a Delaware corporation

By: _____
Name: PR-LIQUID KRETSCHMER
Title: VP, TREASURER

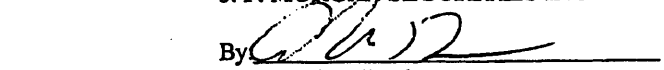
ADMINISTRATIVE AGENT:

BANK OF AMERICA, N.A.

By: _____
Name: Joseph L. Corah
Title: Principal

SYNDICATION AGENT:

J. P. MORGAN SECURITIES INC

By: 

Name: Andrew Brode

Title: Vice President

LENDERS:

BANK OF AMERICA, N.A.

By:_____
Name: Joseph A. Corah
Title: Principal

[signature pages continue]

JPMORGAN CHASE BANK

By: _____
Name: Dawn Lee Lum
Title: Vice President

[signature pages continue]

THE INDUSTRIAL BANK OF JAPAN, LIMITED

By: V. Timiraos

Name: VICENTE L. TIMIRAOS
Title: JOINT GENERAL MANAGER

[signature pages continue]

BANK ONE, N.A.

By: Vincent K. Kelly
Name: Vincent K. Kelly
Title: Managing Director

[signature pages continue]

CITICORP USA, INC.

By: _____
Name: STEPHEN P. ZWICK, V. P.
Title:

[signature pages continue]

MELLON BANK, N.A.

By: /Marsha Wicker
Name: MARSHA WICKER
Title: VP

[signature pages continue]

CREDIT SUISSE FIRST BOSTON,
CAYMAN ISLANDS BRANCH

By:_____
Name: WILLIAM S. LUTKINS
Title: DIRECTOR

By:_____
Name: Robert N. Finney
Title: Managing Director

[signature pages continue]

THE BANK OF NEW YORK

By:_____
Name: Rebecca K. Levine
Title: Vice President

SUNTRUST BANK

By: _____
Name: W. Brooks Hubbard
Title: Vice President

[signature pages continue]

UBS AG, STAMFORD BRANCH

By: _____
Name: Wilfred V. Saint
Title: Associate Director

By: _____
Name: Juan Zuniga
Title: Associate Director

[signature pages continue]

DEUTSCHE BANK AG
New York and/or Cayman Islands Branches

By: _____
Name: Scottye D. Lindsey
Title: Vice President

By: _____
Name: Marguerite Sutton
Title: Vice President

[signature pages continue]

LEHMAN COMMERCIAL PAPER INC.

By:_____
Name: Francis J. Chang
Title: Vice President

[signature pages continue]

WACHOVIA BANK, N.A.

By: _____
Name: Daniel J. Norton
Title: Director

[signature pages continue]

KBC BANK, N.V.

By: _____
Name: RAYMOND F. MURRAY
Title: FIRST VICE PRESIDENT

ROBERT SNAUFFER
FIRST VICE PRESIDENT

[signature pages continue]

FLEET NATIONAL BANK

By: _____
Name: Gordon B. Coughlin
Title: Vice President

[signature pages continue]

BNP PARIBAS

By:
Name: C. Bettles
Title: Managing Director

By:
Name: Janice S. H. Ho
Title: Director

[signature pages continue]

SUMITOMO MITSUI BANKING CORPORATION

By:_____
Name: Al Galluzzo
Title: Senior Vice President

[signature pages continue]

SOCIETE GENERALE

By: _____

Name: RICHARD BERNAL

Title: Director
Corporate Banking

CREDIT LYONNAIS NEW YORK BRANCH

By:_____
Name: Bernard Weymuller
Title: Senior Vice President

[signature pages continue]

BANCA DI ROMA

By: _____

Name: Luca Balestra (#25050)

Title: Senior Vice President and Manager

By: _____

Name: Richard G. Dietz (# 97271)

Title: Vice President

SCHEDULE 2.01

COMMITMENTS
(364-Day Credit Agreement)

Lender	Commitment Amount	Commitment Percentage
Bank of America, N.A.	$20,625,000	8.250000000%
The Chase Manhattan Bank	$20,625,000	8.250000000%
The Industrial Bank of Japan, Limited	$15,000,000	6.000000000%
Bank One, N.A.	$15,000,000	6.000000000%
Citicorp USA, Inc.	$15,000,000	6.000000000%
Mellon Bank, N.A.	$12,500,000	5.000000000%
Credit Suisse First Boston	$12,500,000	5.000000000%
The Bank of New York	$12,500,000	5.000000000%
SunTrust Bank	$12,500,000	5.000000000%
UBS AG, Stamford Branch	$12,500,000	5.000000000%
Deutsche Bank AG	$12,500,000	5.000000000%
Lehman Commercial Paper Inc.	$12,500,000	5.000000000%
Wachovia Bank, N.A.	$12,500,000	5.000000000%
KBC Bank, N.V.	$12,500,000	5.000000000%
Fleet National Bank	$10,625,000	4.250000000%
BNP Paribas	$10,625,000	4.250000000%
The Sumitomo Bank, Limited	$8,750,000	3.500000000%
Societe Generale	$8,750,000	3.500000000%
Credit Lyonnais New York Branch	$6,250,000	2.500000000%
Banca Di Roma	$6,250,000	2.500000000%
Total:	$250,000,000.00	100.000000000%

IDENTIFYING OPTIONS FOR USING CHARITABLE ASSETS TO IMPROVE HEALTH IN THE DISTRICT OF COLUMBIA

Prepared For

CareFirst, Inc.

by

Jack A. Meyer
Emily K. Waldman
New Directions for Policy
Washington, D.C.

August 2, 2002

EXECUTIVE SUMMARY

The creation of a charitable foundation from the District of Columbia's share of the proceeds from the conversion and sale of CareFirst, Inc. presents the District with an historic opportunity. For a variety of reasons, Washington, D.C. has relatively few foundations whose missions and activities are local in nature, as compared to other cities of its size and vitality. This new foundation would not only be the first foundation established since the early 1990's that was dedicated to the health and well-being of the city's residents, it would be one of the largest of its kind in the District. As such, it would provide the citizens of the District with the opportunity and resources to address a number of pressing health care needs.

This paper, presents a menu of policy options that could be pursued using the charitable assets generated by the proposed conversion and merger. The first section of the paper briefly presents a series of health indicators in the District and explains concerns that have been voiced about the health care delivery system. The key findings are that:

(1) The District has a substantially higher incidence of a number of diseases and illnesses than the nation as a whole; and

(2) Many residents of the District lack a medical home and access to affordable and timely primary and preventive care.

This background section also presents an update on some of the more recent developments concerning health care in the District, such as the restructuring of D.C. General Hospital and the creation of the D.C. Healthcare Alliance.

The bulk of this paper then concentrates on identifying opportunities for improving the health care system and health outcomes in the District, including specific examples of activities that would help achieve these improvements and outcomes that could be funded by a foundation. The size of the foundation would be more than sufficient to fund a number of activities. Moreover, the potential improvements and outcomes outlined in this paper are both realistic and achievable, depending on the level of resources ultimately committed to addressing them. The menu of policy options is organized into five broad categories, as follows:

- ***Expansions in public and private coverage.*** Included here, among other things, are tax preferences for employers and workers and measures such as a high-risk insurance pool or a

purchasing cooperative to assist people who, for reasons related to their medical conditions or the small size of their employers, face particularly high premiums.

- ***Strengthening the health care safety net.*** Included are ideas about reallocating funds within the health system to address unmet needs and direct service outreach strategies.
- ***Enhanced health initiatives and disease management strategies.***
- ***Improved access to prescription drugs*** for low-income District residents.
- ***New research and policy activities*** that would help the city coordinate various grant initiatives and leverage funds more effectively.

The purpose of this paper is to inform the Commissioner's review of the proposed conversion. Beyond that, it is CareFirst's desire that this paper will serve to generate some discussion around these policy options and the important public policy issues raised by the potential receipt of hundreds of millions of dollars by the District for charitable purposes. Of course, the charitable foundation created from the conversion and sale of CareFirst, Inc. to WellPoint would be completely separate from CareFirst and WellPoint; any decisions regarding the specific allocation of funds by the foundation would be made independently of both health plans, and would be subject to public review and discussion.

STATEMENT OF PURPOSE AND GOAL

In his letter dated May 21, 2002, Commissioner Mirel requested that the Draft Amended and Restated Application address and explain "for what specific purposes [the charitable assets] should be used upon conversion," among other things.

In accordance with the Commissioner's request, CareFirst presents the following menu of specific purposes for which charitable assets could be used to improve the health of the residents of the District of Columbia. This paper is not intended to specify an exact course of action. This would be premature. Any decisions about the specific allocation of funds would be made by the foundation, without input from CareFirst or WellPoint, but after public discussion and debate, as well as input from stakeholders and elected officials.

In laying out various options available to the District, the following paper first presents information about the health of the District's residents, ongoing challenges and threats to public health and unfolding changes in the health care delivery system. The menu of policy options is organized into five categories: public and private coverage expansion strategies; ways to strengthen the health care safety net; health initiatives and disease management strategies; options related to prescription drugs; and research and policy activities. At the end of each category are some suggestions for fundable activities that could provide some guidelines for a conversion foundation.

STATEMENT OF THE PROBLEM

The charitable assets generated by the proposed conversion and merger would provide the District with the opportunity and resources to address a number of pressing health care needs. The following section outlines some of those health care needs and identifies some of the major problems with the delivery system in the District.

Health Status

Residents of the District of Columbia generally have a higher incidence of health risk factors and disease than the United States as a whole (see Table 1). While there have been improvements in some areas, such as teen pregnancy and infant mortality,[1] and the District does have a lower rate of cerebrovascular disease than the nation as a whole, there are still many opportunities for improvement. For example, *Healthy People 2010* lays out a series of targeted health improvement goals, and those objectives could be used as a benchmark to guide some of the options surrounding health care in the District. The District has also prepared a report based on *Healthy People 2010* that identifies the areas in greatest need of health status improvement for District residents, with a particular focus on eliminating health disparities among racial and ethnic minority populations.[2]

[1] The rate of births to women under age 20 fell from 17.8 percent in 1990 to 15.3 percent in 1998 and the infant mortality rate per 1,000 live births dropped from 23.1 in 1989 to 12.5 in 1998 (although there was a slight increase in 1999 to 15.0 as noted in Table 1). See District of Columbia, *Healthy People 2010 Plan: A Strategy for Better Health.* September 2000.

[2] District of Columbia, *Healthy People 2010 Plan: A Strategy for Better Health.* September 2000.

Table 1. Health Indicators throughout the Life Span: Comparison of District of Columbia Residents to United States Population, 1999

Indicator	District of Columbia	United States
Percent of births with prenatal care beginning in the first trimester	70.6	83.2
Low birth weight: percent of live births	13.3	7.6
Infant mortality rate per 1,000 live births	15.0	7.1
Deaths from heart disease*	286.5	265.9
Deaths from cancer*	260.5	201.6
Deaths from cerebrovascular disease*	55.3	61.4
Deaths from HIV/AIDS*	49.3	5.4
Deaths from hypertension*	43.2	6.2
Deaths from diabetes*	43.0	25.1

*Crude death rate per 100,000 estimated population.

Table Source: District of Columbia Department of Health, State Center for Health Statistics Administration, Vital Statistics Data Sheet, 1999 (includes both District and U.S. data).

Condition of the Health Care Delivery System

To improve these health indicators, the gaps, deficiencies, and imbalances in the District of Columbia's health care system need to be addressed.[3] One of the key problems in the District is the lack of community-based medical homes for many of the city's uninsured and underserved residents.[4]

Background on Recent Developments

About two years ago, the Mayor decided to address the problems plaguing the health care system and D.C. General Hospital. First, he appointed a Health Care System Development Commission to develop recommendations and an implementation plan for changes to the health care system in the District. Following the Commission's work, a series of public forums, and much discussion among stakeholders and policy makers in the District, the city decided to fundamentally restructure the health care delivery system. One of the major pieces of the reform was to shrink and restructure

[3] Much of the following discussion is based on background research done for the Health Care System Development Commission, some of which appears in the District of Columbia's report, *Strategies for Change*. Health Care System Development Commission. Final Report. December 2000. See also *Improving Health Care Access for the Poor: A Case Study of the Washington, D.C. Public Health Care Systems Reform* presented at "Managing Health Systems for Better Health: The Stewardship Function of Health Ministries," Europe and the Americas Forum on Health Sector Reform, Malaga, Spain, February 24-27, 2002 (IESE and the World Bank).

[4] "Medical home" is defined as an individual's regular source of primary and preventive care that also provides an entry point to access diagnostic testing, hospital services, and other necessary and appropriate health care services.

D.C. General hospital, the major safety net hospital in the city and the focus of public dollars expended on healthcare (other than for Medicaid).

About four years prior to this, the Public Benefit Corporation (PBC), a quasi-public entity, had been created by the D.C. City Council in August of 1996 to oversee D.C. General Hospital, the public health clinics, and the school health system. While the PBC was created to oversee an integrated delivery system, the focus of the PBC remained on D.C. General, which was experiencing serious financial problems and drawing large subsidies from the city to stay solvent. Although patients who were part of the PBC system did generally have access to a range of primary, secondary and tertiary care, there remained many uninsured District residents who still did not have adequate access to care.

Many of the health indicators in the District, which were often well below national averages as noted above, showed that District health needs would be better met with better access to primary and preventive care. In addition, with the introduction of Medicaid managed care in the District and the shift from a focus on hospital-based services to more primary and preventive care, the need for hospital care declined and the need for a community-based primary care system became more evident. Faced with concerns about how to continue to fund D.C. General, and with a desire to focus public dollars on primary care, the city decided to fundamentally restructure D.C. General hospital and create the D.C. Healthcare Alliance.

Creation of the D.C. Healthcare Alliance

The D.C. Healthcare Alliance is a new program intended to provide a medical home and continuity of care for much of the city's indigent population.[5] Uninsured District residents with incomes at or below 200 percent of the federal poverty level are eligible to enroll. Alliance enrollees are eligible to receive primary care, specialty care, acute care and ancillary care services, and there are no co-payments or premiums required.

On April 30, 2001, the contract between the District and the D.C. Healthcare Alliance was finalized, and over the course of the next several months, health services previously provided by the PBC were shifted to Greater Southeast Community Hospital, Unity Health Care, Children's National Medical Center, and the George Washington University Hospital. Greater Southeast is the lead

organization in the Alliance, providing the bulk of hospital services and managing the day-to-day operations of the Alliance; Unity Health Care (a federally qualified primary care provider with sites across the city) oversees the six community health centers previously run by the PBC; Children's National Medical Center provides pediatric inpatient and ambulatory services and manages the school health program; and George Washington Hospital provides trauma services and tertiary care to supplement what is offered by Greater Southeast. While most services at D.C. General were closed, the hospital has continued to provide some emergency, urgent care, and outpatient services, and provides intake and referral for the Alliance. In addition, Greater Southeast Community Hospital has contracted with Chartered Healthcare Plan, a managed care organization, to provide administrative services, such as enrollment, care coordination, utilization management, and quality control, for the Alliance.

The Alliance is overseen by the Healthcare Safety Net Administration, which is located at the Department of Health. The Mayor also has established a Health Services Reform Commission (comprised of community leaders, health providers and planners, national health experts, and consumers) to track the Alliance's progress. As of February 14, 2002, an estimated 23,643 people were enrolled in the Alliance.[6]

The Reality: A Fragmented Delivery System

For many, however, the District has not had a well-functioning delivery system. While significant steps have been made in that direction, there is still much work to be done. The District's health care system is plagued with huge pockets of deprivation. There are shortages of physicians and other medical personnel east of the Anacostia River. Minority physicians are in short supply. Some physicians have relocated their practices to Maryland or Virginia. Some areas of the city do not have an accessible community health center.

Nearly one out of six District residents is uninsured (approximately 71,890 in 1999-2000[7]). This is always a problem, but it creates a particular hardship in Washington where the delivery system is fragmented and incomplete. At the first-level of the medical home, grassroots front-line, door-to-

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[5] Information about the D.C. Healthcare Alliance taken from testimony presented to the Committee on Human Services, Council of the District of Columbia, Hearing on the Status of the D.C. Healthcare Alliance Transition, June 22, 2001 (for a complete list of witnesses, see Source List at end of document).
[6] D.C. Healthcare Alliance Newsletter, February 2002.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (from www.statehealthfacts.kff.org).

door care is under-developed, with the notable exception of a successful pediatric van and some work that has been done around school-based health care. At the second level of this model, many of the uninsured are served by about 60 community health centers. These centers struggle to meet the needs of both Medicaid and uninsured patients. But they are under-staffed, occupy facilities that are in need of repair and modernization, have a varied mix of management information systems, and are frequently operating without clear pathways to secondary and tertiary care. The primary care clinics are not well organized into a citywide system although certain umbrella organizations provide some helpful coordination. Some clinics are specialty facilities and do not see patients with all types of conditions.

At the third level, urgent care centers supplementing primary care with specialists, radiology, pharmacy, and advanced diagnostic equipment are few and far between. In short, the safety net providers are not integrated into a smoothly functioning integrated delivery system.

In addition to having a difficult time accessing health care, uninsured patients often cannot obtain the prescription drugs needed to adequately treat their conditions. While there are a variety of ways

ELEMENTS OF MODEL MEDICAL HOME

In a well-functioning primary care system, the basic unit of service is often a community-based medical home that emphasizes primary and preventive care services. A fully developed system of medical homes serving vulnerable populations may be depicted as a continuum, starting with mobile vans and small sites located in shelters, churches, and other locations to meet patients' most basic needs. The next step along the continuum consists of small clinics that provide the full scope of primary care services to adults and children. These often have exam rooms, a small laboratory, small dispensary, administrative space, and support services such as mental health and social services, but not on-site ancillary and urgent care services. Patients might go to these clinics or see primary care physicians in office-based group practices. Further along the continuum are urgent care centers providing all of the services available at community-based medical homes with the addition of on-site laboratory, radiology, and pharmacy services. These facilities have extended hours and serve as a hub for the community-based homes.

To ensure access to care for all residents, regardless of their neighborhood, these facilities need to be located throughout the city, staffed by culturally competent physicians and allied medical personnel, and provide 24-hour coverage in one form or another.

A well-functioning system also requires that when physicians working in these settings determine that a patient needs further medical attention involving referrals to specialists, diagnostic testing, or surgery, they can arrange for timely referrals to avoid dangerous delays in follow-up care. This requires relationships between the various components of the medical home and the secondary and tertiary levels of care.

Finally, a well-run system has accountability for cost and quality. This means that government purchasers of care for lower-income populations need a funding stream for the uninsured and a seamless, integrated system in which people enrolled in the State Children's Health Insurance Program (S-CHIP), Medicaid, and the uninsured are all given medical homes and enrolled in managed systems of care. As part of a procurement process to secure those services, the public buyer includes a requirement that providers and health plans develop standards related to quality.

Strategies For Change, District of Columbia Health Care System Development Commission Final Report

in which the uninsured obtain prescription drugs, the sources do not match needs sufficiently. If providers cannot secure the needed medications at the time the patient is seen and patients are forced to go to pharmacies, they may not fill the prescriptions or take less of the drug than medically indicated to stretch out the supply. Alternatively, physicians may be forced to provide less effective, older medications because those products are less expensive and therefore are the only ones available, or switch patients to different medications based on what samples or donations are available. Clearly, the lack of pharmaceutical access has implications for the health (and perhaps quality of life) of the patient, and that is particularly troublesome in a place like the District with high rates of chronic conditions such as asthma and diabetes that often can be treated effectively with good pharmaceutical management.

Understanding how the uninsured access drugs in the District will demonstrate the magnitude of the unmet need. A recent study by the Non-Profit Clinic Consortium outlines the current mechanisms by which uninsured patients obtain prescription drugs through the District's 13 non-profit clinics.[8]

- Patient Assistance Programs: These programs, the largest source of pharmaceuticals for uninsured District residents, are funded by pharmaceutical manufacturers and provide between $705,000 and $800,000 in drug assistance per year.

- Donations/Samples: Clinics receive donations from local private physicians and, although data are hard to obtain, the estimated value of those donations is approximately $185,000 per year.

- Purchase by Clinics: Clinics spend about $450,000 per year of their own funds to purchase pharmaceuticals to supplement other sources (this number, however, only includes purchases from 11 of the 13 District clinics, and is therefore probably an underestimate).

The same study estimates that it would take an additional 25 percent in funds, *or a total in excess of $1.6 million*, to provide pharmaceuticals to the uninsured in the District.[9]

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[8] The following numbers are taken from: Non-Profit Clinic Consortium. *An Analysis of Clinic Prescription Drug Needs and Their Financing.* Washington, D.C., April 2002.

[9] One recent program that is no longer funded is the Prescription Drug Purchase Assistance (PDPA) program. It was run by one of the clinics and was the result of a class action lawsuit settlement with pharmaceutical manufacturers that funded the purchase of prescription drugs from September 1999 through early 2001. While the PDPA program did temporarily alleviate the problem of access to pharmaceuticals, there has been nothing implemented to replace it, and now patients and providers are back to where they were before the program began.

While some uninsured patients are being enrolled in the D.C. Healthcare Alliance and receive prescription drugs through that program, it appears that this portion of the Alliance may not have been sufficiently funded, and could be an additional source of unmet pharmaceutical needs in the District.

Finally, the city suffers from a lack of organized support for private-sector health insurance. The District is one of the few medium- or large-size cities nationwide without a business health-care coalition. It has no organized purchasing cooperative to make health insurance more affordable for small businesses. It lacks a high-risk pool to assist those who are otherwise "uninsurable." There is no fallback "standard plan" for individuals who cannot afford to buy coverage on their own, as there is in Maryland and other states. The lack of these private-sector supports will exacerbate the access problems of significant numbers of people leaving welfare for work in the near future because they have exhausted their time limits under the Temporary Assistance to Needy Families (TANF) program.

Despite these gaps and flaws, the District's health system has some strengths on which to build. There are premier teaching institutions conducting path-breaking research. The health centers are mobilizing to strengthen the primary care delivery system. There are countless medical groups with experienced physicians. Managed care organizations are working on improving preventive care and disease management. Community groups such as the Marshall Heights Community Development Organization are working to promote better access to care for people in under-served neighborhoods. Foundations are investing in improving health care delivery to vulnerable populations. These resources need to be better organized and coordinated.

On the other hand, Washington, D.C. has relatively few foundations whose missions and activities are local in nature, as compared to other cities of its size and vitality. This new foundation would not only be the first foundation established since the early 1990's that was dedicated to the health and well-being of its residents, it would be one of the largest of its kind in the District.

In summary, while the District has an ample *overall* supply of health care resources, the trained personnel and facilities are very unevenly distributed throughout the city and inefficiently managed. The system is very expensive, and yet many are under-served. A newly formed foundation will have an important opportunity to contribute to the improvement of health care in the District of Columbia.

POLICY OPTIONS

We have identified five policy options that could alleviate the problems enumerated above and improve the health of the residents of the District. Moreover, each policy option would provide the foundation with a number of opportunities to help the District pursue these policy options, either by funding a program directly or more likely by underwriting technical assistance, planning, research and other related activities in support of program efforts. The options presented below comprise a menu of opportunities to improve access to care and health outcomes.

I. COVERAGE EXPANSION

Promote Enrollment in Medicaid and S-CHIP

Improving health will require reducing the number of uninsured. A good starting point is to facilitate greater enrollment of adults and children who are already eligible for either S-CHIP or Medicaid. In the District, children and adults are eligible for these programs if they live in households with incomes below 200 percent of the federal poverty line (FPL). According to one study of the District's residents, about 30 percent of District residents with incomes below this level were uninsured, compared to only 5 percent with incomes above this level. Indeed, according to this 1998 study, about 66,000 of the then-estimated 81,000 uninsured in the District had incomes less than 200 percent of the FPL.[10] (As noted earlier, a more recent study estimated that the number of uninsured in the District dropped to about 72,000 in the 1999-2000 period. Because of a sluggish economy since that time, however, it seems likely that the number of uninsured has drifted upward again.)

Of the 66,000 uninsured with incomes less than 200 percent of the FPL, about 18,000 adults and children were already eligible for S-CHIP or Medicaid (because they meet the other eligibility requirements, namely, families with children, elderly and disabled). A foundation could target these 18,000 for outreach to improve enrollment. The District has been active in trying to expand enrollment within this group. It has used such measures as presumptive eligibility (sign up now if believed eligible, verify later), out-stationing of workers to neighborhood locations, and waiver of asset tests. But more could be done in this area.

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[10] The Lewin Group, Inc. "A Plan to Expand Coverage under Medicaid in the District of Columbia." Prepared for the D.C. Department of Health, Medical Assistance Administration, March 17, 1999.

Another important opportunity involves *extending coverage to low-income adults who currently are not eligible because they do not have children.* More than 38,000 adults with incomes less than 200 percent of the FPL were determined to be uninsured and without dependent children--thus, despite being deemed lower-income, they were ineligible for Medicaid.[11] While children living in poverty are now automatically eligible for Medicaid under federal law, states and the District can only obtain federal Medicaid matching funds for adults without dependent children by receiving a waiver from the United States Department of Health and Human Services (HHS). The District has received a waiver to start this process by extending Medicaid coverage to adults without dependent children who are 50-64 years old. Approval of the waiver took a long time, and implementation of this new pilot program has been slow.

A related challenge is to work with people losing cash assistance under TANF who are eligible for, but not participating in transitional Medicaid coverage. Under the 1996 welfare reform law, people who lose cash assistance may still be eligible for Medicaid for at least a year, and some states have increased this to two years. But women with children frequently are unfamiliar with this coverage, and often take jobs with no employer-sponsored coverage and remain uninsured.

Possible fundable activities:

- To facilitate enrollment of Medicaid and S-CHIP eligible adults and children into public programs (including transitional Medicaid), the foundation could *support outreach and enrollment activities*, such as sponsoring enrollment fairs at schools, funding an enrollment facilitator at local clinics, or helping develop family resource centers. This may be a good opportunity for the foundation to partner with other foundations already doing work in this area such as the Robert Wood Johnson Foundation's Covering Kids program.

- To extend eligibility to adults who currently lack it, the foundation could *provide support for technical assistance* to help with the implementation of the new HHS waiver. This might include tracking and evaluation that could lead to program adaptation and improvements, and a learning curve that would assist later expansions.

Expand Private Sector Coverage

While improvements in public programs are important, the reality is the city probably could not afford to cover all the uninsured. If everyone with incomes below 200 percent of the FPL were

[11] Mayor Anthony Williams' Health Insurance Expansion Plan, March 28, 1999.

enrolled in Medicaid, more than a third of the residents of the city would be participating in this program--an unlikely outcome with significant costs for the city. Therefore, efforts to bolster Medicaid and S-CHIP enrollment should be accompanied by initiatives to support employer-based and other private coverage.

The following list outlines some strategies to encourage private coverage, starting with a list of policy measures designed to lower the cost of coverage and then discussing how subsidies might further encourage private market coverage. The following list of policy options includes some long-term strategies and some strategies that would help address the District's immediate needs. If the foundation chooses to fund initiatives that would focus on expanding private sector coverage, it should work with local policymakers since many of these options would require new District legislation. This section is intended to outline some of the options that local policymakers might pursue. *The role of the foundation generally would be to support work around developing these options, rather than underwriting the cost of the expansion itself.* Fundable activities are listed at the end of this section.

High-risk pools. A number of states have formed "high-risk pools" to offer coverage to people who are priced out of the regular private non-group health insurance market. These are people who are, in effect, uninsurable, not because they will not be offered coverage (federal law requires insurers to offer coverage under certain circumstances such as when people leave a job with employer-sponsored coverage and attempt to buy insurance on their own), but because the premium is well beyond their reach. This occurs when people have some combination of low incomes and known health conditions that create a high probability that they will use a lot of health services in the near future.

High-risk pools enable people to get coverage with premiums that cannot exceed some set amount above the average in their region (e.g., 150 percent of this average). This insurance, however, is usually subject to a substantial deductible, exclusions of certain health services that are normally included in regular insurance, and higher premiums even with the caps. These features of the coverage in high-risk pools make this option unattractive for many people with high health risks. In many states, only 1 or 2 percent of those who are eligible to participate actually do so.[12]

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[12] Achman, Lori and Deborah Chollet. *Insuring the Uninsurable: An Overview of State High-Risk Pools.* The Commonwealth Fund, publication # 472, August 2001.

Opening up public employee insurance pools. One possibility is to allow District residents who buy health coverage on their own and those in small firms (e.g., 2-50 employees) to buy into the Federal Employees Health Benefits Program (FEHBP), a change that would require federal legislation. There is already a precedent for this as the D.C. public school teachers are currently eligible for FEHBP. Alternatively, the city could open up the health benefits program for its own workers to these groups. There is concern on the part of city workers that this would raise premiums. However, this concern could be addressed by building a "firewall" between the new entrants and the city workers, essentially creating a separate risk pool within the program. Alternatively, the city could develop a parallel program that is an FEHBP "look-alike," but has a totally separate structure.

Purchasing cooperative for smaller companies. The District has many small firms--it is not a city dominated by large industrial companies. There are some very small-scale associations through which some small firms can obtain health coverage (e.g., the Chamber of Commerce), but enrollment is small, and these groups do not necessarily adhere to the practices of large cooperatives in such areas as guaranteeing that all firms and workers may participate, regardless of underwriting.

The new foundation may want to survey the numerous purchasing cooperatives that have been tried around the country to discover the ingredients of success and the primary barriers. A number of the cooperatives have either languished at a very small scale or failed. A few have become sustainable and viable.[13] What makes the difference? Could the District develop such a purchasing vehicle that molds the best features of successful approaches around the country?

Reinsurance. Under this approach, the government underwrites health care outlays per patient above some "catastrophic" limit. This helps encourage health plans to offer coverage in situations that they might otherwise consider too risky. In New York State, the government has developed a plan that pays 90 percent of the claims per patient in the range of $30,000 to $100,000. Individual premiums, employer contributions, and patient cost sharing help fund this program for people with incomes under 250 percent of the FPL. Reinsurance programs are also being used in New Mexico and Arizona.[14]

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[13] Wicks, Elliot K., Mark A. Hall, and Jack A. Meyer. *Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers.* Washington, D.C.: The Economic and Social Research Institute, March 2000.

[14] Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer. *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs.* New York, New York: The Commonwealth Fund, publication # 445, February 2002.

Subsidies. The policy steps described above may not be enough to help lower the cost of coverage and enable working families (who do not have access to employer-sponsored coverage) to enroll in private insurance plans. The District may need to use subsidies to make insurance coverage affordable. One version of such subsidies makes use of tax credits. These credits could be made available to employers and/or employees. Credits for employers could have the additional value of helping to attract or retain businesses in the District. A daunting challenge facing this strategy is the difficult tradeoff between fairness and cost. If the credits are provided only to companies newly offering coverage, cost can be kept manageable, but firms that have already been funding health insurance would understandably feel that they were unfairly treated. In contrast, if credits were offered to all companies offering coverage, the cost would balloon and public sector dollars would not be well targeted to the currently uninsured. One way to address this problem would be to target the credits to firms with relatively low average wages; this may raise some administrative problems but could be worth exploring.

Tax credits for workers would cover a portion of their premium contributions and out-of-pocket health costs. Workers with family coverage typically pay about one-fourth of the premium for employer-sponsored coverage and the employer pays the remainder.[15] This worker's portion is now approaching $2,000 a year in many parts of the country. In addition, copayments and deductibles are rising, and coinsurance is being used more widely. These increases add substantial out-of-pocket costs to premium contributions. With support from the foundation, the District could assess the experience of states such as Massachusetts and Rhode Island that are trying to develop premium assistance programs for lower-income employees. Experience to date indicates that these types of initiatives must be carefully designed and heavily "marketed."[16] To avoid low take-up rates, subsidies must cover a good share of the premium—but this, of course, raises the public cost. A variety of media and personal outreach must be combined to get business and workers to participate. Subsidies will also be more effective if firms and workers have a way to use them to obtain affordable group coverage such as purchasing cooperatives (discussed above).

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[15] The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits, 2001 Annual Survey*, Exhibit 7.2.

[16] Silow-Carroll, Sharon, *Employer Tax Credits to Expand Health Coverage: Lessons Learned.* Economic and Social Research Institute. Prepared for The Commonwealth Fund, February 2000.

Possible fundable activities:

- For any of the private sector coverage options listed above, the foundation would not fund the coverage directly, but rather *provide funding for the District to investigate and assess* some of these options in more detail. The District may want to devote staff time or contract with consultants who have experience working in the District to conduct policy work outlining the pros and cons of the various strategies; look in detail at what some other states and localities have done that might be applicable in the District; and develop cost-estimates for the various strategies that seem most promising. This is an immediate need in the District, as public coverage expansions may not be the most effective, affordable, or feasible way of ensuring coverage for all of the District's remaining uninsured.

- If the District were to decide to pursue one or more of the strategies listed (for example, develop a high-risk pool for "uninsurable" individuals along with a tax credit program), more detailed policy work and cost analysis would be needed to develop a specific implementation plan. To help the city meet this need, the foundation could *fund a planning grant.* And, even further down the line, if something like a tax credit or premium subsidy were passed, studies indicate that a significant amount of marketing would be needed to encourage a healthy "take-up" rate. To support this effort, the foundation could *provide start-up funds for activities* such as marketing, or for administrative support to get the program up and running.

II. STRENGTHENING THE SAFETY NET

For the foreseeable future, even with the development of the Alliance, the District will be faced with a substantial number of uninsured people. To address their needs, as well as the needs of people enrolled in Medicaid who still have trouble gaining access to timely services (because of economic, transportation, cultural, language, and/or other barriers), it is important to streamline and rationalize the delivery system to improve health outcomes.

Health system restructuring. One important step is to reallocate funds within the health care system to address unmet needs. Through the development of the Alliance, the District has taken some steps in the direction of the type of health care system restructuring that has been undertaken successfully in other urban areas such as Los Angeles. There, the Department of Health Services transformed its hospital-based public health care system into a provider network focused on ambulatory and primary care. Total budgeted L.A. County hospital beds were reduced by 28 percent

over five years. The County contracts with the community-based organizations, medical groups, and hospitals that can best serve the ambulatory care needs of particular populations or geographic areas. The number of ambulatory care sites more than tripled over five years, and all of the more than 100 new sites are privately managed.

Georgia has taken a somewhat different approach to solving the same type of imbalance in resource allocation. The state added a requirement to its Disproportionate Share Hospital (DSH) program that 15 percent of the DSH funds received by hospitals in the state be used to support primary care services.[17] Following this lead, the District could require recipients of DSH funds to apply some portion of the funds to services for uncompensated care patients referred from the primary care system to the DSH hospital. This would better utilize the current over-supply of hospital beds and better align the size of DSH payments with the actual uncompensated care burden.

Capital improvements. Last year, $5 million was allocated for improvements at Greater Southeast Hospital, and was spent. Another $1 million went to D.C. General for repairs. An additional $5 million was allocated to community health centers, and most of this money is not yet spent. This is a microcosm of the larger problem. The health centers need a business plan for modernization, staffing needs, ancillary services, and the development of linkages to downstream levels of care. The District may want to work with an organization such as the Local Initiatives Support Corporation (LISC), a national nonprofit intermediary that channels private sector financial and technical resources to community development corporations (CDCs). LISC's mission is to assist CDCs in transforming distressed neighborhoods into healthy communities. It serves as a broker, lender, advocate, and technical assistance provider.[18]

The District may also want to begin earmarking a portion of tobacco settlement funds for meeting some of the needs of its primary health care system instead of devoting the money to deficit reduction.

Technical assistance underwritten by the foundation could help the District develop these types of funding strategies, as well as a good plan for prioritizing outlays to get the best return. Some funds could be used for MIS improvement; some for staff; some for plant and equipment improvements.

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[17] For more information, see the section on the Indigent Care Trust Fund on the Georgia Department of Community Health website, www.communityhealth.state.ga.us.

[18] Government of the District of Columbia. *Strategies for Change.* Health Care System Development Commission. Final Report. December 2000.

Another important target would be the development and implementation of quality of care measures and targets for improvements. This could involve a subset of HEDIS indicators for health plans, risk-adjusted mortality rates for hospitals, volume/outcome relationships, or other measures.

Direct Service Outreach. The development of a better infrastructure in the primary health care system can be effectively complemented through grassroots community outreach. For example, a Consumer Health Access Team (CHAT) has been formed by the Department of Health and will work with community organizations like the East Capitol Center for Change. These are four-person teams made up of consumers from underserved areas in the city. These people, who have experience using the public health system in the District, provide advice and counsel to people in emergency rooms, local businesses, churches, laundromats, and buses. They are developing a Web-based system to track their contacts. In addition, they will work with the Department of Health to provide feedback on Alliance services and help the Department of Health monitor and manage the Alliance contract.

A more fully developed program of community health workers has been implemented in North Manhattan, which is also one of the 13 W.K. Kellogg Foundation's Community Voices sites. Community members are trained about eligibility for public programs. They learn outreach strategies, develop communications skills, and evaluate what is working in signing up parents and their children for Medicaid and S-CHIP. Workers go door-to-door to identify people who are eligible for public programs, and they distribute flyers and conduct surveys. Ultimately, some of these community members become paid staff. The workers, in effect, become "extenders" of the traditional medical model and help connect residents with services.

Other possible targets of opportunity for outreach involve door-to-door campaigns to enroll eligible children and parents in S-CHIP and Medicaid, and neighborhood health fairs at grocery stores, recreation centers, etc. to promote the use of preventive tests and access to information on health improvement.

Possible fundable activities:

- The foundation could *fund a study* to look at sites like Los Angeles or Georgia and see if either of those initiatives might be a feasible way to conduct health system restructuring in the District.

- The foundation, working with an organization such as the Non-Profit Clinic Consortium, could *provide support for developing a citywide business plan* for making much-needed capital improvements to the clinics.

- If specific capital needs arose for which there did not appear to be available funding, the foundation could *directly fund some capital improvements*, such as improving waiting rooms (painting, buy toys, etc.) or funding a dental chair.

- The foundation might *fund some additional staff time* to allow for longer clinic hours, or increase the services offered at a clinic (e.g., hire a dental hygienist, etc.).

- The foundation could *provide support to convene the clinics to develop a plan* around how tobacco settlement funds could be used to support the development of health care infrastructure in the city (there has already been some work done in this area).

- The foundation could *underwrite an expansion of direct service outreach* using community health workers (CHWs), now being pilot-tested on a small-scale under a grant from the W.K. Kellogg Foundation.

- The foundation could *fund consultants to provide technical assistance* to clinics to help them implement MIS improvements and develop IT plans, undertake strategic planning, conduct fund-raising activities, etc.

III. Health Initiatives and Disease Management Strategies

Coupled with improvements needed in the safety net delivery system and direct service outreach to enroll eligible people in health coverage and improve access to care, a new foundation could also assist the District in planning new initiatives in disease management and medication compliance. As noted earlier, District residents have an unusually high incidence of various chronic medical conditions such as asthma, diabetes, and cardiovascular diseases.

The city already has a program targeted to asthma management. This effort could be augmented by further support from the foundation community to help the city meet the goals developed under *Healthy People 2010*. For example, national targets require reductions in both the death rate from

asthma for children under five years of age from 2.1 per million in 1998 to 1.0 per million in 2010, and the asthma-related hospitalization rate from 45.6 per 10,000 in 1998 to 25 in 2010.[19]

Corresponding efforts could be mounted with respect to other chronic health conditions in the areas of early detection, medication management, referrals to specialists, and patient self-monitoring. Some of the targets relate not just to death rates and hospital/emergency room use, but also to a reduction in activity limitations. For example, *Healthy People 2010* sets a target for reducing the proportion of adults whose activity is limited due to chronic lung and breathing problems (chronic obstructive pulmonary disease). The targeted decline for adults 45 years of age and older is from 2.2 percent to 1.5 percent.[20] Some medical conditions are exacerbated by environmental conditions such as air quality in the home, infestation, and the presence of lead-based paint.

The medical model can also be expanded to envelop a greater effort to treat substance abuse. The District spends an estimated $1.2 billion annually on problems related to untreated substance abuse, more than it spends on public education.[21] Short-term palliatives are unlikely to help. Services must be designed to meet the needs of specific populations and must be integrated within the community and across public and private programs. Models such as SMART Moves National Prevention Program have been successful in addressing problems related to substance abuse in Atlanta and other cities by increasing youth's self-esteem, assertiveness and ability to resist media pressures.

Possible fundable activities:

- Some of the same mechanisms described in direct service outreach could be used to promote better health among residents, including use of the community health workers. The foundation could *support, for example, training programs* for community health workers that would allow the CHWs to work with District residents on improving their health.

- The foundation could identify one or two chronic diseases such as asthma and diabetes where there is a clear link between preventive care and good disease management, on one hand, and better health outcomes, on the other. To help the city meet the disease-specific

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[19] U.S. Department of Health and Human Services, *Healthy People 2010.* November 2000. Vol. II, pp. 24-13; 24-14. Targets for other age groups follow: For children five to fourteen years old, the corresponding target is a reduction from 3.3 deaths per million to 1.0. For people 15 to 34, the target is a decline from 5.0 to 2.0; for those 35 to 64, a drop from 17.8 to 9.0; and for people 65 and older, from 86.3 to 60.0. With respect to reducing hospitalization rates for asthma, for children under five, the expected reduction is from 45.6 per 10,000 in 1998 to 25 in 2010. For children and adults in the 5-64 year age bracket, the goal is to reduce the asthma-related hospitalization rate from 12.5 to 7.7; and for the elderly, the anticipated reduction is from 17.7 to 11.

[20] U.S. Department of Health and Human Services, *Healthy People 2010.* November 2000. Vol. II, p. 24-20.

goals in these areas, the foundation could *provide assistance in developing an action plan* to implement best practices regarding preventive care, physician education, patient compliance, media campaigns, etc.

- The foundation could *fund a study* of programs in other areas that stretch the medical model to include home safety. A good example is Rhode Island's initiative to use Medicaid funds (with a federal match) to correct problems in apartments and homes related to lead-based paint.

- The new foundation could also *support and help augment the work of the pediatric vans.* These mobile vans are increasing immunizations among children and also conducting basic health screening tests for mothers and children.

- An important component of these activities would be to conduct an inventory of what other foundations are doing in this area and work with existing programs to avoid duplication of services.

IV. Improved Access to Prescription Drugs

As described above, access to pharmaceuticals among low-income groups in the District is a major problem. The amount needed to directly fund prescription drug costs for the uninsured was recently estimated to be in excess of $1.6 million. However, there are other ways in which the problem could be ameliorated without direct funding of prescription drugs.[22]

First, as noted above, one way in which patients obtain drugs is through Patient Assistance Programs. These programs, however, often require a significant amount of paperwork. Different programs have different eligibility criteria, different information requirements from patients and providers, and different applications. In addition, many programs require patients (or providers) to reapply every three months. Clinics vary in how adept they are at accessing these programs, and how adequately staffed they are to handle the paperwork.

The second opportunity to help address this problem involves helping clinics maximize their resources when they do purchase drugs (mostly generics) with their own funds. Often the best prices for pharmaceuticals are those given to the Department of Defense (DOD) or the Public Health

[21] District of Columbia. *Building a Community-Based Health Care System.* 2001-2001 Policy Agenda, Chapter 7-4.

Service (PHS). Only one federally qualified health center (FQHC) and one FQHC look-alike in the District, however, are eligible to purchase pharmaceuticals at the DOD price through the federal 340b program. One additional clinic has access to PHS pricing. The clinics would be well served by obtaining pharmaceuticals at DOD or PHS pricing and stretching their limited resources farther.

Possible fundable activities:

- To help patients access prescription drugs through the Patient Assistance Programs, the foundation could *fund a study* to explore whether an external group could be used to facilitate the clinics' access to these programs; *provide funding to support clinic staff* whose primary function would be to work with these programs; *directly fund technical assistance* to the clinics to help them better access these programs; or *fund the purchase of (and subsequent technical support of) computer software* to help clinics track the applications to these programs, institute better record keeping, and keep up to date on program changes.

- Clinics could also use some of the mechanisms listed above to maximize their receipt of donations and samples (e.g., if a new staff member were hired to work with patient assistance programs, he/she could also work on obtaining donations and samples; or if a study were commissioned, it could also explore how an external group could be used to acquire samples and donations).

- The foundation may want to *fund a study* that would explore how to group the clinics together to maximize their purchasing power and access lower prices. For example, the District of Columbia, because it is treated as a government territory by the DOD, is eligible to purchase drugs at DOD prices and may be able to make or authorize arrangements to enable clinics purchasing pharmaceuticals to obtain discounted prices.

V. Research and Policy Activities

Many of the activities listed above could also be listed as research and policy activities that would help the District further its understanding of policy options around health care issues. While some work might need to be done in specific areas, the District has often commissioned studies to better understand the gaps and needs in the health care system. What appears to be lacking is a way to pull

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[22] Many of these recommendations have been taken from: Non-Profit Clinic Consortium. *An Analysis of Clinic Prescription Drug Needs and Their Financing.* Washington, D.C., April 2002.

the research and policy analysis that has already been done together and use the findings to improve health care in the city.

The District of Columbia, like other major cities, receives support from both federal government agencies and various philanthropic organizations. There are also opportunities for additional support if the city had more technical assistance and staff or consulting support in grant writing and research activities. A newly formed foundation would be well advised to meet with the Kellogg Foundation and the Robert Wood Johnson Foundation to see how new initiatives could be coordinated with and support the Community Voices and the Communities in Charge programs. Other funders with an interest in the city include the Annie E. Casey Foundation and the Health Resources and Services Administration (HRSA).

Possible fundable activities:

- A new foundation could assist the city by *organizing a steering committee of private funders* that would coordinate the initiatives and leverage funds effectively. Some coordination and planning have been attempted. This is an area where the city would benefit from some financial support and technical assistance to add more formal structure to some of the more informal discussions and plans.

- A new foundation could also *assist the city in developing the capacity to conduct program planning, budgeting, and evaluation.* For example, requests for waivers from the federal government require complex calculations of offsetting savings projected to accompany new health coverage initiatives, with a goal of establishing "budget neutrality." New interventions take place against a backdrop of constantly changing conditions in the health care system and the local economy, complicating evaluation designs. There is a need for data system improvements, and the development of flexible, multi-faceted evaluation designs that blend data analysis, qualitative studies, focus groups, and surveys. As the Alliance evolves and grows in the future, it will be important to track and evaluate its progress in meeting the goals of improved health outcomes and effective cost management. As noted above, the city has taken some steps to include an evaluation component in the development of the Alliance, and clearly any foundation efforts in this area would need to coordinate with the District and not duplicate the city's efforts.

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ABOUT THE AUTHORS

Jack A. Meyer, Ph.D., is the founder and President of New Directions for Policy. Dr. Meyer has conducted policy analysis and directed research on health care issues for several major foundations as well as federal and state government and the business sector. He has led projects developing policy options for reforming the overall health care system and directed research on employers' innovations in health care purchasing. Many of these projects have highlighted new strategies for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty.

Emily K. Waldman, M.H.S., is a Senior Policy Analyst at New Directions for Policy. Most recently, Ms. Waldman has researched state and local initiatives to expand health coverage for the working uninsured. She also has evaluated public- and private-sector strategies to improve access to health insurance coverage and health care delivery. Ms. Waldman has conducted policy research and analysis on the issues confronting urban safety net institutions and academic medical centers, as well as studied the implications of managed care programs for people dually eligible for Medicare and Medicaid.

ABOUT NEW DIRECTIONS FOR POLICY

New Directions for Policy (NDP) is a Washington-based organization that assists purchasers and providers of health care and government through policy research and analysis, strategic planning, and program evaluation. NDP's purposes are to promote more effective operation of the health care system, and to aid the development of sound public policy on health care and social welfare issues. NDP analyzes the forces driving health care spending, designs innovative strategies to improve financing and delivery systems, and evaluates reforms to extend health coverage to the uninsured.

AMENDED FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

Group Hospitalization & Medical Services, Inc.
and CareFirst Blue Choice, Inc. to be acquired by
WellPoint Health Networks Inc.

Filed: August 19, 2002

- Letter from David M. Funk of Funk & Bolton, P.A. on behalf of CareFirst, Inc., Group Hospitalization and Medical Services, Inc. and WellPoint Health Networks Inc. to Commissioner Lawrence H. Mirel of the District of Columbia dated August 19, 2002

- Amended Form A Statement dated August 19, 2002

- Supplement to Amended Form A Statement

- Exhibits:

  - **Exhibit 2-B1A** – Annual Report on Form 10-K for WellPoint for the year ending December 31, 2001 and Amended Annual Report on Form 10-K/A for the year ending December 31, 2001

  - **Exhibit 2-B6A** – Annual Report to Stockholders for WellPoint for the year ending December 31, 2001
    http://www.wellpoint.com/investor_info/annual_reports/

  - **Exhibit 2-B11A** – Quarterly Report on Form 10Q for WellPoint for the period ending June 30, 2002

  - **Exhibit 2-C1** – PreAcquisition Organizational Chart of WellPoint and its Affiliates

  - **Exhibit 2-C2** – PostAcquisition Organizational Chart of WellPoint and its Affiliates

  - **Exhibit 3-A** Biographical Affidavits for Directors and Executive Officers of WellPoint

  - **Exhibit 4-C** – WellPoint Unsecured Revolving Credit Facility Agreements

  - **Exhibit 6-A1A** – Annual Report for CareFirst, Inc. for the year ending December 31, 2001
    http://www.carefirst.com/pages/company/annualreports.htm

  - **Exhibit 7** – Expert Opinion Issued by New Directions for Policy entitled Identifying Options for Using Assets to Improve Health in the District of Columbia

SUPPLEMENT TO AMENDED FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

WellPoint Health Networks Inc., CareFirst, Inc. and Group Hospitalization and Medical Services, Inc. (collectively, the "Applicants") have amended the Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer ("Amended Application") filed with the Department of Insurance and Securities Regulation ("Department") and the Office of Corporation Counsel ("Corporation Counsel") on January 11, 2002, to update the information supplied in the original application. The Insurance Commissioner has identified several issues that the Applicants have been asked to address in the Amended Application. This supplement is intended to provide the information requested by the Insurance Commissioner and establish, prima facie, that the conversion of Group Hospitalization and Medical Services, Inc. ("GHMSI") and the acquisition of GHMSI by WellPoint Health Networks Inc. ("WellPoint") should be approved.

Before addressing the substantive issues, the Applicants reaffirm that the agreement between the parties governing this transaction is the Agreement and Plan of Merger entered into on November 20, 2001 (the "Merger Agreement"). The Merger Agreement has not been amended, and it is the Merger Agreement (and related transactions) that the Applicants are requesting the Insurance Commissioner to review and approve. Therefore, in response to the Insurance Commissioner's inquiries about changes resulting from recently enacted Maryland legislation, there have been no changes.

The Applicants also wish to point out that they intend to submit pre-filed written testimony and oral testimony at the hearing the Insurance Commissioner plans to hold on this Amended Application, addressing in greater detail many topics addressed in this supplement to the Amended Application. Witnesses will include executives from CareFirst, Inc. ("CareFirst"), GHMSI, WellPoint and experts retained by CareFirst in connection with the decision to convert (including GHMSI's conversion) and merge with WellPoint. Finally, it should be pointed out that, in order to provide the information in a structured fashion, this supplement to the Amended Application contains information derived from one or the other of the Applicants individually, or in some instances from public documents.

The Boards of Directors' Decision to Convert and Selection of WellPoint as a Merger Partner

1. The Boards of Directors

In 1998, as part of the business combination of CareFirst of Maryland, Inc. ("CFMI") and GHMSI, CareFirst was created as a nonprofit holding company that acted as the sole member of CFMI and GHMSI. In 2000, the Delaware Blue Cross Blue Shield plan ("BCBSD") became affiliated with CFMI and GHMSI, with CareFirst as its sole member. As of the addition of BCBSD, CareFirst acted and continues to act as a holding company and the sole member of all three operating companies. Under the regulatory approval orders, to ensure that each of the jurisdictions CareFirst serves is adequately

represented at the holding company level where the ultimate corporate direction and decisions are made, the CareFirst Board of Directors is made up of members of the Boards of Directors of all three operating companies. In this regard, six of CareFirst's directors are nominated by GHMSI.

In addition, each of the operating companies has its own Board which is responsible for the operations of its respective company. In practice, the CareFirst, CFMI and GHMSI Boards meet simultaneously. BCBSD's Board sometimes meets separately, but over the course of the last year has on numerous occasions met simultaneously with the other three Boards. The Boards are actively involved in providing overall direction to the corporations, through the approval of annual business plans, budgets, and the long-term strategy for the corporations. The Boards are also involved directly in all major decisions that affect the companies' subscribers. The Boards have six regularly scheduled meetings per year, including a 2-day annual planning session. As the Boards considered the companies' strategic direction, and particularly in 2001, the Boards met more frequently.

2. The Strategic Planning Process

Over the years, the CareFirst Board, as part of its fiduciary obligation to the companies and its subscribers, has continuously reviewed and established the strategic direction both from a short-term and long-term perspective for the companies. In this regard, the Board established a Strategic Planning Committee (the "Committee"), whose purposes include the provision of assistance and expertise to management in developing and monitoring the long-range strategic plan, and developing and recommending to the Board the strategic plan for the companies. The six members of the Committee consist of Board members from each of the operating companies of CareFirst, including two members of GHMSI's Board.

As part of their responsibility, the Committee has, over the years, retained a number of external expert advisors, including Accenture Ltd. ("Accenture"), Bear Stearns and Credit Suisse First Boston ("CSFB"). In addition, the law firm of Piper Rudnick LLP ("Piper") has provided legal guidance regarding development and execution of the strategic plan and transactions. The Committee and the Boards also receive input and recommendations from management. In all cases, the Committee and the Boards have actively probed the opinions of the experts and management to assure themselves that they are reasonable and based on legitimate business principles consistent with the fiduciary obligation of the Boards.

At all times, the Boards considered the business rationale for each alternative and the pros and cons of each as to how each would allow CareFirst to better achieve its strategic direction and, more importantly, how each would affect subscribers, CareFirst's associates and the citizens of the jurisdictions served by CareFirst. As the competitive landscape changed in the health care industry, the pros and cons and strengths and weaknesses of each potential alternative varied.

The strategic planning process is ongoing. During the mid to late 1990s, GHMSI and CFMI had emerged from a period of financial distress, where they focused on turning the business around, regaining profitability, and getting back on their feet. After

successfully turning GHMSI and CFMI around, they had to determine what long-term strategic direction to take. In 1999, CareFirst initiated a competitive bidding process for a strategic advisor. As a result, CareFirst retained Accenture (then Andersen Consulting) in early 1999 to assist it in analyzing the health care environment and developing a strategic plan. Accenture focused on three objectives: (1) to assess the competitive environment and the industry trends that could have implications on how health plans evolve, and specifically how CareFirst was going to be affected; (2) to assist management in developing a three-year strategic vision and direction for CareFirst; and (3) to determine key enabling strategies to fulfill that strategic vision. In the ensuing months, Accenture worked closely with all four Boards and the Committee to help CareFirst select the best strategic direction for the companies.

Based on its research, Accenture advised the Boards that it saw three major trends. First, that the health care industry was shifting toward consumerism, with individual members having a greater participation in the process of selecting insurance (as opposed to employers), as well as in care decisions and in the tailoring of products to meet individual consumers' needs. Second, that the health care industry was consolidating, both nationally and regionally, and that the consolidation was a threat to CareFirst's position in the region. Third, new technologies were reshaping the health care business. As eCommerce technologies were changing cost structures, and driving heightened member expectations, health plans had to invest in new technologies to remain competitive and to meet these expanding customer demands. Accenture also noted that new competitors were launching radically different business models. Accenture advised the Boards that, although CareFirst had a strong place in the market, it was not particularly well positioned for where the industry was going. Accenture advised the Boards that it was concerned CareFirst would be subscale in the long-term relative to its competitors.

Accenture looked at a range of options available to CareFirst, ranging from remaining status quo, to a niche strategy (by retreating to a segment of the market in which CareFirst was strong and building defenses around the niche), to organic growth, to business combinations. Accenture advised CareFirst that maintaining status quo or following a niche strategy were not optimal choices for CareFirst's future. Accenture believed that maintaining status quo would not allow CareFirst to thrive over the long term due to a number of reasons, including the speed at which the marketplace was changing, and CareFirst's insufficient access to capital necessary to make investments in consumer-oriented products and eCommerce. Accenture similarly concluded that a niche strategy would not allow CareFirst to thrive over the long term because it would require CareFirst to shrink considerably, thereby losing important advantages of scale.

Accenture focused on growth strategies and set long-term goals for the company. Accenture ultimately concluded that a nonprofit or for-profit business combination would be an expedient way to achieve CareFirst's objectives. Accenture evaluated potential business partners for CareFirst based on a structured screening process. After screening the potential partners, three candidates emerged as the most desirable to help CareFirst achieve its objectives. Those were Highmark Inc. ("Highmark"), WellPoint and Trigon Healthcare Inc. ("Trigon"). One of the reasons WellPoint emerged as a candidate, according to Accenture, was because it scored particularly high in its ability to quickly get CareFirst to a more consumer capable company.

Following Accenture's analysis of trends in the health care environment and strategic planning assistance to CareFirst based on those trends, CFSB, a highly respected investment-banking firm, was retained to assist the Boards in their evaluation of the strategic alternatives for CareFirst, and later to implement a strategy.

Following several months of preliminary advisory services, CSFB first met with the Committee on June 1, 2000 to discuss preliminary observations regarding the current market position and future prospects of CareFirst, the competitive market environment in the health care industry in the Mid-Atlantic region, key drivers for future success, and an overview of the strategic opportunities available to CareFirst. The Committee requested further analysis of the available opportunities. Among the opportunities considered for CareFirst were those similar to the opportunities considered by Accenture, such as: (i) remaining nonprofit, (ii) converting to a for-profit stock corporation and engaging in an initial public offering ("IPO"), and (iii) pursuing a strategic affiliation (as a nonprofit with another nonprofit entity) or merger transaction (after conversion to a for-profit corporation).

Regardless of the path pursued, the Committee and the Boards of Directors considered it important that CareFirst remain Blue. CareFirst had built its current market position through its Blue heritage, and the retention of its Blue status was essential to the business plan for the CareFirst companies in the future. The number of restrictions imposed by the Blue Cross Blue Shield Association on Blue licensees would make it virtually impossible for a non-Blue plan to acquire CareFirst and maintain the Blue license. Therefore, any transaction contemplated by CareFirst would necessarily involve a Blue plan.

Throughout the ongoing process of considering strategic alternatives, the Boards and Committee considered whether to enter into another affiliation with a nonprofit Blue plan. On July 11 and July 27, 2000, CSFB met with the Committee and reviewed strategic alternatives, including a possible affiliation with Highmark, which is the nonprofit Blue Cross of Western Pennsylvania and Blue Shield of Pennsylvania. At those meetings, CSFB presented reports to the Committee regarding the appropriateness of an affiliation with Highmark. From July through November 2000, CSFB advised the Committee as it pursued a possible strategic affiliation with Highmark. During that time, CareFirst's senior management and CSFB met on several occasions with senior management of Highmark to discuss Highmark's philosophy, strategic direction, and how an affiliation between CareFirst and Highmark would be structured in terms of control, commitment to associates and access to better products for subscribers. In October and November of 2000, CSFB refined its analysis of a potential Highmark affiliation.

CSFB advised the Committee that an affiliation with Highmark, while it may have added certain economies of scale, would not provide significant access to capital, a key goal of the Committee in its review of the available opportunities for CareFirst. In December 2000, CSFB provided the Boards with a report analyzing the advantages and disadvantages of the various strategic options. Based on CSFB's recommendation, the meetings that had been held with Highmark management and the Boards' discussion, the Boards determined that an affiliation with Highmark was not in the best interest of the companies because it would not further the strategic imperatives the Boards felt were

important. The Boards' decision was based on the following: (1) a Highmark affiliation would provide only a limited access to capital markets; (2) it would provide virtually no acquisition currency; (3) the complicated existing governance and management structure of Highmark would be further exacerbated by an affiliation with CareFirst (the Boards found it difficult to conceive of a reasonable governance/management structure); (4) there would be limited ability to effectuate efficiencies through systems integration with Highmark; and (5) the complicated structure resulting from a Highmark affiliation would make further strategic moves virtually impossible.

As a result of their analyses, the Boards terminated discussions with Highmark and turned their focus to Trigon and WellPoint, the large, for-profit Blue plans that would provide CareFirst with access to the capital it needed to maintain its position in the health insurance market in the Mid-Atlantic region. At that time, Anthem, Inc. ("Anthem"), which was also a large Blue plan, was still in the process of a demutualization in preparation for its IPO, the timing of which was uncertain. The IPO occurred in October 2001. The Boards were concerned about the complexity of Anthem's regulatory process and the uncertainty of its access to capital. In addition, Anthem neither articulated its strategic plan nor explained how the purchase of CareFirst would fit within that strategic plan. For all of these reasons, Anthem was not viewed as a viable strategic partner for CareFirst.

In order to secure the best possible deal for CareFirst, CSFB recommended, and both the Committee and the Boards agreed, that an arm's length bid process be undertaken. CSFB believed, in an environment of competition, that such an auction process tends to provide the best possible deal because it forces the interested parties to negotiate aggressively.

In February 2001, following additional discussions between CSFB and the Committee, and after preliminary due diligence on Trigon and WellPoint, CSFB distributed to each party a bidding procedures letter that set out the parameters of the bid process. The letter requested definitive proposals that addressed a number of key transaction issues considered important by the Boards, including the price to be offered, the sources of financing, a proposed method for protecting the absolute value of a non-cash component of the consideration (if any), a mark-up of a proposed merger agreement prepared by CareFirst, location of corporate headquarters, corporate name and branding, composition of the Board, continued role of existing directors of the Maryland, District of Columbia and Delaware operating subsidiaries, location of employees and facilities by jurisdiction, commitment to CareFirst employees, continued relationships with CareFirst providers, continued service of existing CareFirst market segments, and a proposed timeline for consummation of the transaction.

Preliminary bids were received from the two potential candidates on March 2, 2001. Over the course of the next eight months, the Committee and Boards received numerous reports from CSFB and management comparing the status and progress of negotiations with WellPoint and Trigon. Comparisons of each of the bids were uniformly made with regard to a number of criteria that the Boards and Committee felt accurately reflected the key issues impacting CareFirst and its constituencies. These criteria were the price, the form of consideration (cash/stock), the exchange ratio, the degree of downside price protection, the existence of financial requirements, the termination

provisions, the representations and warranties, the definition of material adverse change, the potential post-closing obligations to any charitable foundations, headquarters location, the extent of Board representation, management role and composition, and the effect on CareFirst associates and subscribers. CareFirst received legal advice from Piper throughout the process, including advice concerning the Boards' fiduciary duties with respect to the transaction.

The Boards, with the advice of Piper, believed that while achieving a high price was a critical factor, it was not the sole determining factor. The Boards believed that other important issues needed to be considered, along with price. The Boards believed that it was crucial not to approve a proposed transaction that would have an adverse impact on CareFirst's associates or its customers. Ultimately, the Boards approved a proposal that offered the highest price because WellPoint's original offer of $1.2 billion was raised twice through negotiation to $1.3 billion, matching Trigon's price proposal.

In addition to successfully persuading WellPoint to increase its bid price, the intense negotiation process leading to the proposed WellPoint transaction resulted in WellPoint agreeing to the maintenance of corporate headquarters for each of the CareFirst operating Blue plans, to the creation of a new headquarters for WellPoint's Southeastern Region in Maryland, and an agreement that CareFirst associate benefits could not be changed for four years from the date of the definitive agreement unless such changes were considered to be in the best interests of CareFirst as determined by CareFirst's CEO. The parties also agreed that for five years from closing, the benefits under the pension plan cannot be diminished for vested participants who are at least 45 years old and have a sum of age plus years of service of 65 or more.

CSFB met with the Committee on November 5, 2001 to review the revised proposals of the two candidates. After considering the financial advice of CSFB and the advice of other advisors with respect to other terms in the two offers, the Committee recommended the submission of the WellPoint proposal to the Boards for final approval. On November 20, 2001, the Boards met, considered the alternative proposals, the recommendation of the Committee and voted to enter into a definitive agreement with WellPoint.

It bears pointing out that during the early stages of the bidding process, and again in November 2001, Anthem sought to participate in the bidding process. As stated above, Anthem was not viewed as a viable partner for CareFirst due to a number of uncertainties of a transaction with Anthem. In November 2001, although Anthem had become public and appeared to have sufficient capital in the short run to consummate a transaction, CSFB advised the Boards that due to the newness of its IPO, there were financial uncertainties. Also, CSFB and the Boards agreed that there was still no demonstrable strategic benefit to CareFirst in a transaction with Anthem. In addition to CSFB's advice, the Boards asked Piper for legal advice regarding the Boards' fiduciary obligations to stop the bidding process to allow Anthem to enter. Piper advised the Boards that they had acted reasonably and had exercised good business judgment in not allowing Anthem to enter the bidding process.

3. The Boards' Rationale for Selecting WellPoint

The Boards approved the proposed transaction with WellPoint because it met all of the major criteria the Boards used to evaluate proposals, and the Boards believed it was superior to Trigon's proposal. The Boards foresaw the following benefits from the transaction with WellPoint: (1) continuation of existing CareFirst products and services along with enhancements to those products and services; (2) a slowed rate of increase in premiums because of the increased financial strength WellPoint will bring to CareFirst; (3) ensured continued local decision making on health care issues and policy; (4) a benefit to providers through increased technology investments that will result in on-line, real time verification and claims status review; (5) continued employment and maintained regulatory oversight; and (6) the largest per capita public benefit donation to charitable foundations in the history of Blue Cross Blue Shield Plan conversions.

The Boards also believed that the WellPoint proposal was superior to the Trigon proposal for the following reasons: (1) the Trigon proposal would have resulted in substantial layoffs of the CareFirst workforce because of the relatively small size of Trigon, vis-à-vis CareFirst, whereas WellPoint, because of its significantly larger size and the structure of the organization it proposed, did not pose that threat;[1] (2) Trigon proposed a management structure whereby there would be essentially dual CEOs, which the Board believed was unworkable and would have resulted in confusion in leadership and a lack of unified direction; (3) Trigon had proposed to move the headquarters of the public company from Richmond to Maryland, but the proposal was later withdrawn with an explicit requirement that headquarters would remain at Trigon's headquarters in Richmond, Virginia; (4) Trigon had no significant experience in integrating companies it purchased, whereas WellPoint had significant positive experience in that regard and a very strong track record of improving performance in companies it acquired; (5) Trigon required that should its stock fall below a certain price, both it and CareFirst would share in the decline creating the potential that the foundations would not receive the full value of the purchase price to benefit the communities, while the purchase price of the WellPoint proposal was guaranteed; and (6) the Trigon proposal permitted termination by Trigon after 18 months if the transaction had not been completed, while the WellPoint proposal was committed for three years.

After analyzing the terms of each proposal and in light of the Boards' objectives to ensure that the foundations receive a fixed amount of value at closing, CSFB also advised the Committee and the Boards that WellPoint's proposal was the financially superior offer. A key reason for CSFB's recommendation was that the WellPoint purchase price was fixed at $1.3 billion. By contrast, the Trigon purchase price assumed that Trigon would bear the risk of a decline in its stock price until the price declined to $50 per share, but that CareFirst and Trigon would share the impact of any decline thereafter. Thus, if the Trigon stock price fell below $50 per share, so too did the aggregate purchase price for CareFirst decline. This lack of downside value protection for the foundations in the Trigon proposal created an uncertainty as to the purchase price because the holder of CareFirst common stock was to assume the risk that Trigon's stock may be worth less at closing than at the execution of a merger agreement.

[1] Trigon did promise that layoffs would not occur, but the Boards did not believe that the Trigon transaction was feasible without layoffs.

In connection with the proposed transaction, the CareFirst Board requested that CSFB provide an opinion as to whether the merger consideration of $1.3 billion was fair to the CareFirst stockholders, which will ultimately be the foundations, from a financial point of view. On November 20, 2001, CSFB advised the Board that, as of November 20, 2001, the aggregate consideration of $1.3 billion to be received by the CareFirst stockholders in the transaction with WellPoint was fair from a financial point of view.

Finally, the Boards confirmed that the proposed transaction with WellPoint meets all Blue Cross Blue Shield Association licensure guidelines. With the Boards' strategic objectives satisfied, the Boards unanimously voted to approve the Merger Agreement with WellPoint on November 20, 2001.

The Conversion of GHMSI and Acquisition by WellPoint is in the Best Interest of GHMSI Subscribers and the Insurance-Buying Public

1. Accenture's Reports

As discussed at length above, the Boards of CareFirst and GHMSI engaged a number of external expert advisors, including Accenture. In addition to the ongoing assistance Accenture provided the Boards during 1999, Accenture was retained for two later projects based on its expertise with respect to the health care industry. In September 2001, CareFirst retained Accenture for an engagement that encompassed an analysis of potential implications of conversion on CareFirst's constituents, which included contract holders, employees, health care providers and the affected communities. The result of this engagement was a report dated November 16, 2001, titled "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response" (the "Assessment").

In November 2001, Accenture was asked to prepare a Community Impact Statement for CareFirst. The objective of this report was to determine the probable impact of CareFirst's conversion to a for-profit business entity and its acquisition by WellPoint upon the availability, accessibility and affordability of health care in the primary communities served by CareFirst. The result was the document titled "Community Impact Analysis of the Proposed Conversion of CareFirst to a For-Profit Business Entity and the Merger Between CareFirst and WellPoint Health Networks Inc" (the "Impact Statement").

The Insurance Commissioner has asked GHMSI in connection with the Amended Application to provide details to support the conclusion reached in the Impact Statement, namely that there is reason to conclude that availability, accessibility and affordability of health care in the District of Columbia has the strong potential to be positively impacted by the conversion of GHMSI and subsequent acquisition by WellPoint. Applicants will explain in this section of the Amended Application many of the reasons why the conversion of GHMSI and its acquisition by WellPoint will positively impact the accessibility, availability and affordability of health care in the District of Columbia.

However, before doing so, Applicants would like to emphasize that CareFirst retained Accenture to assess the impact of the transaction on the accessibility, availability and affordability of health care because of Accenture's expertise in these areas. The Assessment and Impact Statement represent the independent conclusions reached by

Accenture based on extensive research and Accenture's expert knowledge of the health care industry. It should be noted that the fees charged by Accenture for the Assessment and Impact Statement are not dependent in any way upon the approval or disapproval of the proposed transaction by any of the respective jurisdictions. Accenture's conclusions are supported by detailed analysis, objective assumptions and relevant supporting data. Appended to the Assessment and Impact Statement are source materials compiled and reviewed by Accenture.

2. The Conversion and Acquisition Will Positively Impact Accessibility, Availability and Affordability of Health Care in the District of Columbia

To assess the probable impact of the conversion of GHMSI and acquisition of GHMSI by WellPoint on the District of Columbia, and specifically the accessibility, availability and affordability of health care services, it is first appropriate to address the reasons driving the decision to convert and merge with WellPoint and the possible implications of not converting and merging with a company such as WellPoint. Many of the reasons are discussed above, but will be discussed in greater detail in this section. CareFirst and GHMSI acknowledge and are proud of the fact that GHMSI holds a strong position in the health care market in the District of Columbia and the Mid-Atlantic region and is able to serve its subscribers' needs. GHMSI has achieved its current position in the marketplace, in part, through the advantages and growth achieved by the business combination of the Maryland, District of Columbia and Delaware plans.

The health care industry in the Mid-Atlantic, however, is consolidating and CareFirst must compete with large national for-profit health carriers. National carriers are becoming increasingly active players in the Mid-Atlantic region, and CareFirst and GHMSI must compete on measures of service, access, choice, quality and affordability with these larger, innovative and well-capitalized for-profit companies. In terms of market share, CareFirst's top three competitors (Aetna, Kaiser and MAMSI) increased their market share in CareFirst's market area from 22% in 1995 to 37% in 2000, which amounts to a 68% growth in market share. It is within this context that CareFirst and its Board of Directors began to examine the strategic options that were available that would best allow CareFirst to serve its subscribers now and in the future, and secure a strong Blue presence for years to come. CareFirst identified a number of threats to its continued success and stability, including:

- An increasing inability to provide as much focus as needed for innovation to meet the needs of customers and providers;
- Continuing consolidation among national insurers which precluded preferred partnering;
- National pricing practices of competitors which were undercutting CareFirst's prices;
- CareFirst's limited ability to leverage its products and services over a large national base;
- Limited reserves and inadequate capital to invest in technology, enhance products and services, and protect the companies from an unexpected or catastrophic event; and
- A limited – and dwindling – universe of partnership opportunities that could negatively affect CareFirst's ability to sufficiently control its future.

Although CareFirst believed that its strategy of affiliation of contiguous Blue plans, including GHMSI, was valuable in addressing local and regional competition, the affiliations did not leave CareFirst in a strong position to counter national competitors, fight the effects of continued industry consolidation, or provide the type of capital infusion necessary to invest in improved technologies, products and services to compete effectively. It was evident to CareFirst that a long-term strategy was needed for CareFirst to remain strong and stable in the face of a consolidating marketplace.

As part of CareFirst's long-range planning process, Accenture was engaged to identify the strategic imperatives that would need to be met to secure CareFirst's long-term future and to assist it in identifying the strategic options that would best allow CareFirst to meet those imperatives. To remain a leading health care company with the ability to provide the level and type of service demanded by consumers, and to compete in an increasingly consolidating marketplace, Accenture identified three strategic imperatives for CareFirst: (1) it must be of a size where revenues of $11 billion to $16 billion annually are available to remain competitive over the long term; (2) it must increase its access to capital to provide the anticipated $300 million over five years necessary to invest in technology, service, and other enhancements necessary to comply with regulatory mandates and compete effectively with national insurers; and (3) it must strengthen its competitive position in core market segments throughout its service area.

With Accenture's assistance, CareFirst and GHMSI considered a variety of strategic options for the future which were designed to address the three strategic imperatives identified by Accenture, including: remaining a private, nonprofit company; affiliating with another nonprofit company; converting to for-profit status and undertaking its own IPO; and converting to for-profit status followed by a merger. After thorough consideration, CareFirst determined that conversion and merger would meet the need for enhanced scale and capital so long as it met certain conditions. Those conditions included:

- An ability to make CareFirst stronger and more stable for its customers while ensuring that local headquarters would be maintained and local employment protected;
- The ability to better serve customers and providers through enhanced customer service and administrative improvements;
- Provisions offering access to capital to enable CareFirst to make needed investments in technology and initiatives to allow it to serve customers and providers better; and
- Provide fair value for the company in the form of a charitable trust that would enable elected officials in the jurisdictions in which CareFirst and its affiliates were domiciled to address the needs of the communities.

CareFirst and GHMSI believe that CareFirst in its current configuration will become less able to serve its customers over time and therefore less competitive in the marketplace. The conversion and acquisition will allow CareFirst to provide enhanced products and improved service to customers and providers. Also, because WellPoint holds a Blue Cross Blue Shield brand license, the transaction will help to secure the long-term future of the "Blue" brand in the District of Columbia and assist in keeping insurance affordable. Other specific benefits identified by CareFirst include:

- **Financial Stability** – CareFirst is now a $6 billion company (based on premiums and premium-equivalents) with $600 million in statutory surplus and 3.1 million members (including Blue Card members in which CareFirst is the host Plan). However, CareFirst's net margin of less than 1.5 percent of gross revenues leaves CareFirst with only limited resources to invest in the costly technology enhancements needed to better serve customers, create and implement new, more flexible products, particularly in the individual and small group markets and comply with expensive state and federal requirements such as the Health Insurance Portability and Accountability Act.
- **Preservation of a Strong Locally Led Blue Plan –** WellPoint – which already operates Blue Plans in California, Georgia and Missouri -- shares a common belief with CareFirst and commitment to the concept that health care is best when it is locally managed and locally delivered.
- **Capital Infusion to Enhance Efficiency and to Serve Customers Better –** Because WellPoint is a for-profit, publicly traded company, CareFirst will have increased access to capital to invest in improving its operations and to improve its ability to serve customers. This will avoid the need for CareFirst to enter the debt market, which would be costly to its subscribers and which, in almost all cases, would be insufficient to meet its needs.
- **Creation of $1.3 Billion in Funding for the Public Good –** As part of the agreement, WellPoint will pay $1.3 billion to acquire CareFirst. The full value of CareFirst will go to charitable trusts in the three jurisdictions where CareFirst affiliates are domiciled. The District of Columbia's share of the proceeds can be used to help maintain accessible, available and affordable health coverage in the District of Columbia. At the same time, CareFirst will remain an active, contributing corporate citizen in all of the communities it serves, contributing money, volunteer involvement and leadership in support of a variety of charitable and civic organizations and endeavors. The District of Columbia will benefit from the transaction occurring now, at a time when CareFirst is a market leader and its value is high.
- **Enhanced Products and Services –**The conversion and acquisition will allow CareFirst to enhance and improve the types of products and services it offers customers, including:
    1. The creation of customized products providing members with increased flexibility and additional choices regarding deductibles and co-pays.
    2. Innovative disease management programs, pharmacy discount programs, and expanded alternative medicine offerings.
    3. Resources that will allow CareFirst to invest in needed technology improvements that will allow it to answer subscriber calls more quickly and more accurately.
    4. Improvements to on-line capabilities which could include measures such as 24 hour-a-day, 7 day-a-week enrollment for prospective members, claims tracking, physician selection, and address changes in real time. CareFirst will have access to resources now unavailable to invest in improvements that will make it easier for customers to manage their health care.
    5. As part of a for-profit, national insurer CareFirst will be better positioned to slow the rate of premium increases than it could as an independent,

regional insurer. It is clear that medical inflation – increases in prescription drug costs and care costs linked to the development of new technology – will continue to climb. No insurer is immune to these trends. But, by aligning with a much larger, national insurer, CareFirst will have resources to invest to increase efficiency, and the ability to share administrative costs over a much larger subscriber base. CareFirst's ability to limit rising premiums is directly linked to its ability to operate more efficiently.

The Insurance Commissioner has asked that the Amended Application include a pre-transaction and post-transaction comparison of items such as products, premiums, competition, and health care contracts, open enrollment, and coverage for small groups, uninsurable and the poor. As an initial matter, WellPoint currently has no plans to discontinue any of CareFirst or GHMSI's existing products or services, or to alter contracts or relationships with health care providers. WellPoint is not going to raise subscribers' premiums as a result of this transaction. WellPoint subscribes to the philosophy that health care is locally delivered and locally consumed and plans for GHMSI to continue to be managed locally. WellPoint's focus is on choice and value, and it remains committed to serving the needs of GHMSI's subscribers and providing affordable, quality products to the residents of the District of Columbia.

If the acquisition is approved, WellPoint plans to achieve growth through the introduction of new products and services to GHMSI consumers and District of Columbia residents. WellPoint, in conjunction with local management, will assess what improvements can be made in light CareFirst's current business operations and the local market and regulatory environments. Neither WellPoint nor GHMSI can predetermine what business decisions will be made after the acquisition, but their shared goal is to increase the products and services available to District of Columbia consumers, and improve upon the existing products where feasible. WellPoint's track record for innovation and current products and service offerings make this shared goal attainable.

3. WellPoint's Products, Services, and Program Participation

WellPoint serves customers in all markets, including large group, small group, individual, senior, public entities, the State Children's Health Insurance Program and Medicaid. Areas of focus for WellPoint include the individual and small group markets, and WellPoint views the uninsured populations as an opportunity to expand its customer base. WellPoint believes that one way to expand into the uninsured markets is through educating the public as to available products, such as small group guaranteed-issue products in California. WellPoint continually conducts research to inform the development of new products that will encourage both small employers and uninsured families or individuals to participate in the insurance system.

To enhance marketability of its plans to market segments such as the uninsured, WellPoint introduced the HMO Saver product through Blue Cross of California. HMO Saver is 20 to 25% more affordable than traditional HMO plans in order to attract young families and the uninsured. To make the premiums low, co-payments for physician office visits mirror those of a typical HMO. However, the hospital component is designed more like a PPO with a deductible for certain hospital and outpatient benefits.

WellPoint also offers a PPO Saver product in California. This product takes the concept of offering a lower-priced option to attract younger individuals and families even further. The product includes coverage for hospitalization with a $500 deductible, first dollar coverage for two physician office visits per year for each adult and four office visits each year for each child. There is also first dollar coverage for basic lab, x-ray and pharmaceuticals. The result is that the pricing of the PPO Saver is very attractive to the uninsured population.

A unique product pioneered by WellPoint, which it offers in the small group market, is FlexScape. FlexScape offers an array of health coverage programs for small businesses. FlexScape offers small employers greater cost predictability through fixed premium contribution options while also providing employees with a full breadth of health plan choices.

With FlexScape's defined contribution feature, an employer's monthly contribution level is fixed at a certain dollar amount. Employees are responsible for any monthly premium amount in excess of their employer's contribution and can manage their share of costs by choosing the health care coverage that best fits their lifestyle, their budget and their family's needs. FlexScape offers a wide choice of affordable plans in the high, medium and low price range. Employees within the small group can choose any option. FlexScape also includes products that help small business owners pay their employees' premiums on a pre-tax basis.

FlexScape provides small business owners with the kind of competitive and attractive health benefits package that helps recruit and retain employees. In addition, because of its affordability, cost predictability and employee empowerment options, FlexScape is a viable option for uninsured businesses or those contemplating dropping employee health care coverage due to rising costs. Blue Cross Blue Shield of Georgia has decided to test similar product features to expand coverage in its small group market.

Because each employee in a small group varies in his or her health care preference, financial situation, and lifestyle, WellPoint designed EmployeeElect, which offers small group employees nine standardized options from which they can choose. EmployeeElect, offered through Blue Cross of California, allows a young, single employee to choose one of WellPoint's HMOs and an employee with a family that values a broader network to choose a PPO.

Blue Cross of California introduced a program similar in concept to EmployeeElect in the individual market. Its PlanScape product offers a FamilyElect feature, which allows each member of the family to pick whatever products meets his or her particular needs. For example, a married couple with a child might make the following choices: the wife may choose the PPO in which her OB/GYN participates and her husband may choose a different product. However, they may choose an HMO for their child because her visits to the pediatrician are more frequent and they prefer the low co-payments for office visits. Although the family members may be enrolled in different plans the family receives one bill.

With market innovations like PlanScape, WellPoint believes it can penetrate more of the uninsured market than ever before. Basic coverage in California can start as low as $21 per person per month (depending on age and area), allowing individuals and families to afford protection from unforeseen or catastrophic medical expenses.

WellPoint offers numerous Medicare supplement plans, which typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Select is a PPO based product that offers supplemental Medicare coverage. WellPoint also offers Medicare Select II, a hybrid product that allows seniors over the age of 65 to maintain their full Medicare benefits for any out of network benefits while enrolled in a supplemental plan that allows them to choose their own physician with a co-payment. As of 2001, these plans served approximately 200,000 members. WellPoint also offers Blue Cross Senior Secure, a HMO plan operating in defined geographic areas, under a Medicare + Choice contract with the Centers for Medicare & Medicaid Services ("CMS"). This contract entitles WellPoint to a fixed per-member premium from CMS. In addition to physician care, hospitalization and other benefits covered by Medicare, the benefits under the plan typically include prescription drugs, routine physical exams, hearing tests, immunizations, eye exams, counseling and health education services.

In California, WellPoint saw a need for California's Indian tribes to obtain affordable private health insurance. In response, Blue Cross of California designed a program that would meet the tribe members' needs. The California Indian Health Care Program offers Indian tribes a selection of two popular Blue Cross of California small group plans with low deductibles and out-of-pocket fees for office visits and prescription drugs. The program also includes value-added features such as Healthy Extensions, MedCall, and Baby Connection. The programs have been made available on a guarantee issue basis to all 103 federally recognized tribes throughout California. The governing body of each tribe acts as the administrator for its tribal members, selecting a health plan of choice and contributing 100 percent of the eligible tribal members' premium.

WellPoint has been a significant partner in the Medicaid program. In California, Blue Cross of California participates in Medi-Cal managed care in thirteen counties, serving over 700,000 members. Blue Cross of California is the first choice of more enrollees than any other participating private health plan. Blue Cross of California has worked hard to serve these populations in a culturally competent and linguistically sensitive manner. Blue Cross of California has established a community resource centers to assist members with obtaining Medi-Cal services and benefits.

Blue Cross of California also participates in California's Healthy Families Program in all 58 counties through both an HMO and EPO model. Blue Cross of California currently serves approximately 207,000 members. Blue Cross of California serves approximately 6,000 AIM (Access for Infants and Mothers) members in 45 counties. Blue Cross of California is also the state administrator and a participating plan for the state high-risk pool – MRMIP (Managed Risk Medical Insurance Program) – providing coverage for over 11,000 members who are uninsurable.

In Oklahoma, UNICARE Health Plan of Oklahoma (a WellPoint Subsidiary) also participates in SoonerCare Plus as the State's only non provider-owned Medicaid HMO.

The program is offered in twelve counties and serves approximately 33,000 enrollees. In Puerto Rico, WellPoint has entered into a joint venture to provide services to approximately 425,000 members enrolled in the Health Care Reform HMO Program for the Medicaid, SCHIP, and other low-income uninsured populations. In Virginia, UNICARE Health Plan of Virginia participates in Medallion II, the Medicaid HMO program, and FAMIS, the SCHIP program, serving over 38,000 members.

The Managed Risk Medical Insurance Board, which is dedicated to improving the health of Californians by increasing access to affordable, comprehensive, quality health care coverage in California, awarded Blue Cross of California two grants under the Healthy Families Program totaling $9 million from 1998-2003 to partner with local traditional and safety net providers to increase access to care in rural areas and to increase access to care for special populations such as migrant and seasonal farm workers, forestry and fishery workers, and American Indians. The grants will be used to provide additional providers and bilingual staff in rural areas, extend clinic hours, and support three mobile service units.

WellPoint believes that understanding the impact cultural differences have in delivering health care is essential in order to improve access to quality health care. By sponsoring community resource centers with multilingual and multicultural outreach specialists, WellPoint assists members in state sponsored programs in bridging the gap to better care through more appropriate utilization of health care services. WellPoint's efforts to reach underserved communities are supported by the use of interpreters and the development and dissemination of translated written materials.

In terms of ancillary benefits, WellPoint offers a variety of dental plans. WellPoint's dental plans include Dental Net, its California dental HMO, and Blue Cross Dental Select HMO, a hybrid plan, a dental PPO and traditional indemnity plan. WellPoint's dental plans provide primary and specialty dental services and as of 2001, served approximately 2.2 million members.

WellPoint also offers pharmacy services and pharmacy benefit management services to its members. WellPoint's pharmacy services incorporate features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Pharmacy benefit management services provided by WellPoint include management of drug utilization though outpatient prescription drug formularies and retrospective review and drug education for physicians, pharmacists and members. As of 2001, WellPoint has 29 million risk and non-risk pharmacy members and 54,000 participating pharmacies.

In 2001, WellPoint's wholly owned pharmacy benefit management (PBM) company, WellPoint Pharmacy Management Company, ranked as the largest health plan-owned and the fourth largest PBM in the United States. As of December 31, 2001, approximately 22 million members were from external clients, such as other health plans and smaller PBMs, while more than 10 million members were enrolled in a WellPoint medical plan. WellPoint Pharmacy Management Company provides many options for employer groups to choose from to meet their prescription drug and benefit needs.

Large group customers select WellPoint Pharmacy Management Company for pharmacy benefit services for a number of reasons, including its agility in implementing pharmacy programs and initiatives, such as the adoption of generic drugs and utilization management programs. WellPoint Pharmacy Management Company also offers large group customers easy access to pharmacy and prescription drug information, enabling them to better monitor their own cost trends and utilization. A major benefit of WellPoint Pharmacy Management Company is its ability to integrate medical and pharmacy data. WellPoint Pharmacy Management Company also focuses on educating physicians and members about appropriate prescription drug use for better medical outcomes for members.

In addition to WellPoint's innovative products and program participation, WellPoint also has invested in several customer service initiatives for its subscribers. For example, WellPoint offers Healthy Check Centers to both individual and group members. Through the Healthy Check Centers, annual check-ups can be performed for a low fee, with the deductible waived. At the end of the check-up, the member receives a copy of the test results, educational materials and a personal health appraisal, which includes an evaluation and specific health recommendations.

WellPoint has also invested in establishing the largest telemedicine infrastructure in the United States. The program supports five specialty centers (academic, children's hospitals, and private specialty centers) and 43 primary care centers. The program uses live, real-time videoconferencing technology to link specialists and rural health care providers across great distances.

WellPoint is also one of the first health plans to give subscribers the option of paying their health insurance premiums automatically with a credit card. By providing members with innovative payment options, WellPoint is addressing evolving customer needs while working to improve customer service, customer retention and ultimately billing efficiency. In addition to providing a convenient payment method for members, internal processing has been streamlined and costs associated with cash and check handling have been reduced. The initiative also works to reduce billing errors and serves as a key customer service differentiator.

In 2001, WellPoint modified its incentive compensation arrangements for California medical groups to include a component that rewards physician groups for the delivery of quality health care and patient service. The quality measures, which are determined with each medical group, may include such items as patient satisfaction surveys, waiting times for appointments, number of complaints and grievances, peer and staff reviews, and patient turnover. In addition, the measurements include physician performance in managing chronic diseases such as asthma, diabetes or hypertension and adherence to screening guidelines for breast, cervical and prostate cancer. WellPoint's advances in physician bonus incentives demonstrate its commitment to encouraging the delivery of quality health care and patient service by its physician groups.

Throughout 2001, WellPoint engaged in strategic initiatives with key health care professionals to encourage innovation in health care delivery for the benefit of members. WellPoint's collaboration with nonprofit Catholic Health Care West (CHW) and a joint initiative with nonprofit California Health Alliance (CHA) illustrate how resources can

be combined to enhance quality and create greater efficiency. The WellPoint/CHW initiative focuses on care coordination, patient safety and technology enhancements through:

- A collaborative effort to recruit and retain nurses at CHW facilities;
- The hiring of clinical pharmacists at CHW facilities to help ensure appropriate medication use among patients receiving care while reducing the risk of harmful drug interactions; and
- Enhancements to technology and related professional services to improve electronic claims and other data transmission for more efficient and accurate transactions.

WellPoint's initiative with CHA is designed to assist physicians in reducing administrative burdens and costs. Together, WellPoint and CHA are exploring new technologies while striving to enhance member wellness through education and promotion of the best clinical care practices.

WellPoint's development of fast, reliable and affordable electronic data interchange (EDI) initiatives promotes the delivery of quality health care services and new efficiencies in communication with health care professionals. EDI contributes to health care affordability, improves information accuracy between health care participants, improves the quality of health care delivery and its supporting processes, and enhances information availability for members and health care professionals.

WellPoint's objective of reducing administrative burdens in the health care system is demonstrated through its recently enhanced Provider Access website. With new tools and functionality, physicians and hospitals have the ability to more closely track claims payments and status. Provider Access offers valuable coverage and payment information online. Health care professionals are able to view the same information that a service representative can supply over the phone, thereby saving time, eliminating paperwork and improving cash flow. In addition, the enhanced web resource instantly informs physician office staff about patient benefits and eligibility information and provides verification of payments for medical claims.

One of the unique and innovative ways that WellPoint delivers value to its large group employer customers is through mybcclink.com, an online, real-time benefits service. Traditionally, group administrators noted eligibility changes on forms that were mailed to Blue Cross of California, where associates keyed in the changes. This process led to a delay between the time a change was noted and the time it took effect.

Now, using mybcclink.com, group administrators can make changes that become effective immediately. This online system allows them to log on to a web site where they can add, change or delete employee eligibility records; order replacement identification cards; locate physicians, hospitals and other health care professionals in their network; view current and historical billing information; and conduct a number of other useful functions. In addition to inputting changes, group administrators can download eligibility data and create ad hoc reports. As soon as a group administrator makes a change via mybcclink.com and the data is successfully transmitted, the Blue Cross of California system is immediately updated, eliminating lag time. Due to the success of this real-time

benefits service in California, WellPoint has plans to offer a similar system to large group customers in other strategic geographies.

Consumers' desire for on-demand information and services has led WellPoint to create a series of high tech tools to assist agents, brokers and consultants in meeting their customers' expectations. These include:

- *AgentFinder* - a unique service that lets online insurance shoppers search for a local, independent insurance agent by simply typing in their zip code and selecting the type of product - individual, small group or senior.
- *AgentConnect* - allows independent agents, brokers and consultants to link from their website to WellPoint's online sales tools. Applicants can view rates and benefits, search for providers and submit electronic applications without leaving the agent's office.
- *AgentOnline* - provides agents, brokers and consultants with the resources to grow their business by providing discounted Internet access and web design services to establish a basic Internet presence.

For many of the reasons described above, WellPoint was chosen by Fortune Magazine as the "Most Admired Health Care Company" for an unprecedented fourth consecutive year in 2002. In addition to having the highest overall score in its industry, WellPoint was the highest-ranking health care company in all eight reputation categories: social responsibility, innovation, financial soundness, employee talent, use of corporate assets, long-term investment value, quality of management, and quality of products and services. WellPoint was the top ranked company in social responsibility for the second year in row. The WellPoint-owned Blue Cross of California has received "Best of Blue" awards for innovation in patient care and best practices in partnerships from the Blue Cross Blue Shield Association. Given WellPoint's demonstrated record of excellence, the Board of GHMSI is confident that its affiliation with WellPoint will serve the existing subscribers of GHMSI and will enhance availability, affordability, and accessibility of health care in the District of Columbia.[2]

4. Other WellPoint Transactions

Blue Cross of California

The Insurance Commissioner has asked GHMSI to include in this Amended Application an analysis of how previous WellPoint transactions have proven the conclusions reached in the Impact Statement to be true. The first relevant transaction is the conversion of Blue Cross of California. In 1991 Blue Cross of California began a process of restructuring in which it transferred substantially all of its operating assets to a newly formed for-profit company, WellPoint Health Networks, in exchange for all of WellPoint's stock. In February 1993, WellPoint completed an IPO in which it sold 19.5 million shares of newly issued stock to the public for $510 million. The California

[2] As is evidenced by WellPoint's 10-K statements, filed as exhibits 2-B1 through 2-B5 to the original Form A filed on January 11, 2002, and the 10-K statement filed as Exhibit 2-B1A to this Amended Application, WellPoint is a financially strong company and its acquisition of GHMSI will not jeopardize the financial stability of GHMSI or prejudice the interests of GHMSI's policyholders. D.C. Code § 31-703(g)(1)(c).

Department of Corporations concluded that step this was not a conversion of BCC to a for-profit entity and began to work with WellPoint to complete the conversion process. This process was completed in May of 1996 with the creation of two independent foundations, funded by cash and WellPoint stock, each dedicated to programs that increase access to public health care for underserved populations within the state and to improving the overall health status of the people of California. At the time of conversion, these foundations held a combined $3 billion in assets. As a result of WellPoint's success, the value of these foundations is now greater than $4 billion.

These two independent foundations are dedicated to improving the health of all Californians, particularly uninsured families and underserved communities. These foundations operate without any influence from WellPoint. Today, The California Endowment (TCE) is California's largest health care foundation, currently reporting assets of $3,490,256,400. Since its inception, TCE has awarded more than 2,100 grants totaling nearly $695,000,000 to community-based organizations throughout California. TCE funds in three broad areas: Multicultural Health, Health and Well-Being, and Access. The foundation is community-based, funding projects such as: The 100% Campaign to promote insuring all California children and The Agricultural Worker Health Program-- a 5-year, $50 million initiative to improve the health of California's agricultural worker community.

The California Health Care Foundation (CHCF) has six program areas—Quality; iHealth and Technology; Improving Care Delivery; Health Insurance Markets and The Uninsured; Provider Systems; and Medi-Cal/Healthy Families. Examples of projects include providing technical assistance to hospitals on legislatively-mandated medication error reduction plans; developing Health-e-App, a Web-based enrollment system for California public health insurance programs; and implementing improved models of care for children with special health care needs. CHCF also developed a Web-based resource for small firms interested in purchasing health coverage.

In addition to the enormous value added to the communities by the creation of these foundations, Blue Cross of California, since the conversion, increased its number of subscribers, number of employees, the products and services available to subscribers and California residents, and involvement in public programs. Detail concerning many of these areas is contained in WellPoint's 10-K Statements and Annual Reports, which were included in the original Form A filing with the Department, and documentation appended to the Assessment performed by Accenture, which will be provided to the Department. As Accenture's data demonstrates, from 1994 to 2000, Blue Cross of California experienced robust membership and network growth and decreased its administrative expense ratio throughout the improvements. Most members surveyed were unaware of the company's change in corporate form. In addition, most of WellPoint's innovative products, public program involvement and services described above were implemented after the Blue Cross of California's change from nonprofit to for-profit form. The Blue Cross of California conversion demonstrates that, far from losing something of value in the conversion of the State's Blue plan, California gained an innovative and thriving Blue insurer that contributed to its subscribers and the community in a myriad of ways and also gained through the creation of two foundations dedicated to addressing the health needs of Californians.

BlueCross BlueShield of Georgia

On March 15, 2001, WellPoint acquired Cerulean Companies, Inc., the parent company of BlueCross BlueShield of Georgia ("BCBSGA"). In connection with the transaction, WellPoint strongly urged the creation of a health care foundation with the proceeds of the transaction. Ultimately, the transaction funded Health Care Georgia, Inc. with $114 million to be used to improve health care for all Georgia citizens.

Following the transaction, the Georgia plan has continued to operate as Blue Cross Blue Shield of Georgia, in much the same manner as prior to the transaction. The corporate headquarters remain in Atlanta and the operations center remains in Columbus, Georgia. The plan continues to be locally operated, with 12 of the 14 senior management roles remaining filled by former management. Before the merger there were 17 regional sales and service centers. After the merger two centers were combined resulting in 16 locations. The Georgia operations of WellPoint's affiliate UNICARE Life & Health Insurance Company have been consolidated with the BCBSGA operations and UNICARE's products have been converted to BCBSGA products.

BCBSGA underwent a complete review of its product portfolio available to both individuals and small groups. The result is a series of products recently introduced that are designed specifically for these markets. Additions to the product portfolio include the FlexScape and PlanScape products similar to those offered by Blue Cross of California as described above. A similar review focused on national accounts resulting in improved sales and services to that market segment.

The success of the Georgia transaction is evidenced by the numbers. As of December 31, 2000, BCBSGA had slightly less than 1.9 million members in both insured and ASO products. As of December 31, 2001 that number had grown by over 100,000 members. All major business segments experienced growth. During that same time period, the employee population of BCBSGA increased. BCBSGA continues to have 100% hospital participation in the indemnity network. In addition, there has been no change in the participation of the PPO or HMO hospital networks. The physician networks have also experienced growth in the indemnity, PPO and HMO networks since the transaction, providing greater choice to subscribers.

Blue Cross Blue Shield of Missouri

On January 31, 2002, WellPoint acquired RightCHOICE Managed Care, Inc., which, through its affiliates, operates as Blue Cross Blue Shield of Missouri and HealthLink, which offers provider network contracting services and other health benefits administration services in the states of Missouri, Illinois, Iowa, Arkansas, Indiana, Kentucky and West Virginia.

The acquisition was first announced in October 2001, and followed the reorganization of RightCHOICE on November 30, 2000 which created the Missouri Foundation for Health, Missouri's largest health related foundation. In connection with the WellPoint acquisition of RightCHOICE, the Missouri Foundation for Health received cash and WellPoint stock increasing its total assets to nearly $950 million. Those assets are now being used by the Missouri Foundation for Health to serve the needs of the underinsured and uninsured Missourians in Blue Cross Blue Shield of Missouri's service

area. On August 9, 2002, the Missouri Foundation for Health announced that it had awarded its first grants which totaled $2.6 million, to 21 community organizations and agencies serving Missourian's health related needs. The Missouri Foundation for Health expects to issue an additional $8 million in grants in 2002, and up to $40 million in 2003.

Following the merger, Blue Cross Blue Shield of Missouri continues to serve the health care benefit needs in its service area in substantially the same manner as prior to the merger. The corporate headquarters of Blue Cross Blue Shield of Missouri and HealthLink remain in the St. Louis metropolitan area, and operations centers remain in Cape Girardeau and Springfield, Missouri. In fact, St. Louis became the regional headquarters for WellPoint's Central Region, which includes not only Blue Cross Blue Shield of Missouri and HealthLink, the former RightCHOICE companies, but also includes a UNICARE affiliate of WellPoint. Central Region management consists of former RightCHOICE managers and two WellPoint officers. While part of the WellPoint family and the Central Region, each of Blue Cross Blue Shield of Missouri, HealthLink and UNICARE continue with separate management teams and operations centers.

In the six months since the merger, Blue Cross Blue Shield of Missouri and HealthLink have reviewed their products but have made no substantial changes to the product offerings, except that WellPoint Pharmacy Management Company has begun to serve as the Pharmacy Benefit Manager for the Blue Cross Blue Shield of Missouri products. In addition, RightCHOICE Insurance Company, a small insurer in Illinois has announced its intent to exit from the market, but its members are being offered UNICARE products on a guaranteed issue basis. Missouri management also views the merger as a positive opportunity to consider the addition of new product offerings relying on WellPoint's experience, strong marketing expertise, ability to better serve national accounts, and its broad portfolio of products -- particularly specialty products, including life, dental and long term care.

Since the merger, Blue Cross Blue Shield of Missouri and HealthLink continue to grow, adding approximately 47,000 and 20,000 members respectively. The employee population has remained substantially stable and there have been no significant changes in the hospital and physician networks as a result of the merger.

Looking at precedent, WellPoint's track record suggests that it will work to enhance availability and accessibility of health care in the District of Columbia. If the Amended Application is approved, WellPoint will work with CareFirst to learn about the District of Columbia's uninsured populations, its small business sector, and its public programs in an effort to further enhance GHMSI's products and programs already in place to better serve District of Columbia residents.

The Applicants must demonstrate that the acquisition of GHMSI by WellPoint is not likely to be hazardous or prejudicial to the insurance-buying public. D.C. Code § 31-703(g)(1)(F). The Board of GHMSI believes that, far from having any likelihood of hazard or prejudice, this acquisition will be in the best interests of the insurance-buying public, providing residents of the District of Columbia with increased choice and innovation in the marketplace with the same high standard of quality and service they expect from GHMSI today. In addition, the District of Columbia's share of the proceeds of the transaction provides an unprecedented opportunity to address the unmet health care needs of the residents of the District of Columbia.

The Acquisition of GHMSI Will Not Adversely Impact Competition

Currently, GHMSI possesses 27% of the combined health insurance markets in the District of Columbia and Northern Virginia, and 24% percent of the Northern Virginia market. WellPoint, through its UNICARE Life & Health Insurance Company subsidiary, transacts health insurance business in the District of Columbia and Northern Virginia. UNICARE, WellPoint's only affiliated company that transacts insurance business in the District of Columbia and Northern Virginia, currently holds less than 1% of the health insurance market in the District of Columbia and approximately 3% of the health insurance market in Virginia. UNICARE's Northern Virginia market share percentage includes insureds in counties in which GHMSI does not write business, making UNICARE's share in the overlapping counties less than 3%. Given GHMSI's significant presence in the District of Columbia and Northern Virginia, and UNICARE's minimal share of the market, the affiliation of the entities will have a negligible competitive impact on GHMSI's service area.

The addition of UNICARE's market share to that of GHMSI will not result in GHMSI experiencing a sufficient increase in market power to meaningfully impact its ability to renegotiate contracts with health care providers or hospitals, reduce compensation to health care providers or hospitals or alter the geographic dispersion of health care providers. The Mid-Atlantic region is a highly competitive market environment. Due to the competitiveness in the market, if GHMSI were to increase its D.C. market share by less than 1% and its Northern Virginia market share by less than 3%, GHMSI will not gain an unfair competitive advantage. GHMSI will continue to have an incentive to maintain the size of its physician and hospital networks to stay competitive with other carriers. Indeed, the size and scope of a health plan's networks is a key customer purchase criteria, providing a market incentive to expand networks, not reduce them. This conclusion is supported by the BCBSGA acquisition, after which the size of provider networks increased.

GHMSI's Statutory and Charted Purpose

GHMSI, as a nonstock, nonprofit corporation offering subscriber contracts as part of hospital and medical service plans, is licensed under Title 31, Subtitle 35 of the District of Columbia Code ("Act"). To qualify as a hospital or medical services plan under the Act, GHMSI is required to be "organized bona fide for the purpose of establishing, maintaining and operating a hospital service plan, a medical service plan, or combination of the two." D.C. Code § 31-3505. Hospital and medical service plans, respectively, are (1) a plan for providing hospital and related services to subscribers, or benefits and indemnification for such services; and (2) a plan for providing medical and related services to subscribers, or to benefits and indemnification for such services.

Thus, GHMSI, as a licensed hospital and medical services plan, must be organized for the purpose of establishing, maintaining and operating plans for the provision of hospital and medical services to subscribers, or to provide benefits or indemnification for those services. Consistent with its governing statutes, GHMSI's charter identifies the following powers:

> SEC 2. [GHMSI] is hereby authorized and empowered (a) to enter into contracts with individuals or groups of individuals to provide for hospitalization and medical care of such individuals, upon payment of specified premiums, and to issue such individuals appropriate certificates evidencing such contracts; (b) to enter into contracts with hospitals and other providers for the care and treatment of such individuals, in accordance with the terms of such certificates; (c) to cooperate, consolidate, or contract with individuals, groups or organizations interested in promoting and safeguarding the public health; and (d) to engage in any lawful business that is incidental to or supportive of the business and affairs of this corporation.
>
> SEC. 3. Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders.

GHMSI's governing laws and charter make clear that its purpose is to provide its subscribers (the terms "subscribers" and "contract holders" will be used interchangeably) with medical and hospital services by issuing contracts for such services in exchange for premiums, and by contracting with health care providers for the provision of those services. Further, GHMSI must not be operated for profit, but instead for the benefit of its certificate holders.

GHMSI's Products, Services and Practices

To fulfill its corporate purpose and obligation to its contract holders, GHMSI offers a broad spectrum of products designed to meet the needs of all of its contract holders in both the individual and group markets.[3] In the individual market, GHMSI offers an indemnity comprehensive major medical plan with two deductible options and $1 million policy maximum. GHMSI also offers its BluePreferred PPO to District of Columbia residents under the age of 65. This preferred provider health insurance plan has a $2 million policy maximum. The BluePreferred plan offers a variety of deductible and coinsurance levels, enabling individuals to tailor benefits to meet their particular health needs and budget. BluePreferred includes preventative care benefits and a co-payment prescription drug plan. BluePreferred is available in a medically underwritten product, as well as special, HIPAA-only plans that are not medically underwritten. GHMSI offers a group PPO conversion plan for individuals who leave the group, with co-payment prescription drug benefits.

In addition to its PPO products, GHMSI offers BlueChoice HMO in the individual market, which provides comprehensive coverage including preventative services, office visits, medical and surgical services, 365 days of hospitalization, mental illness and substance abuse benefits, maternity care, eye examinations, and prescription drug benefits. Dental benefits are also available on the BlueChoice product. BlueChoice

[3] All of the products and services which will be described are either offered by GHMSI directly to its contract holders, or are offered through an affiliate of GHMSI and available to contract holders of GHMSI.

is available at a variety of co-payments, and can be purchased by HIPAA eligible applicants without medical underwriting. BlueChoice has a group conversion plan available for individuals who leave group membership. The group conversion plan provides comprehensive benefits including preventative care, diagnostic testing, surgery, hospitalization, and emergency care. GHMSI also offers three indemnity individual Medicare supplemental plans to District of Columbia residents, all of which are guaranteed issue products.

GHMSI offers a wide array of products to its group certificate holders, both in the small and large groups. In order to provide choice to the employees of its group contract holders, GHMSI offers Point of Enrollment (POE) options, which are standard packaged product combinations that give employees a choice between two or three health plans at the time they enroll. The employee chooses the health plan that best meets his or her needs, and can change plans annually. There are twenty-five variations offered to employers, encompassing all of GHMSI's products in its portfolio.

The group product offerings include traditional indemnity products with first-dollar coverage and a wide range of benefit options. GHMSI's comprehensive major medical products allow employers to choose from a range of benefits, deductibles, no-deductible first dollar benefits, and out of pocket maximums to gain control over costs while providing employees with the benefits they need. These products include preventative care benefits, well childcare with immunizations, routine adult physicals, and routine GYN visits, mammograms, and prostate-cancer screening. Contract holders can use any provider, whether or not belonging to the network, but a higher cost is attendant to using out-of-network providers. Group PPO products are also offered.

GHMSI has traditionally offered HMO products to its group contract holders. In 2001, BlueChoice was launched as a regional HMO covering the District of Columbia, Maryland and parts of Northern Virginia. The BlueChoice regional HMO (feasible as a result of the business combination) meets the geographic needs of GHMSI's employer groups and offers a broad choice of primary care physicians and specialists, and simplified product choices. As a service to GHMSI's contract holders, the BlueChoice HMO includes a 24-hour advice line. GHMSI offers two point of service products (BlueChoice Opt-Out and BlueChoice Opt-Out Plus), through which the contract holder (or employee) chooses a primary care physician and coordinates their specialist and hospital care through the primary care physician. The Opt-Out Plus contract holders are not responsible for charges that exceed an established Plan Allowance.

CareFirst combined CFMI and GHMSI's networks under the BluePreferred (PPO) and BlueChoice (HMO), providing subscribers a wider range of products across a wider service area. This allows an employer with offices in the District of Columbia and Maryland to contract for BluePreferred or BlueChoice and have one network accessible wherever the individual employees live.

In addition to the individual and group products described above, GHMSI offers several ancillary products to residents of the District of Columbia, including pharmacy, dental, vision, basic and voluntary life and disability, and flexible benefits. Pharmacy (prescription drug) benefits are available through the Managed Care Pharmacy Card Program, which provides contract holders with an integrated prescription drug program

that offers both retail and mail order options. The mail order service allows medication to be delivered to the contract holder's home. In an effort to keep contract holder's prescription drug costs down, a pharmacy benefit manager is used to contract with pharmacies and negotiate average wholesale price discounts and reduced dispensing fees. An extensive network of local and national pharmacies provides maximum access to contract holders. In 2000, a three-tier prescription drug program was implemented in an effort to control rising prescription costs. Contract holders can use generic and preferred name-brand drugs at lower co-payments. GHMSI provides prescription drug benefits because it views them as a key component of a contract holder's complete benefit package that increases contract holder satisfaction and potentially saves costs through lowered medical expenses.

GHMSI also offers a variety of dental plans to its contract holders. The traditional dental plan comprises several benefit levels: (1) level I-diagnostic and preventative services; (2) level II-surgical and restorative services; (3) level III-benefits for prosthetic services; and (4) level IV-benefits for orthodontic services. The Preferred Dental Plan is much like the traditional dental plan, but costs for contract holders are kept down by use of participating dentists who agree to a greater discount from their usual fee. Dental HMOs are also available, which cover the entire breadth of dental services subject to a co-payment schedule. The provider network is smaller than with the Preferred Dental Plan, but premiums are also lower. GHMSI also offers two voluntary dental plans, which provide benefits according to an indemnity fee schedule. These dental products are underwritten, insured and administered by an outside vendor.

Other products GHMSI makes available to its contract holders are vision plans, life and disability insurance, and an alternative therapies discount program. Vision benefits are available to contract holders of indemnity and HMO products. GHMSI's indemnity and HMO products offer group and individual customers routine eye exams for a small co-payment and discounts on lenses and frames. GHMSI also offers Group Term Life, Accidental Death and Dismemberment, Short-Term Disability and Long-Term Disability products to all of its customer accounts, regardless of size. In an effort to expand its products, CareFirst Options was introduced, which is an alternative therapies discount program. CareFirst Options will continually add options to meet contract holder demands. GHMSI also expanded its disease management program to all lines of business.

GHMSI also provides a BlueCard Program for its traditional indemnity and PPO contract holders. This program is possible only as a result of GHMSI's membership in the Blue Cross Blue Shield Association ("BCBSA"). The BlueCard Program allows contract holders to receive health care benefits through other Blue Cross Blue Shield plans while traveling outside of CareFirst's service area. Participating and PPO providers and the independent Blue Cross Blue Shield plans are linked nationally through a single claim processing network that saves providers and contract holders time and money. Contract holders have easy telephone access to information on conveniently located provider networks, allowing them to take advantage of local network discounts. Providers can submit claims to the Blue Cross Blue Shield plan that is local to where the service was provided. The provider's local Blue Cross Blue Shield plan handles claims payment, problem resolution and inquiries.

There have been two recent additions to the BlueCard program for the benefit of contract holders. BlueCard now provides HMO contract holders with access to the BlueCard Traditional Network of health care providers for urgent and referred out-of-area services. Also, the BlueCard Managed Care/POS was added to allow designated plans to offer their accounts a national POS capability. The BlueCard program saved D.C.-area CareFirst members $133.5 million in 2001.

Contract holders also have access to the BlueCard Worldwide network of participating hospitals. The BlueCard Worldwide program provides access to a worldwide network of traditional inpatient, outpatient and professional health care providers. The program includes a broad range of medical assistance and claim support services.

Away From Home Care ("AFHC") is an out-of-area program available to members of Blue Cross Blue Shield sponsored HMOs. Under this program, Guest Membership Care can be received from another Blue Cross Blue Shield HMO while a contract holder is temporarily residing outside of the service area. This allows contract holders who are away for an extended period of time, such as a college student, to obtain guest membership with another Blue Cross Blue Shield HMO at no additional premium charge.

Under AFHC, contract holders, while traveling, obtain Urgent Care benefits for non-life-threatening illness or injury. There are no claim forms to fill out, and the process is hassle-free to the contract holder. Specific follow-up treatment also is available while a contract holder is traveling. As with Urgent Care, the process is hassle-free with no claim forms to fill out.

Effective January 1, 2000, GHMSI introduced complimentary alternative medicine (CAM) to its contract holders. CAM enables contract holders to obtain discounts on fitness centers, chiropractors, massage therapists, spas, yoga centers, and nutrition service providers. There are no limits on visits, and members simply present their identification cards to receive the discount. Another benefit GHMSI offers its HMO and POS accounts are disease management programs. Disease management programs include asthma, diabetes, and end-stage renal disease management programs.

Due to the broad spectrum of products it offers, GHMSI provides price points from which all of its contract holders, both individual and employer group, can select to meet their particular needs. For example, CareFirst offers plans that cover entire families for under $300 per month. Similarly, a 25-year-old male can get medical, dental and vision coverage all for well under $100 per month.

GHMSI also provides a number of services to its contract holders, including health education programs. These programs are designed to provide valuable information that will help contract holders maintain healthy lifestyles. Some health education programs include Prenatal Education, Diabetes Education, Smoking Cessation Sessions, Diet and Weight Management, Stress Management, and Infant Care and Parenting Classes.

As a service to its contract holders, in June 2000, CareFirst introduced "My Care First," an interactive, on-line health information resource on www.carefirst.com. Through My Care First, GHMSI contract holders can obtain up-to-date information on free health education seminars, including the topics and locations of the seminars. Among other benefits, there are health news articles, weekly features, and descriptions of available benefits and services.

As a result of its efforts, BlueChoice received the Excellent Accreditation rating from the National Committee for Quality Assurance ("NCQA"), the highest accreditation standing. The NCQA noted strengths in the BlueChoice Program, including quarterly surveys to measure customer satisfaction, medical director involvement in medical necessity and coverage issues, timeliness of utilization management decisions, and processes for resolving customer complaints and appeals. CareFirst's service to its Federal Employee Health Plan members earned it the Blue Cross Blue Shield Association's "High Performance/Low Cost" award for excellent service.

GHMSI believes that its contract holders should have access to quality health care providers that are conveniently located to the contract holder. To that end, GHMSI attempts to maintain extensive health care provider networks for its contract holders. As of August 2001, GHMSI had over 11,000 providers in its HMO network, over 15,000 providers in its PPO network, and over 18,000 providers in its participating provider network. GHMSI also had 118 hospitals in its HMO network, 122 hospitals in its PPO network, and 125 hospitals in its participating provider network. Selection criteria for participation in the networks are driven by physician performance.

Also, in keeping with its obligation to its certificate holder, GHMSI is a member of the BCBSA and operates under the Blue Cross Blue Shield brand license. The BCBSA is a national trade association of Blue Cross Blue Shield that grants the right to use the BCBSA trademark through licensing agreements with local plans. The license to use the trademark is contingent upon compliance with the stringent licensing and membership standards established by the BCBSA. The BCBSA prides itself as a consumer advocate with the public interests at heart. As a member of BCBSA, GHMSI is able to offer benefits to its contract holders such as the BlueCard Program described above.

The Insurance Commissioner asked GHMSI to consider in its Amended Application how its products, services and practices differ from those of a for-profit health insurer. One difference is that as a nonprofit hospital and medical services corporation, GHMSI is statutorily required to make provision for compliance with the District of Columbia's open-enrollment requirements, including the provision of other public services. D.C. Code § 31-3514. Pursuant to this obligation, GHMSI offers non-medically-underwritten products, available 365 days per year, to District of Columbia residents. The open-enrollment product is prominently advertised for residents of the District of Columbia. The open-enrollment product offered is a provider network product, which contains benefits for hospitalization, medical and surgical services, mental health, and substance abuse services. Drug benefits are available for an additional co-payment. As of July 2002, 281 District of Columbia residents and a total of 1,948 residents in GHMSI's service area are covered by GHMSI's open-enrollment product. Although a for-profit health insurer may offer open-enrollment products, a for-profit health insurer has no statutory obligation to offer open-enrollment products.

Another requirement of the open-enrollment statute is that GHMSI provide health-related educational support to residents of its service area. In furtherance of this obligation, CareFirst and GHMSI offer the educational programs described above. They also make charitable donations to a variety of District of Columbia based entities. A list of recent charitable donations is set forth later in this Amended Application. CareFirst and GHMSI believe that giving back to the community is not unique to nonprofit corporations, but is a shared obligation of good corporate citizens, nonprofit and for-profit alike. WellPoint, as indicated later in this Amended Application, also contributes to the communities it serves.

Whether GHMSI's product and service offerings, practices and policies differ from those of a for-profit insurer will necessarily depend on the for-profit insurer to which GHMSI is compared. GHMSI believes that a successful for-profit insurer must have a similar focus on providing affordable, quality products to its customers in order to remain competitive in today's marketplace. WellPoint has such a focus. WellPoint's philosophy is to achieve success by growing market share. WellPoint aims at growing market share by offering affordable, innovative products, customized to meet consumers' needs, and exploring markets like the uninsured and underinsured, which some insurers may not pursue.

GHMSI also has a shared goal with its for-profit counterparts of achieving premium and revenue income. Although GHMSI, as a nonprofit hospital and medical services plan, has no shareholders (which distinguishes it from a for-profit corporation), GHMSI must generate revenues adequate to meet its current and anticipated obligations. GHMSI, as with its for-profit counterparts, has minimum capital and surplus requirements it must maintain to meet its licensing requirements. D.C. Code § 31-3505(d). GHMSI, also like its for-profit counterparts, is subject to medical costs and medical cost inflation. GHMSI also must make sure that its rates are not inadequate in relation to the benefits and services offered. D.C. Code § 31-3508(e). GHMSI's rates are subject to the Commissioner's approval, and the Commissioner must ensure that rates are not inadequate, excessive or unfairly discriminatory in relation to the benefits offered. D.C. Code § 31-3505(c); *see also* D.C. Code § 31-3508(e). In light of the similar obligations and regulation between GHMSI and for-profit insurers, the products and services could exhibit many similarities.

The Merger With WellPoint Will Help to Expand GHMSI's Products and Services

Although GHMSI provides its certificate holders with a broad spectrum of product and service offerings, its desire to continue to serve its contract holders and improve its service to its contract holders was an important part of its decision to merge with WellPoint. Ten years ago, GHMSI was on the verge of financial ruin. Although solid Board oversight and effective management have helped to turn GHMSI around, a turnaround also significantly aided by the opportunities created by the business combination, GHMSI feared that it would become less competitive in the marketplace and less able to serve its customers over time unless it took steps to further grow and increase its access to capital.

The Boards of Directors of CareFirst and GHMSI spent over two years considering the potential strategic options that were best for the companies, their employees, the contract holders and the communities they served. After extensive due diligence, as discussed previously in this Amended Application, CareFirst and GHMSI decided that a conversion and merger were in the best interests of all involved, and WellPoint was the best merger partner. WellPoint's philosophy of growing revenues by growing market share, which it accomplishes by offering affordable, innovative products to its customers, will benefit GHMSI policyholders. WellPoint intends to increase the coverage options and services available to GHMSI policyholders, not decrease them. A detailed description of WellPoint's innovative products is described above. One example of how WellPoint may be able to expand upon GHMSI's current product offerings is by offering its PlanScape product to GHMSI's group contract holders. Unlike GHMSI's current POE plan, PlanScape offers a Family Elect feature allowing different family members to enroll in different plans and receive one bill.

WellPoint's status as a Blue Cross Blue Shield plan also will keep the Blue Cross Blue Shield brand name intact, will allow the Blue-branded products to remain available and will allow GHMSI's contract holders to continue to benefit from BCBSA oversight of GHMSI. CareFirst and GHMSI recognized that they needed to combine with another Blue Cross Blue Shield Plan to continue to offer District of Columbia residents and GHMSI's contract holders the benefits of the Blue Cross Blue Shield brand license, and they accomplish this goal by merging with WellPoint. The conversion and merger with WellPoint will also create additional funding to serve the unmet health care needs of District of Columbia residents. The District of Columbia will share in the $1.3 billion purchase price, through the creation of a public benefit foundation, which can be used for a variety of purposes to serve residents of the District of Columbia. The funding would not be available absent the transaction and is a major benefit of the transaction.

GHMSI's Charter Declaration as a Charitable and Benevolent Corporation

GHMSI's charter sets forth its purpose—to provide hospitalization and medical care to its subscribers. GHMSI's status as a nonprofit corporation does not give rise to an esoteric charitable and benevolent obligation different from its charted purpose. The distinction between nonprofit and for-profit corporations is that nonprofit corporations do not distribute profits or net earnings to those who control the corporation, whereas profits and net earnings of for-profit corporations are ultimately distributed to the owner-shareholders. *See, e.g., Medlock v. Medlock*, 642 N.W.2d 113, 126 (Neb. 2002) ("The primary distinction between nonprofit corporations and for-profit corporations is found in the nondistribution constraint, which bars the nonprofit corporation from distributing profits or net earnings to those who control the corporation.").

The nondistribution constraint does not prohibit a nonprofit corporation from engaging in commercial activity. *Id.* In fact, a nonprofit hospital and medical services plan, such as GHMSI, is by definition engaged in a commercial enterprise and must operate in many ways like its for-profit counterparts in order to compete in the current market environment. Although GHMSI receives some tax benefits, its revenue is derived from business operations, not from charitable donations. GHMSI is subject to similar regulatory restrictions and rate-approval requirements as for-profit insurers in the District of Columbia. GHMSI is subject to the same costs and expenses as its competitors, such as medical costs, agent and broker commissions and administrative expenses.

As GHMSI does not have shareholders, it necessarily must conduct its business for the benefit of someone other than its shareholders. GHMSI's charter makes clear for whose benefit it conducts its business. GHMSI is to be operated for the benefit of its certificate holders. (*See* Sec. 3 of GHMSI's charter). D.C. law also makes it clear that a charitable health care entity's charted purpose is its charitable purpose. As part of the Health Care Entity Conversion Act of 1997, the following legislative finding was made: "charitable health care entities hold all their assets in trust, and those assets are irrevocably dedicated, as a condition of their tax-exempt status, to the specific charitable purposes set forth in the articles of incorporation of those entities." D.C. Code, § 44-601.

In light of its nonprofit status and corporate purpose, Congress declared GHMSI to be a "charitable and benevolent" corporation and exempt from most taxes.[4] This declaration does not change GHMSI's corporate purpose or obligations. Rather, because of GHMSI's nonprofit status and corporate purpose, it was "declared" to be charitable and benevolent and exempt from taxation by Congress. The charitable and benevolent declaration is common language in tax-exemption provisions. For example, the provision of the District of Columbia Code governing taxation of fraternal benefit societies states that such a society is "declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment." D.C. Code § 31-5320. Fraternal benefit societies are operated for the benefit of their members. D.C. Code § 31-5301.

The Maryland statute governing nonprofit health service plans (under which CFMI is licensed) contained language similar to that in GHMSI's charter when the statute was enacted in 1937. The statute read: "EXEMPT FROM TAXATION. Every corporation licensed under the provisions of this sub-title is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district and municipal tax, other than taxes on real estate and office equipment." *See* Md. Ann. Code, Article 48A § 208 (1937). This provision was later repealed and the only tax the Maryland plan currently does not pay is premium tax, a tax exemption that applies to for-profit HMOs as well as nonprofit health service plans.

In fact, Blue Cross Blue Shield plans, like GHMSI, do not qualify as charitable organizations, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. Although Blue Cross Blue Shield plans historically were treated as tax-exempt organizations, the Tax Reform Act of 1986 stripped Blue Cross Blue Shield plans of their tax-exempt status. Subsection (m) was added to Section 501 of the Internal Revenue Code, which provides that a corporation is tax exempt under § 501(c)(3) or (4) "only if no substantial part of its activities consists of providing commercial-type insurance." 26 U.S.C. § 501(m). Section 833 was also added to the Internal Revenue Code, which makes Blue Cross Blue Shield plans generally taxable in the same manner as stock insurance companies. 26 U.S.C. § 833(a)(1).

[4] GHMSI's charter is an Act of Congress. The full tax exemption provision, contained in Section 8, reads: "This corporation is hereby declared to be a charitable and benevolent institution, and all of its funds an[d] property shall be exempt from taxation other than taxes on real estate and unemployment compensation."

After the 1986 revisions to the Internal Revenue Code, GHMSI filed to pay federal income taxes in 1987 and has paid federal income taxes since that time. Taxes are currently paid on behalf of GHMSI by CareFirst through a joint tax filing made on behalf of GHMSI, and the Maryland and the Delaware plans.[5] Thus, the tax exemption provision in GHMSI's Congressional charter only partially controls GHMSI's current tax treatment. It certainly does not alter GHMSI's obligations.

After the conversion, GHMSI intends to be re-chartered as a life insurer in the District of Columbia.[6] In many ways, GHMSI's purposes will remain unchanged: GHMSI will remain committed to providing the highest quality of health insurance to its subscribers and will remain committed to playing a role in the District of Columbia as a good corporate citizen.

GHMSI's Pre-conversion and Post-Conversion Charitable and Community Involvement Activities

GHMSI has always made it a goal of the company to give to the community and to stay involved in community activities. Although charitable donations and community involvement are not part of its charted purpose, GHMSI believes that all corporations, profit and nonprofit alike, should give back to the communities they serve. To that end, donations have been made to the District of Columbia based organizations listed below since 2000:

Year-to-Date: 2002	
Sister to Sister Everyone Has a Heart Foundation	$25,000
Providence Health Foundation	$10,000
SummerTime Reading Together (START)	$10,000
Chesapeake Habitat for Humanity	$5,000
Howard University	$5,000
United States Association of Former Members of Congress	$3,000
Alzheimer's Association	$2,000
Prevention of Blindness	$1,000

Year 2001	
Washington Hospital Center/NBC4	$125,000
American Lung Association	$30,000
Komen National Race for the Cure	$15,000
Leukemia/Lymphoma Society of America	$10,000
SummerTime and Reading Together (START)	$10,000
Chesapeake Habitat for Humanity	$9,000
American Heart Association	$6,500
District of Columbia Hospital Association	$5,000

[5] GHMSI paid federal income taxes of $4,342,587 in 1999, $12,952,512 in 2000, and estimates that it will pay $13,034,093 in 2001.

[6] Following the conversion of GHMSI and its acquisition by WellPoint, GHMSI will be a stock life insurance company with minimum capital of $1,000,000 and minimum paid-up surplus of $500,000 in accordance with D.C. Code § 31-4408. As a result, GHMSI will satisfy D.C. Code §§ 31-703(g)(1)(A) and 31-3515(b)(4)(A). Indeed, with surplus of [current surplus], GHMSI will possess capital and surplus in an amount sufficient to provide for the security of GHMSI's contract holders as required by D.C. Code § 31-3515(b)(4)(B).

March of Dimes	$5,000
Providence Health Foundation	$5,000
Howard University	$3,000
Greater Washington Urban League	$2,500
Larry King Cardiac Foundation	$2,500
MedStar Health	$2,500
Children's Charities Foundation	$1,000
Prevention of Blindness Society	$1,000
Year 2000	
Susan G. Komen Foundation	$15,000
Washington/Baltimore 2012 Coalition	$10,000
March of Dimes	$7,500
DC Chamber of Commerce	$5,000
National Leukemia Society	$5,000
The Greater Washington Board of Trade	$4,500
American Heart Association	$3,000
Washington Hospital Center	$3,000
Providence Health Foundation	$2,500
AIDSWALK-DC	$1,000
Duke Ellington School for the Arts	$1,000
Howard University Hospital	$1,000
United Way of the National Capital Area	$1,000

CareFirst also makes donations to other organizations that benefit citizens of the District of Columbia and beyond. For example, in 1999, CareFirst and its associates, jointly, donated more than $683,000 to six different United Way organizations, serving organizations in the District of Columbia, as well as Maryland, Virginia, and West Virginia.

CareFirst, GHMSI, and WellPoint cannot predict exactly what GHMSI's charitable and community involvement activities will be after the merger, just as GHMSI would not be able to state what its future charitable and community involvement activities would be in the absence of the merger with WellPoint. WellPoint, however, is committed to the local communities it serves and, historically, has demonstrated that commitment through charitable contributions. For example, Blue Cross of California a WellPoint-owned Blue Cross Blue Shield plan, increased charitable contributions to the community subsequent to its conversion to for-profit status.

A certain benefit WellPoint will provide if the transaction is consummated is the $1.3 billion purchase price it will pay for CareFirst, which will, in part, be used to benefit residents of the District of Columbia. A foundation will be created to meet the needs of District of Columbia residents. Although the specific purpose of the foundation and the size of the contribution are not certain, the foundation's creation (if the transaction is consummated) is assured.

There Are No Post-Conversion Plans to Decrease Employment Levels in the District of Columbia

WellPoint intends for the governance and operations of CareFirst and GHMSI to remain local. WellPoint does not believe in centralizing operations, but believes that all health care plans should be locally managed and operated.[7] WellPoint management recognizes that health care is locally delivered and locally consumed, and decision-making should be made locally. This philosophy has been put into action with WellPoint's acquisition of Georgia's Blue Cross Blue Shield plan, where: (1) former Georgia managers occupy 12 of the top 14 officer positions in the surviving corporation; (2) a member of the former BCBS of Georgia Board is now a member of WellPoint's Board of Directors; (3) WellPoint established medical, hospital, and consumer advisory boards comprised of members from local communities, hospitals, and physician groups; and (4) the Georgia Blue Cross Blue Shield plan's corporate headquarters and service center remain in Georgia.

Significantly, employment levels increased in Georgia following WellPoint's acquisition of the Georgia Blue Cross Blue Shield plan, employment levels increased after WellPoint's acquisition of the Missouri Blue Cross Blue Shield plan, and employment levels have increased dramatically in the years since Blue Cross of California converted. The increase in employment levels is consistent with WellPoint's philosophy of growing membership. As membership grows, a sufficient number of employees must be available to serve the members. WellPoint's commitment to local governance and the likelihood of high employee retention is one of the reasons CareFirst selected WellPoint as its merger partner. CareFirst and GHMSI's Boards of Directors considered one of their duties as being to their employees, and believe they fulfilled this duty by selecting WellPoint as a partner.

The Merger Agreement between CareFirst and WellPoint contains provisions designed to ensure continued local governance of CareFirst, which, in turn, suggests continued high employment levels in CareFirst's service area, including the District of Columbia. An advisory board will be formed for GHMSI. Each member of GHMSI's current Board of Trustees will be appointed to the advisory board (subject to the person's acceptance of the appointment). The advisory board will provide guidance regarding the company's relationship with subscribers, physicians and hospitals, and the general public. A "Transition Team," will be created, well represented by local CareFirst executives, to facilitate the combination of the operations of CareFirst and WellPoint. WellPoint agreed to nominate for election to its Board of Directors a non-employee member of CareFirst's Board of Directors and to use its best efforts to have the CareFirst designee elected to the Board. CareFirst's CEO will remain responsible for the business operations of the surviving corporation. CareFirst's other senior executives will continue to hold significant responsibility with respect to the business of the surviving corporation. These provisions concerning continued local governance carry with them continued local employment.

[7] Indeed, GHMSI recently has entered into a 10-year lease for office space in the District of Columbia. WellPoint's support of this move is a measure of its commitment to GHMSI's local governance and to maintaining employment levels in the District of Columbia.

No Part of the Assets or Surplus of GHMSI Will Inure to Any Officer or Director of GHMSI or CareFirst

Although no part of the assets or surplus of a nonprofit hospital and medical services plan can inure to the benefit of its directors and officers, nonprofit corporations are permitted to compensate their directors and officers for services provided to the corporation. The need to compensate directors and officers is recognized with respect to nonprofit corporations under Section 501(c)(3) of the Internal Revenue Code. A commercial nonprofit corporation such as GHMSI, which operates in a competitive market environment, has a heightened need for skilled management.

The Internal Revenue Code, using language similar to Section 31-3515 of the District of Columbia Code, defines a tax-exempt corporation as one for which no part of the net earnings inures to the benefit of any private shareholder or individual. 26 U.S.C. § 501(c)(3). There is abundant authority for the fact that compensating directors and officers of charitable organizations for their services does not violate the no-inurement provision in the Internal Revenue Code. *See, e.g., Mabee Petroleum Corp. v. United States*, 203 F.2d 872, 876 (5th Cir. 1953). The provision is violated only if salaries are used as a device for securing the profits of the corporation for its officer or directors. *See* 4A Austin Wakeman Scott & William Franklin Fratcher, The Law of Trusts § 372.1 (4th ed. 1989); Restatement (Second) of Trusts § 376 (1959). Thus, where payments are not the distribution of profits under the guise of salaries, there is no private inurement. *See B.H.W. Anesthesia Foundation, Inc. v. Comm'r of Internal Revenue*, 72 T.C. 681, 686 (1979).

To ensure that the all compensation arrangements are appropriate and to fulfill GHMSI's obligation to its contract holders, an Executive Compensation Committee of the CareFirst Board of Directors was established to specifically deal with compensation issues. In November 1999, the Board of Directors of CareFirst engaged Hay Group, Inc., a leading executive compensation consulting firm, to assist the Executive Compensation Committee of the Board of Directors in reviewing and evaluating CareFirst's compensation arrangements and benefit programs. Based on a thorough review of the CareFirst compensation arrangements and comparable compensation arrangements for similar corporations, Hay Group, Inc. concluded that the compensation arrangements in place at CareFirst relating to the acquisition of CareFirst are justifiable, appropriate and commercially reasonable. The Executive Compensation Committee of the CareFirst Board of Directors relied, in large part, on the assistance of Hay Group, Inc. in determining that the company's compensation plans were appropriate.

Gene Bauer, a Managing Director with Hay Group, Inc., submitted written testimony to the Maryland Insurance Commissioner in March of this year in connection with the conversions of CareFirst and CFMI. Mr. Bauer discussed the compensation arrangements in detail, and concluded that they are justifiable, appropriate and commercially reasonable. Mr. Bauer concluded that, ultimately, the compensation arrangements inure to the public benefit because they serve to maximize the value of CareFirst's public or charitable assets for the direct benefit of the owners of these assets – the State of Maryland, the State of Delaware and the District of Columbia – by helping to retain critical executives and provide incentives to top management to secure the full market value in a transaction. Mr. Bauer's testimony is applicable with equal force to the

proceedings in the District of Columbia. A copy of his written testimony will be filed with the Department. Because the compensation arrangements are justifiable, appropriate and commercially reasonable, they do not result in the inurement of any part of the assets or surplus to an officer, director, or trustee of GHMSI.

The Insurance Commissioner has requested that, in this Amended Application, the Applicants address compliance with Condition 12 of Order A-HC-97-01. Condition 12 of Order A-HC-97-01 applied to the compensation contracts with the executives of GHMSI that had change of control provisions triggered by the business combination that was conditionally approved by Order A-HC-97-01. The GHMSI executives left the employ of GHMSI in connection with the business combination and the Department received notice of their departure. Condition 12 does not apply to this transaction. Nevertheless, the executive compensation plans have been submitted to the Department in connection with the conversion of GHMSI and can be reviewed by the Department under D.C. Code § 31-3515 to ensure that no part of the assets or surplus of GHMSI inures to the benefit of a director or an officer.

The Insurance Commissioner has also asked that this Amended Application address the applicability, effect and compliance with recent Maryland legislation (HB 1254) prohibiting remuneration to officers and directors of nonprofit health service plans as a result of the conversion or acquisition thereof. There is nothing that CareFirst or CFMI must do at this time to comply with the Maryland legislation. The Department will be notified if any of the information or documentation submitted to the Department in connection with the acquisition of GHMSI by WellPoint or the conversion of GHMSI is revised or changed as a result of the Maryland legislation. Moreover, the Maryland legislation does not affect the Applicants' ability to comply with District of Columbia law.

CareFirst and GHMSI's Boards Do Not Have a Fiduciary Duty to Propose Allocation of the Purchase Price or Direct Its Use.

The Insurance Commissioner requested GHMSI to explain: (a) why the Applicants have not proposed how the proceeds from the transaction should be divided as between GHMSI, CFMI, and BCBSD; (b) which entities should be the recipient of the proceeds, and for what specific purposes they should be used upon completion of the transaction; and (c) what, if any consideration was given by the Boards of GHMSI and CareFirst, Inc., as to whether the Boards have any fiduciary obligation to make concrete proposals regarding the disposition of the proceeds of the transaction as part of the plan of conversion.

GHMSI is involved in decisions made by the CareFirst Board, where the ultimate corporate direction and decisions are made, through its 6 elected members to CareFirst's Board, and GHMSI maintains its own Board which is responsible for the operation of GHMSI. From the outset of the proposed transaction, the Boards have gone to great lengths to solicit expert advice, consider the opinions of senior management and actively investigate strategic alternatives to ensure that the companies' fiduciary obligations to the companies are fulfilled. As described in other areas of this narrative, the Board conducted a lengthy process of due diligence in arriving at the conclusion that converting to for-profit status and merging with WellPoint was in the best interests of GHMSI, its subscribers and the public.

To ensure that the Boards fulfilled their fiduciary duties, advice was received from Piper regarding the specific fiduciary duties involved in the proposed conversion and merger transaction. The general rule requires members of the Board to act in good faith when making business judgments and decisions on behalf of the corporation. As a result of being a nonprofit entity, the Boards also carry a duty to act in good faith on behalf of the public and in furtherance of the charitable purpose for which the corporation was formed. Although GHMSI's chartered obligation is to operate for the benefit of its subscribers, the Boards were also obligated to consider the interests of the public in connection when the decision to convert and merge with WellPoint. Specifically, the Boards were obligated to obtain fair value for CareFirst to maximize the value of the charitable assets that will go to the foundations to be used to benefit the public. The Board also examined non-price related factors such as the financial condition of WellPoint and the effect of the transaction on the affordability and availability of health care in the areas serviced by CareFirst to make sure the transaction was in the best interests of the members and the public.

The Boards received expert opinions that included advice on the valuation of CareFirst as the holding company (see previous discussion regarding CSFB). However, the Boards did not receive valuation advice that included a breakdown of the entities that make up CareFirst. In addition, the Boards did not receive advice regarding potential charitable uses of the proceeds of the conversion and merger with WellPoint. Consequently, the Applicants did not provide the Insurance Commissioner with such information.

In light of the fact that this transaction will result in the largest per capita charitable contribution resulting from a Blue conversion, the Applicants believe that the Department and the Corporation Counsel should guide the determination as to what foundation or foundations should be named or created to receive the charitable contribution of GHMSI. Further, the foundations themselves, with no influence by CareFirst or WellPoint, should decide the manner in which their share of the proceeds should be used, provided those uses are consistent with those of GHMSI as required by Section 44-603(c)(12) of the D.C. Code. At the request of and to assist the Insurance Commissioner and Corporation Counsel in this regard, CareFirst has engaged the services of Dr. Jack Meyer at New Direction for Policy (NDP) to conduct research into the current status of the health care system in the District of Columbia and to propose options for improving health care for D.C. residents using the charitable assets of the conversion and merger transaction. The report entitled "Identifying Options For Using Charitable Assets to Improve Health In The District of Columbia" ("the Report") is attached to the Amended Application as Exhibit 7. The Report provides a detailed analysis of the status of health care in the D.C. area, as well as several options for the use of the charitable proceeds from the proposed transaction. While the choice of foundation or foundations to receive the GHMSI charitable contribution rests with the Insurance Commissioner and Corporation Counsel, the Applicants hope that the Report provides a useful framework to guide the public discussion on these important issues.

Compliance With Condition 2 of Order A-HC-97-01

The Insurance Commissioner has asked the Applicants to address in this Amended Application how GHMSI complied with Condition 2 of Order A-HC-97-01. The referenced condition, in connection with the 1997 business combination of CFMI and GHMSI, required GHMSI to retain a financial consultant at its own expense to advise the Department as to the specific information needed for determining the value of GHMSI, and to submit the information within 30 days of the final determination by the financial consultant. In compliance with the condition, GHMSI commissioned Ellin & Tucker, Chartered to perform a valuation analysis of CFMI and GHMSI. The report was finalized on January 16, 1998. The report was submitted to the Department within 30 days of January 16, 1998.