ANTHEM INC
Form 424B4
October 30, 2001

FILED PURSUANT TO RULE NO. 424(b)(4)
REGISTRATION NOS. 333-67714
333-72438

48,000,000 Shares

Anthem, Inc.

Common Stock

This is an initial public offering of shares of common stock of Anthem, Inc. The offering is being made in connection with the conversion of Anthem Insurance Companies, Inc. from a mutual insurance company to a stock insurance company in a process called demutualization. All of the shares of common stock are being sold by Anthem, Inc.

In addition to these shares, an estimated 54,861,000 shares of our common stock will be issued to eligible statutory members of Anthem Insurance Companies, Inc. in the demutualization.

Prior to this offering, there has been no public market for our common stock. Our common stock has been approved for listing on the New York Stock Exchange, subject to official notice of issuance, under the symbol "ATH".

Concurrently with this offering, we are offering 4,000,000 6.00% equity security units for an aggregate offering of $200.0 million, plus up to an additional $30.0 million if the underwriters' option to purchase additional units is exercised in full, by means of a separate prospectus. Each unit consists of (a) a contract to purchase shares of our common stock and (b) a 5.95% subordinated debenture.

See "Risk Factors" beginning on page 10 to read about factors you should consider before buying shares of our common stock.

Neither the Securities and Exchange Commission nor any other regulatory body has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

	Per Share	Total
Initial public offering price	$36.00	$1,728,000,000
Underwriting discount	$ 1.656	$ 79,488,000
Proceeds, before expenses, to Anthem, Inc.	$34.344	$1,648,512,000

To the extent that the underwriters sell more than 48,000,000 shares of common stock, the underwriters have the option to purchase up to an additional

7,200,000 shares from Anthem, Inc. at the initial public offering price less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York on November 2, 2001.

Goldman, Sachs & Co.
Merrill Lynch & Co.
Morgan Stanley
JPMorgan
Banc of America Securities LLC
Credit Suisse First Boston
Lehman Brothers
UBS Warburg
ABN AMRO Rothschild LLC
Dresdner Kleinwort Wasserstein
A.G. Edwards & Sons, Inc.
McDonald Investments Inc.
Utendahl Capital Partners, L.P.

Prospectus dated October 29, 2001.

UNDER INDIANA LAW, FOR A PERIOD OF FIVE YEARS FOLLOWING THE EFFECTIVE DATE OF THE DEMUTUALIZATION, NO PERSON MAY ACQUIRE BENEFICIAL OWNERSHIP OF 5% OR MORE OF THE OUTSTANDING SHARES OF OUR COMMON STOCK WITHOUT THE PRIOR APPROVAL OF THE INDIANA INSURANCE COMMISSIONER AND OUR BOARD OF DIRECTORS. THIS RESTRICTION DOES NOT APPLY TO ACQUISITIONS MADE BY US OR MADE PURSUANT TO AN EMPLOYEE BENEFIT PLAN OR EMPLOYEE BENEFIT TRUST SPONSORED BY US. THE INDIANA INSURANCE COMMISSIONER HAS ADOPTED RULES UNDER WHICH PASSIVE INSTITUTIONAL INVESTORS COULD PURCHASE 5% OR MORE BUT LESS THAN 10% OF OUR OUTSTANDING COMMON STOCK WITH THE PRIOR APPROVAL OF OUR BOARD OF DIRECTORS AND PRIOR NOTICE TO THE INDIANA INSURANCE COMMISSIONER. SEE "DESCRIPTION OF CAPITAL STOCK--CERTAIN PROVISIONS OF INDIANA LAW."

[ALTERNATE PAGE FOR POSTING ON YAHOO! NET ROAD SHOW WEBSITE AND ANY PROSPECTUS DELIVERED ELECTRONICALLY]

TABLE OF CONTENTS

PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus. As a result, it does not contain all of the information that you should consider before investing in our common stock. You should read the entire prospectus carefully, including the "Risk Factors" section and the consolidated financial statements and the notes to those statements. References to the term "Anthem Insurance" refer to Anthem Insurance Companies, Inc., an Indiana insurance company. References to the term "Anthem" refer to Anthem Insurance and its direct and indirect subsidiaries before the demutualization, and to Anthem, Inc., a newly-formed Indiana holding company, and its direct and indirect subsidiaries, including Anthem Insurance, after the demutualization, as the context requires. References to the terms "we," "our," or "us," refer to Anthem, before and after the demutualization.

Anthem

We are one of the nation's largest health benefits companies, serving over seven million members, or customers, primarily in Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. We hold the leading market position in seven of these eight states and own the exclusive right to market our products and services using the Blue Cross(R) Blue Shield(R), or BCBS, names and marks in all eight states under license agreements with the Blue Cross Blue Shield Association, or BCBSA, an association of independent BCBS plans. We seek to be a leader in our industry by offering a broad selection of flexible and competitively priced health benefits products.

Our product portfolio includes a diversified mix of managed care products, including Health Maintenance Organizations or HMOs, Preferred Provider Organizations or PPOs, and Point of Service or POS plans, as well as traditional indemnity products. We also offer a broad range of administrative and managed care services and partially insured products for employer self-funded plans. These services and products include underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, claims processing and other administrative services. In addition, we offer our customers several specialty products including group life, disability, prescription management, workers compensation, dental and vision. Our products allow our customers to choose from a wide array of funding alternatives. For our insured products, we charge a premium and assume all or a

majority of the health care risk. Under our self-funded and partially insured products, we charge a fee for services, and the employer or plan sponsor reimburses us for all or a majority of the health care costs.

Our managed care plans and products are designed to encourage providers and members to select quality, cost-effective health care by utilizing the full range of our innovative medical management services, quality initiatives and financial incentives. Our leading market shares enable us to realize the long-term benefits of investing in preventive and early detection programs. We further improve our ability to provide cost-effective health benefits products and services through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. These measures have allowed us to achieve significant growth in membership (78%), revenue (68%), and net income (135%) from 1996 through 2000.

Our Operating Segments

Our reportable segments are strategic business units delineated by geographic areas within which we offer similar products and services, but manage with a local focus to address each geographic region's unique market, regulatory and health care delivery characteristics. The regions are:

- the Midwest, which includes Indiana, Kentucky and Ohio;
- the East, which includes Connecticut, New Hampshire and Maine; and

- the West, which includes Colorado and Nevada.

In addition to our three geographic regions, we have a Specialty segment and an Other segment. Our Specialty segment includes business units providing:

- group life and disability insurance benefits;
- pharmacy benefit management;
- dental administration services; and
- third party occupational health services.

Various ancillary business units (reported with the Other segment) include:

- AdminaStar Federal, a subsidiary which administers Medicare programs in Indiana, Illinois, Kentucky and Ohio; and
- Anthem Alliance Health Insurance Company, a subsidiary which primarily provided health care benefits and administration in nine states for the Department of Defense's TRICARE program for military families. On May 31, 2001, the TRICARE operations were sold.

The Other segment also includes intersegment revenue, expense eliminations and corporate expenses not allocated to reportable segments.

Our Strategy and Operating Principles

Our strategic objective is to be among the best and biggest in our industry with the size and scale to deliver the best product value with the best people.

To achieve these goals, we offer a broad selection of flexible and

competitively priced products and seek to establish leading market positions. We believe that increased scale in each of our regional markets will provide us competitive advantages, cost efficiencies and greater opportunities to sustain profitable growth. The key to our ability to deliver this growth is our commitment to work with providers to optimize the cost and quality of care while improving the health of our members and improving the quality of our service.

The following are key elements to our strategy and operating principles:

- Promote Quality Care: We believe that our ability to help our members receive quality, cost-effective health care will be key to our success. We promote the health of our members through education and through products that cover prevention and early detection programs that help our members and their providers manage illness before higher cost intervention is required.

- Product Value: We aim to create products that offer value to our customers. By offering a wide spectrum of products supported by broad provider networks, we seek to meet the differing needs of our various customers.

- Operational Excellence: To provide cost-effective products, we continuously strive to improve operational efficiency. We actively benchmark our performance against other leading health benefits companies to identify opportunities to drive continuous performance improvement.

- Technology: We continuously review opportunities to improve our interactions with customers, brokers and providers. By utilizing technologies, we seek to make the interactions as simple, efficient and productive as possible.

- Growth: We believe that profitable growth, both organic and through acquisitions, is an important part of our business. Increased scale allows us to increase customer convenience and improve operating margins, while keeping our products competitively priced. Expansion into new geographic markets enables us to reduce exposure to economic cycles and regulatory changes and provides options for business expansion.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. Our telephone number is (317) 488-6000.

The Demutualization

This offering of our shares and the concurrent offering of our equity security units, or the units, are made in connection with the conversion of Anthem Insurance from a mutual insurance company into a stock insurance company in a process called demutualization. Upon demutualization, all membership interests in Anthem Insurance will be extinguished, and Anthem Insurance's eligible statutory members will receive consideration in exchange for the extinguishment of their membership interests. Their consideration will be in the form of Anthem, Inc. common stock or cash.

The terms of the demutualization are governed by the plan of conversion. The plan requires approval by Anthem Insurance's statutory members who are eligible to vote on the plan and by the Indiana Insurance Commissioner. Anthem Insurance's statutory members approved the plan on October 29, 2001. The

Indiana Insurance Commissioner approved the plan on October 25, 2001.

Anthem Insurance has formed an Indiana subsidiary, Anthem, Inc., the issuer of the common stock offered by this prospectus. The demutualization of Anthem Insurance includes the following steps, all of which will occur on or promptly after the effective date of the demutualization:

- Anthem Insurance will convert from a mutual insurance company into a stock insurance company;
- all membership interests in Anthem Insurance will be extinguished;
- the converted Anthem Insurance will become a wholly-owned subsidiary of Anthem, Inc.;
- Anthem Insurance's eligible statutory members will be entitled to receive shares of common stock of Anthem, Inc. or cash, as consideration for the extinguishment of their membership interests in Anthem Insurance;
- shares of Anthem, Inc. common stock will be sold to the public pursuant to this offering;
- equity security units will be sold to the public pursuant to the units offering; and
- a portion of the net proceeds from this offering and the units offering will be paid to eligible statutory members of Anthem Insurance who receive cash instead of shares of Anthem, Inc. common stock in the demutualization, as set forth in "Use of Proceeds."

If the demutualization is not completed for any reason, Anthem Insurance will remain a mutual insurance company, no shares of Anthem, Inc. common stock will be sold to the public pursuant to this offering and no equity security units will be sold pursuant to the units offering.

Offering of Equity Security Units

Concurrently with this offering, we are offering 4,000,000 equity security units for an aggregate offering of $200.0 million, plus up to an additional $30.0 million if the underwriters' option to purchase additional units is exercised in full, by means of a separate prospectus. Each unit initially consists of (a) a contract to purchase shares of our common stock and (b) a 5.95% subordinated debenture.

The purchase contract underlying a unit obligates holders to purchase, and us to sell, for $50, on November 15, 2004, a number of newly issued shares of our common stock equal to a settlement rate based on the average trading price of our common stock at that time. We will pay quarterly contract fee payments on the purchase contracts at the annual rate of 0.05% of the stated amount of $50 per purchase contract, subject to our rights to defer these payments.

The debentures will be unsecured and will be subordinated in right of payment to all of Anthem, Inc.'s existing and future senior indebtedness. The debentures will mature on November 15, 2006. Each debenture will initially bear interest at the rate of 5.95% per year, payable quarterly, subject to our rights to defer these payments. The applicable interest rate on the debentures outstanding on and after August 15, 2004 will be reset, and the debentures

remarketed, as described under "Description of the Equity Security Units."

During any period in which we defer contract fee payments or interest payments on the debentures, in general we cannot declare or pay any dividend or distribution on our capital stock or take specified other actions.

Before settlement of the purchase contracts through the issuance of common stock, the units will be reflected in our diluted earnings per share calculations using the treasury stock method. Under this method, the number of shares of our common stock used in calculating earnings per share for any period will be deemed to be increased by the excess, if any, of the number of our shares that would be required to be issued upon settlement of the purchase contracts over the number of shares that could be purchased by us in the market, at the average market price during that period, using the proceeds that would be required to be paid upon settlement. Consequently, there will be no dilutive effect on our earnings per share, except during periods when the average market price of our common stock is above $43.92 per share.

The closing of the offering of the units is conditioned on the concurrent closing of the initial public offering, as well as the closing of the demutualization.

The Offering

Common stock offered.....	48,000,000 shares
Common stock outstanding after the offering and the demutualization..	102,861,000 shares
Use of proceeds.....	Our net proceeds from the offering will be approximately $1,616.5 million (or $1,863.8 million if the underwriters exercise their option to purchase additional shares in full), based on the initial public offering price of $36.00 per share. We will also receive estimated net proceeds of approximately $191.0 million from the concurrent offering of units (or $219.9 million if the underwriters exercise their option to purchase additional units in full). From the aggregate net proceeds from both offerings, we estimate that we will pay $1,625.0 million to those eligible statutory members of Anthem Insurance who receive cash instead of shares of common stock in connection with the demutualization. We will use the remaining proceeds from the offerings for general corporate purposes.
Dividend policy.....	We currently do not intend to pay cash dividends on our common stock. Future dividends will be subject to our financial condition, declaration by our board of directors and other factors described

under "Dividend Policy."

New York Stock Exchange symbol..... "ATH"

Unless we specifically state otherwise, the information in this prospectus does not take into account the sale of up to 7,200,000 shares of our common stock, which the underwriters have the option to purchase from us to cover over-allotments. In addition, the information in this prospectus regarding the number of shares of our common stock to be outstanding after this offering does not include shares of common stock issuable upon the settlement of the purchase contracts that are a part of the equity security units being offered concurrently herewith.

Our common stock outstanding after the offering also excludes 7,000,000 shares available for issuance pursuant to awards of options, restricted stock, stock appreciation rights, performance stock and performance awards under our 2001 Stock Incentive Plan. See "Management--Stock Incentive Plan." In addition, our common stock outstanding after the offering excludes shares issuable under our Employee Stock Purchase Plan. The Employee Stock Purchase Plan reserves for issuance and purchase by employees 3,000,000 shares of our common stock. See "Management--Employee Stock Purchase Plan."

Recent Developments

On May 30, 2001, we signed a definitive agreement with Blue Cross and Blue Shield of Kansas, Inc., or BCBS-KS, pursuant to which we have agreed to acquire BCBS-KS for $190.0 million in cash. The transaction is expected to close in early 2002, subject to the approval of BCBS-KS policyholders, the approval of the BCBSA, the approval of the Kansas Department of Insurance and other regulatory approvals. See "Risk Factors--Our pending acquisition of Blue Cross and Blue Shield of Kansas involves risks which could cause our business to suffer" and "Recent Developments--Pending Acquisition of Blue Cross and Blue Shield of Kansas."

Prior to May 31, 2001, our subsidiary Anthem Alliance Health Insurance Company provided health care benefits and administration in nine states for the United States Department of Defense's TRICARE program for military families. On May 31, 2001, we sold the TRICARE operations to a subsidiary of Humana, Inc. for $45.0 million.

For the first nine months of 2001, net income increased 65.5% to $254.5 million compared with net income of $153.8 million for the first nine months of 2000. Net income excluding net realized gains on investments and demutualization expenses was $215.0 million for the first nine months of 2001, a 48.0% increase compared with $145.3 million for the first nine months of 2000. Total operating revenue was $7.5 billion for the first nine months of 2001, a 20.9% increase compared with $6.2 billion for the first nine months of 2000. Membership was 7.8 million at September 30, 2001, a 9.9% increase compared with 7.1 million at September 30, 2000. See "Recent Developments--Nine Months Financial Information."

Summary Consolidated Financial and Other Data

The following table summarizes financial information for Anthem. We prepared this information using our unaudited consolidated financial statements for the six-month periods ended June 30, 2001 and 2000 and our consolidated financial statements for each of the years in the five-year period ended December 31, 2000, which have been audited by Ernst & Young LLP. You should read this information with our audited consolidated financial statements and notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this prospectus. In our opinion, the summary financial data for the six-month periods ended June 30, 2001 and 2000 include all adjustments, consisting of only normal recurring adjustments, necessary for a fair presentation of that data. The summary consolidated financial and other data do not necessarily indicate the results to be expected in the future.

	As of and for the Six Months Ended June 30,		As of and for the Year Ended December 31,				
	2001(1)	2000(1)	2000(1)	1999(1)	1998	1997	1996
	(unaudited)		($ in Millions)				
Income Statement Data							
Revenues							
Premiums	$4,542.8	$3,589.3	$7,737.3	$5,418.5	$4,739.5	$4,581.4	$4,445.9
Administrative fees	430.3	356.5	755.6	611.1	575.6	445.9	452.9
Other revenue	22.6	18.9	50.6	51.0	74.6	82.7	108.5
Total operating revenue	4,995.7	3,964.7	8,543.5	6,080.6	5,389.7	5,110.0	5,007.3
Net investment income	109.0	95.0	201.6	152.0	136.8	125.2	141.9
Net realized gains (losses) on investments	(10.9)	6.5	25.9	37.5	155.9	97.0	73.3
Gain on sale of subsidiary operations	25.0	--	--	--	--	--	--
	5,118.8	4,066.2	8,771.0	6,270.1	5,682.4	5,332.2	5,222.5
Expenses							
Benefit expense	3,870.8	3,080.6	6,551.0	4,582.7	3,934.2	3,833.3	3,715.1
Administrative expense(2)	991.6	817.5	1,808.4	1,469.4	1,420.1	1,358.9	1,268.7
Interest expense	28.0	27.0	54.7	30.4	27.9	23.7	19.5
Amortization of goodwill and other intangible assets	15.7	11.4	27.1	12.7	12.0	9.6	10.7
Demutualization expenses	3.0	--	--	--	--	--	--
Endowment of non-profit foundations(3)	--	--	--	114.1	--	--	--
	4,909.1	3,936.5	8,441.2	6,209.3	5,394.2	5,225.5	5,014.0
Income from continuing operations before income taxes and minority interest	209.7	129.7	329.8	60.8	288.2	106.7	208.5
Income taxes	68.6	38.9	102.2	10.2	110.9	24.1	53.0

Minority interest (credit)	(1.9)	0.5	1.6	(0.3)	(1.1)	3.5	15.0
Income from continuing operations	143.0	90.3	226.0	50.9	178.4	79.1	140.5
Discontinued operations, net of income taxes							
Loss from discontinued operations prior to disposal	--	--	--	--	(3.9)	(125.1)	(44.4)
Loss on disposal of discontinued operations	--	--	--	(6.0)	(2.1)	(113.0)	--
Net income (loss)	$ 143.0	$ 90.3	$ 226.0	$ 44.9	$ 172.4	$ (159.0)	$ 96.1

	As of and for the Six Months Ended June 30,		As of and for the Year Ended December 31,				
	2001(1)	2000(1)	2000(1)	1999(1)	1998	1997	1996
	(unaudited)		($ in Millions, except ratios)				
Other Data--unaudited(4)							
Operating revenue and premium equivalents(5)	$6,883.1	$5,559.0	$11,800.1	$8,691.6	$7,987.4	$7,269.3	$6,772.3
Benefit expense ratio	85.2%	85.8%	84.7%	84.6%	83.0%	83.7%	83.6%
Administrative expense ratio:							
Calculated using operating revenue	19.8%	20.6%	21.2%	24.2%	26.3%	26.6%	25.3%
Calculated using operating revenue and premium equivalents	14.4%	14.7%	15.3%	16.9%	17.8%	18.7%	18.7%
Return on revenue	2.8%	2.2%	2.6%	0.7%	3.0%	(3.0)%	1.8%
Return on revenue--continuing operations	2.8%	2.2%	2.6%	0.8%	3.1%	1.5%	2.7%
Return on equity	N/A	N/A	12.6%	2.7%	10.7%	(10.1)%	6.0%
Members (000s)	7,779	7,030	7,270	6,265	5,167	5,261	4,078
Ratio of earnings to fixed charges(6)	8.49	5.80	7.03	3.00	11.33	5.50	11.69
Pro forma ratio of earnings to fixed charges(6)(7)	6.78	--	5.52	--	--	--	--
Balance Sheet Data							
Cash and investments	$4,029.6	$3,418.4	$ 3,714.6	$2,972.4	$2,805.1	$2,415.6	$2,123.4
Total assets	5,838.0	5,364.0	5,708.5	4,816.2	4,359.2	4,131.9	4,085.8
Policy liabilities	1,593.8	1,625.5	1,698.3	1,431.1	1,118.1	1,143.9	1,231.5
Debt	597.7	597.5	597.7	522.2	302.1	305.9	245.9
Total policyholders'							

surplus(8).....	2,063.9	1,756.3	1,919.8	1,660.9	1,702.5	1,524.7	1,625.2

---

(1) On October 27, 1999 and November 16, 1999 Anthem acquired New Hampshire-Vermont Health Service, formerly d/b/a Blue Cross Blue Shield of New Hampshire, and Rocky Mountain Hospital and Medical Service, Inc., formerly d/b/a Blue Cross and Blue Shield of Nevada/Colorado. On June 5, 2000, Anthem acquired Associated Hospital Service of Maine, formerly d/b/a Blue Cross and Blue Shield of Maine. These acquisitions were accounted for as purchases and the net assets and results of operations have been included in our consolidated financial statements from the respective purchase dates. Below is information for the six months ended June 30, 2001 and 2000 and for the years ended December 31, 2000 and 1999 that is included in Anthem's consolidated financial statements for the acquisitions that were completed in those periods:

	As of and for the Six Months Ended June 30,							
	2001				2000			
	Total Revenues	Operating Gain	(000s) Assets	(000s) Members	Total Revenues	Operating Loss	(000s) Assets	(000s) Members
BCBS-ME.....	$ 457.6	$ 3.0	$ 326.4	496	$ 59.6	$(2.5)	$264.8	468

	As of and for the Year Ended December 31,							
	2000				1999			
	Total Revenues	Operating Gain	(000s) Assets	(000s) Members	Total Revenues	Operating Loss	(000s) Assets	(000s) Members
BCBS-NH.....	$ 591.0	$11.6	$ 316.8	479	$ 77.9	$(0.3)	$250.6	366
BCBS-CO/NV.....	678.6	6.5	545.8	595	76.9	(3.4)	521.5	486
BCBS-ME.....	489.4	8.7	339.5	487	--	--	--	--
Total.....	$1,759.0	$26.8	$1,202.1	1,561	$154.8	$(3.7)	$772.1	852

Operating gain (loss) consists of operating revenue less benefit expense and administrative expense.

(2) The 1999 administrative expense includes a non-recurring charge of $41.9 million related to the settlement agreement with the Office of Inspector General. See Note 14 to our audited consolidated financial statements.

(3) During 1999, Anthem reached agreements with the states of Kentucky, Ohio and Connecticut to resolve any questions as to whether Anthem or the predecessor/successor entities were in possession of property that was impressed with a charitable trust. The endowment of non-profit foundations reflects contributions made for the benefit of charitable foundations in these states. See Note 3 to our audited consolidated financial statements.

(4) The benefit expense ratio represents benefit expense as a percentage of premium revenue. The administrative expense ratio represents administrative expense as a percentage of operating revenue and has also been presented as a percentage of operating revenue and premium equivalents. Return on revenue represents net income (loss) as a percentage of total revenues. Return on revenue--continuing operations represents income from continuing operations as a percentage of total revenues. Return on equity, which is only presented for annual periods, represents net income (loss) as a percentage of the average of the sum of policyholders' surplus at the beginning and the end of the period.

(5) Operating revenue and premium equivalents is a measure of the volume of business serviced by Anthem that is commonly used in the health benefits industry to allow for a comparison of operating efficiency among companies. It is calculated by adding to premiums, administrative fees and other revenue the amount of claims attributable to non-Medicare, self-funded health business where Anthem provides a complete array of customer service, claims administration and billing and enrollment services. The self-funded claims included for the six months ended June 30, 2001 and 2000 were $1,887.4 million and $1,594.3 million, respectively, and for the years ended December 31, 2000, 1999, 1998, 1997 and 1996 were $3,256.6 million, $2,611.0 million, $2,597.7 million, $2,159.3 million and $1,765.0 million, respectively.

(6) For purposes of this computation, earnings are defined as pretax earnings from continuing operations before adjustment for minority interest, plus interest expense, and amortization of debt discount and expense related to indebtedness. Fixed charges are interest expense, including amortization of debt discount and expense on indebtedness.

(7) For purposes of the pro forma ratio of earnings to fixed charges, fixed charges also reflect interest payments on the debentures included in the units at a rate of 5.95% ($11.9 million and $6.0 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively) and amortization of underwriting discounts and estimated unit offering expenses ($3.0 million and $1.5 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively). The pro forma ratio of earnings to fixed charges has been presented to give effect to the additional fixed charges related to the issuance of the units. The pro forma ratio does not give effect to any pro forma earnings resulting from the use of the net proceeds from the units offering.

(8) Policyholders' surplus represents shareholders' equity prior to demutualization.

RISK FACTORS

An investment in our common stock involves a number of risks. The performance of our common stock and the units will reflect the performance of our business related to, among other things, our competition and general economic, market and industry conditions. The price of our common stock and the units may decline, and the value of your investment could decrease. You should consider carefully, in addition to the other information contained in this prospectus, the following factors before investing in shares of our common stock. In reviewing information contained in this prospectus, you should bear in mind that past experience is no indication of future performance.

Our ability to contain health care costs and implement increases in premium rates affects our profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through underwriting criteria, utilization management, product design and negotiation

of favorable provider contracts. The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, inflation, new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care are beyond any health plan's control and may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations.

In addition to the challenge of managing health care costs, we face pressure to contain premium prices. Our customer contracts may be subject to renegotiation as customers seek to contain their costs. Alternatively, our customers may move to a competitor to obtain more favorable premiums. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates for government-sponsored programs. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

Our reserves for policy benefits may prove inadequate.

The reserves we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, enrollment in our plans, expenses, general economic conditions and other factors. Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability may be adversely affected if we are unable to maintain our current provider agreements and to enter into other appropriate agreements.

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other health benefits providers. The failure to maintain or to secure new cost-effective health care provider contracts may result in a loss in membership or higher medical costs. In addition, our inability to contract with providers, or the inability of providers to provide adequate care, could adversely affect our business.

A reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

Although our same store membership (excluding acquisitions) increased by 518,000 members, or 8.3%, from 1999 to 2000, a reduction in the number of enrollees in our health benefits programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include:

- failure to obtain new customers or retain existing customers;
- premium increases and benefit changes;
- our exit from a specific market;
- reductions in workforce by existing customers;

- negative publicity and news coverage;
- failure to attain or maintain nationally-recognized accreditations; and
- general economic downturn that results in business failures.

See "Management's Discussion and Analysis of Financial Condition and Results of Operations" for more detailed membership information for past years.

The health benefits industry is subject to negative publicity, which can adversely affect our profitability.

The health benefits industry is subject to negative publicity. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by:

- adversely affecting our ability to market our products and services;
- requiring us to change our products and services; or
- increasing the regulatory burdens under which we operate.

In addition, as long as we use the BCBS names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services.

Changes in state and federal regulations may affect our business, financial condition and results of operations.

Anthem Insurance and our other insurance and HMO subsidiaries are subject to extensive regulation and supervision by the insurance regulatory authorities of each state in which they are licensed or authorized, as well as to regulation by federal and local agencies. See "Legal and Regulatory Matters." We cannot assure you that future regulatory action by state insurance authorities will not have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and

Medicaid, changes in government regulations or policy with respect to, among other things, reimbursement levels, could also adversely affect our business, financial condition and results of operations.

Moreover, state legislatures and Congress continue to focus on health care issues. Congress is considering various forms of Patients' Bill of Rights legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under the Employee Retirement Income Security Act of 1974, or ERISA. Additionally, there recently have been legislative attempts to limit ERISA's preemptive effect on state laws. If adopted, such limitations could increase our liability exposure and could permit greater state regulation of our operations. Other proposed bills and regulations at state and federal levels may impact certain aspects of our business, including provider contracting, claims payments and processing and confidentiality of health information. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business. Further, as we continue to

implement our e-business initiatives, uncertainty surrounding the regulatory authority and requirements in this area may make it difficult to ensure compliance.

We face risks related to litigation.

We may be a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include:

- claims relating to the denial of health care benefits;
- medical malpractice actions;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts;
- disputes related to self-funded business;
- disputes over co-payment calculations;
- claims related to the failure to disclose certain business practices; and
- claims relating to customer audits and contract performance.

A number of class action lawsuits have been filed against us and certain of our competitors in the managed care business. The suits are purported class actions on behalf of certain of our managed care members and network providers for alleged breaches of various state and federal laws. For more information about these and other lawsuits filed against us, see "Legal and Regulatory Matters--Litigation." While we intend to defend these suits vigorously, we will incur expenses in the defense of these suits and we cannot predict their outcome.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic, treble or punitive damages may be sought. We currently have insurance coverage for some of these potential liabilities. Other potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future.

We have also received subpoenas from the Office of Inspector General, or OIG, related to our Medicare fiscal intermediary Part A and Part B operations and our Federal Employee Program operations. See "Legal and Regulatory Matters--Other Contingencies."

We are using the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the Blue Cross Blue Shield

Association. The termination of these license agreements could adversely affect our business, financial condition and results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive use of the BCBS names and marks in the states of Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. The license agreements contain certain requirements and restrictions regarding the operations of Anthem and our use of the BCBS names and marks, including:

- minimum capital and liquidity requirements;
- enrollment and customer service performance requirements;
- participation in programs which provide portability of membership between plans;
- disclosures to the BCBSA relating to enrollment and financial conditions;
- disclosures as to the structure of the BCBS system in contracts with third parties and in public statements;
- plan governance requirements;
- a requirement that at least 80% of a licensee's annual combined net revenue attributable to health care plans within its service area must be sold, marketed, administered or underwritten under the BCBS names and marks;
- a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services;
- a requirement that we guarantee the contractual and financial obligations of our licensed affiliates; and
- a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of AdminaStar Federal, our subsidiary which serves as a fiscal intermediary providing administrative services for Medicare Parts A and B.

We believe that we and our licensed affiliates are currently in compliance with these standards.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the BCBS names and marks in one or more of Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. Furthermore, BCBSA would be free to issue a license to use the BCBS names and marks in these states to another entity. Events which could cause the termination of a license agreement with BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency, the appointment of a trustee or receiver or the commencement of any action against Anthem Insurance seeking its dissolution. We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace. Accordingly, termination of the license agreements could have a material adverse effect on our business, financial condition and results of operations. We have obtained the consent of the BCBSA in order to continue our licenses following the demutualization.

Our insurance and HMO subsidiaries are subject to risk-based capital

requirements. Our failure to meet these standards could subject us to regulatory actions.

Anthem Insurance and our other insurance and HMO subsidiaries are subject to risk-based capital, or RBC, standards, imposed by their states of domicile. These laws are based on the RBC

Model Act adopted by the National Association of Insurance Commissioners, or NAIC, and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Anthem Insurance and our other insurance and HMO subsidiaries are currently in compliance with the risk-based capital requirements imposed by their respective states of domicile.

Compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, is expected to be costly.

In December 2000, the Department of Health and Human Services, known as HHS, promulgated certain regulations under HIPAA related to the privacy of individually identifiable health information, or protected health information. The new regulations require health plans, clearinghouses and providers to:

- comply with various requirements and restrictions related to the use, storage and disclosure of protected health information;
- adopt rigorous internal procedures to protect protected health information; and
- enter into specific written agreements with business associates to whom protected health information is disclosed.

The regulations establish significant criminal penalties and civil sanctions for noncompliance. In addition, the regulations could expose us to additional liability for, among other things, violations by our business associates. We must comply with the new regulations by April 14, 2003. Although we have not quantified the costs required to comply with the regulations, we believe the costs could be material.

Regional concentrations of our business may subject us to economic downturns in those states.

Our operating segments include regional companies located in the Midwest, East and West, with most of our revenues generated in the states of Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. Due to this concentration of business in a small number of states, we are exposed to potential losses resulting from the risk of an economic downturn in these states. If economic conditions in these states deteriorate, we may experience a reduction in existing and new business, which may have a material adverse effect on our business, financial condition and results of operations.

A downgrade in our ratings may adversely affect our business, financial condition and results of operations.

Claims paying ability and financial strength ratings by recognized rating organizations have become an increasingly important factor in establishing the competitive position of insurance companies and health benefits companies. Rating organizations continue to review the financial performance and condition

of insurers, including Anthem Insurance and our other regulated subsidiaries. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. We believe our strong ratings are an important factor in marketing our products to our customers, since ratings information is broadly disseminated and generally used throughout the industry. If our ratings are downgraded or placed under surveillance or review, with possible negative implications, the downgrade, surveillance or review could adversely affect our business, financial condition and results of operations. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders, and are not evaluations directed toward the protection of investors in our common stock, the units or the debentures and should not be relied upon when making a decision to purchase shares of the common stock offered hereby.

Our investment portfolio is subject to varying economic and market conditions, as well as regulation.

Our investment portfolio consists primarily of fixed maturity securities, indexed mutual funds, short-term investments, cash and other investments. The market value of our investments varies from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. Although there have been adverse economic conditions over the last three quarters, Anthem's liquidity has not been impacted in a negative manner. Our portfolio, which is largely comprised of fixed maturity securities, has returned 2.43%, 1.15% and 1.31% over the last three quarters ended June 30, 2001. The fixed maturity portfolio has an average credit rating of approximately double-A, and the equity securities portfolio is currently invested in S&P 500 and S&P 400 index mutual funds. We cannot assure you that our investment portfolio will produce positive returns in future periods.

Anthem Insurance and our other regulated subsidiaries are subject to state laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain investment categories, such as below-investment-grade fixed income securities, mortgage loans, real estate and equity investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

As a Medicare fiscal intermediary, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties.

Anthem, like a number of other BCBS companies, serves as a fiscal intermediary for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers. Anthem serves as a fiscal intermediary for Medicare Part A for Indiana, Kentucky, Ohio, Illinois, New Hampshire, Maine, Vermont and Massachusetts and as a fiscal intermediary for Medicare Part B for Indiana and Kentucky. As a fiscal intermediary for these programs, we receive reimbursement for certain costs and

expenditures, which is subject to adjustment upon audit by the federal Centers for Medicare and Medicaid Services, or CMS, formerly the Health Care Financing Administration, or HCFA. The laws and regulations governing fiscal intermediaries for the Medicare program are complex, subject to interpretation and can expose a fiscal intermediary to penalties for non-compliance. Fiscal intermediaries may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. In the last five years, at least eight Medicare fiscal intermediaries have made payments to settle issues raised by such audits or reviews. These payments have ranged from $700,000 to $51.6 million, plus a payment by one company of $144 million. In the fourth quarter of 1999, one of our subsidiaries reached a settlement agreement with the federal government in the amount of $41.9 million to resolve an investigation into the Medicare fiscal intermediary operations of a predecessor of the subsidiary. The period investigated was before we acquired the subsidiary. While we believe that we are in compliance in all material respects with the regulations governing fiscal intermediaries, there are ongoing reviews by the federal government of our activities under certain of our Medicare fiscal intermediary contracts. Our affiliate, AdminaStar Federal, Inc., has received several subpoenas from the OIG, Health and Human Services, and from the U.S. Department of Justice seeking documents and information concerning its responsibilities as a Medicare Part B contractor in its Kentucky operations, and requesting certain financial records from AdminaStar Federal, Inc. and from us related to our Medicare fiscal intermediary Part A and Part B operations. For additional information, see "Legal and Regulatory Matters--Other Contingencies."

We face significant competition from other health benefits companies.

As a health benefits company, we operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, legislative reform, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. This environment has produced and will likely continue to produce significant pressures on the profitability of health benefits companies. Many of our competitors are larger and have greater financial and other resources. In addition, the Gramm-Leach-Bliley Act, which gives banks and other financial institutions the ability to affiliate with insurance companies, could result in new competitors with significant financial resources entering our markets. As of December 31, 2000, we had the following approximate market share, based on number of members, in each of the eight core states in which we operate: Indiana, 29%; Kentucky, 38%; Ohio, 20%; Connecticut, 29%; New Hampshire, 31%; Maine, 40%; Colorado, 16%; and Nevada, 5%. We cannot assure you that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, financial condition and results of operations. For a more detailed discussion of our competition, please refer to "The Business of Anthem--Competition."

Acquisitions we have made or may make in the future may not be successful, which could cause our business and future growth prospects to suffer.

We have built a significant portion of our current business through mergers and acquisitions and we expect to pursue acquisitions in the future. The following are some of the risks associated with acquisitions that could have a material adverse effect on our business, financial condition and results of operations:

- some of the acquired businesses may not achieve anticipated revenues,

earnings or cash flow;

- we may assume liabilities that were not disclosed to us;
- we may be unable to integrate acquired businesses successfully and realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- acquisitions could disrupt our ongoing business, distract management, divert resources and make it difficult to maintain our current business standards, controls and procedures;
- we may finance future acquisitions by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future acquisitions; and
- we would be competing with other firms, many of which have greater financial and other resources, to acquire attractive companies.

Our pending acquisition of Blue Cross and Blue Shield of Kansas involves risks which could cause our business to suffer.

We have signed a definitive agreement with BCBS-KS pursuant to which we have agreed to acquire BCBS-KS. Under the agreement, BCBS-KS will demutualize and become a subsidiary of ours. BCBS-KS policyholders eligible to receive consideration in its demutualization will be entitled to receive $190.0 million, which we will pay in cash to the escrow described below and which amount thereafter may be reduced as described below. However, we and BCBS-KS may agree to place less than the full $190.0 million in the escrow account, in which case the portion of the $190.0 million not placed in escrow will be distributed directly to eligible BCBS-KS policyholders. The amount held in

the escrow account will be used to pay costs, expenses and liabilities relating to an investigation by the OIG of possible improper claims against Medicare by BCBS-KS, and to pay costs and expenses of the escrow, with any remaining amount to be distributed to eligible BCBS-KS policyholders. In addition, eligible BCBS-KS policyholders will be entitled to receive an additional amount, to be calculated based on the consolidated book value of BCBS-KS on the closing date of the acquisition, which is expected to be paid as a special distribution by BCBS-KS to its eligible policyholders. The proposed acquisition is expected to close in early 2002, and must be approved by the policyholders of BCBS-KS, the BCBSA, the Commissioner of Insurance of the State of Kansas and other regulators, and is subject to other conditions.

This proposed acquisition involves a number of risks, including:

- if the amount of the purchase price that we will place in escrow is not sufficient to pay in full the costs, expenses and liabilities relating to the OIG investigation and the escrow, those remaining costs, expenses and liabilities would reduce the value of BCBS-KS;
- if the final resolution of the OIG investigation results in operational restrictions being placed upon BCBS-KS, which could include BCBS-KS being disqualified from performing under federal contracts for a period of up to five years, or if such restrictions and/or a disqualification were extended to other corporate affiliates of BCBS-KS (which after

completion of the transaction would include Anthem), then the value of BCBS-KS would be reduced and the operations of Anthem could be negatively impacted;

- there may be liabilities that we assume but that were not disclosed to us;

- we may be unable to integrate the operations of BCBS-KS successfully and realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems; and

- the acquisition could distract our management and divert resources.

See "Recent Developments--Pending Acquisition of Blue Cross and Blue Shield of Kansas" for a discussion of BCBS-KS and the proposed acquisition.

The failure to effectively maintain and modernize our operations in an Internet environment could adversely affect our business.

Our businesses depend significantly on effective information systems, and we have many different information systems for our various businesses. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. For example, HIPAA's administrative simplification provisions and the Department of Labor's claim processing regulations may ultimately require significant changes to current systems. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable to such third parties' failure to perform adequately. As a result of our merger and acquisition activities we have acquired additional systems. Our failure to maintain effective and efficient information systems, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could have a material adverse effect on our business, financial condition and results of operations.

Also, like many of our competitors in the health benefits industry, our vision for the future includes becoming a premier e-business organization by modernizing interactions with customers, brokers, agents, employees and other stakeholders through web-enabling technology and re-designing internal operations. We are developing our e-business strategy with the goal of becoming widely regarded as an e-business leader in the health benefits industry. The strategy includes not only sales and

distribution of health products on the Internet, but also implementation of advanced self-service capabilities benefiting customers, agents, brokers, partners and employees. There can be no assurance that we will be able to successfully realize our e-business vision or integrate e-business operations with our current method of operations. The failure to develop successful e-business capabilities could result in competitive and cost disadvantages to us as compared to our competitors.

A challenge to the plan of conversion or the Indiana Insurance Commissioner's approval may create uncertainty about the status of the demutualization, the issuance of our shares of common stock sold in this offering and the issuance of the units sold in the units offering.

The plan of conversion and Anthem Insurance's Amended and Restated Articles of Incorporation are subject to approval by the Indiana Insurance Commissioner. That approval is a condition of the effectiveness of the demutualization. The Indiana Insurance Commissioner approved the plan of conversion and Anthem Insurance's Amended and Restated Articles of Incorporation on October 25, 2001.

Section 27-15-15-2 of the Indiana demutualization law provides that any action challenging the validity of, or arising out of, acts taken or proposed to be taken under any order of the Indiana Insurance Commissioner in connection with a plan of conversion must be commenced within 30 days after the Indiana Insurance Commissioner issues the order or determination. The 30-day appeal period will not have expired prior to the effective date of the demutualization and this offering. We cannot predict whether any action challenging the plan of conversion or the approval thereof will be commenced or what aspects of the plan an action might challenge. In the event that the order of the Indiana Insurance Commissioner is challenged, a successful challenge could result in monetary damages, a modification of the plan or the Indiana Insurance Commissioner's approval of the plan being set aside. A successful challenge would likely result in substantial uncertainty relating to the terms and effectiveness of the plan, including the demutualization of Anthem Insurance, the issuance of the shares of our common stock sold in this offering, the issuance of the units sold in the units offering, payment of consideration and the extinguishing of all membership interests. A substantial period of time might be required to reach a final determination. In addition, pursuant to the Indiana demutualization law, if certain claims have been asserted against Anthem Insurance and remain unresolved on the effective date of the demutualization, distribution of consideration to some or all eligible statutory members may be delayed by more than six months, by establishing one or more trusts for the purpose of holding assets on and following the effective date of the demutualization that are adequate to satisfy such claims. Any one or more of these outcomes could have a material adverse effect on the market price of our common stock and the units.

Our ability to meet our obligations may be affected by the limitation on dividends state insurance laws impose on our regulated subsidiaries.

After the demutualization, we will be a holding company whose assets will include all of the outstanding shares of common stock of Anthem Insurance. As a holding company, we will depend on dividends from Anthem Insurance and its receipt of dividends from our other regulated subsidiaries. State insurance laws may restrict the ability of our regulated subsidiaries to pay dividends. For a discussion of these restrictions, see "Management's Discussion and Analysis of Financial Condition and Results of Operations--Liquidity and Capital Resources--Anthem, Inc." Our ability to pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on the debentures and other debt, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, financial condition and results of operations and the value of our common stock and the units.

The initial public offering price of our common stock may not be indicative of the market price of our common stock after this offering and our stock price could be highly volatile.

The initial public offering price of our common stock is based on numerous factors and may not be indicative of the market price of our common stock after this offering. Factors including:

- variations in actual or anticipated operating results;
- changes in or failure to meet earnings estimates of securities analysts;
- market conditions in the health benefits industry;
- regulatory actions and general economic and stock market conditions; and
- the availability for sale, or sales, of a significant number of shares of our common stock in the public market,

may have a significant effect on the market price of our common stock after this offering. Accordingly, the market price of our common stock may decline below the initial public offering price.

Sales of shares by eligible statutory members who receive shares in the demutualization may reduce the market price of our common stock.

Anthem Insurance's eligible statutory members who receive shares in the demutualization will not be required to pay any cash purchase price for those shares, and generally will be free to sell their shares in the public market after the demutualization. Only eligible statutory members who receive 30,000 or more shares of our common stock in the demutualization (whom we estimate would hold an aggregate of approximately 11.5 million shares of our outstanding common stock after the offering) and continue to hold 30,000 or more shares will have volume and manner of sale restrictions on the sales of their shares in the public market. For a period of 180 days after the effective date of the demutualization, these large shareholders will be able to sell their shares only under a large holder sale program that we will establish. See "The Plan of Conversion--Large Holder Sale Program" for a description of the large holder sale program and its limitations. We anticipate that eligible statutory members receiving shares of our common stock in the demutualization will receive notices regarding the number of shares registered in their name approximately four to six weeks after the effective date of the demutualization. Sales of substantial amounts of common stock, or the perception that such sales could occur, could reduce the prevailing market price for our common stock. We believe the following facts may increase selling pressure on our common stock:

- Some of Anthem Insurance's eligible statutory members, in particular holders of group policies who did not elect to receive common stock in the demutualization, are nevertheless likely to receive common stock instead of cash because the amount of cash available for payments to eligible statutory members will be limited. Those members may be especially likely to sell the shares of common stock they receive in the demutualization in order to realize cash proceeds.
- Some eligible statutory members may be fiduciaries of benefit plans that are subject to ERISA or other legal or regulatory restrictions on their investments. Those members, particularly if they originally did not elect to receive common stock in the demutualization, may determine that the exercise of their fiduciary duties requires them to promptly sell the shares of common stock they receive in the demutualization.
- We intend to provide a program for the public sale of our common stock, at prevailing market prices and without paying brokerage commissions or similar expenses, to allow each of our shareholders who owns 99 or fewer shares of our common stock to sell those shares or to purchase additional shares to round-up their holdings to 100 shares. This program would begin no sooner than the first business day after the 180th day following, and no later

than the last business day before the twelfth-month anniversary of, the effective date of the demutualization, and it would continue for at least three months. We estimate that when we complete the demutualization we will have approximately 150,000 eligible statutory members who will in total receive in excess of five million shares that we believe would be eligible to participate in this commission-free sales program.

Applicable laws and our articles of incorporation and bylaws may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interests.

State laws and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

Under the Indiana demutualization law, for a period of five years following the effective date of the demutualization, no person may acquire beneficial ownership of 5% or more of the outstanding shares of our common stock without the prior approval of the Indiana Insurance Commissioner and our board of directors. This restriction does not apply to acquisitions made by us or made pursuant to an employee benefit plan or employee benefit trust sponsored by us. The Indiana Insurance Commissioner has adopted rules under which passive institutional investors could purchase 5% or more but less than 10% of our outstanding common stock with the prior approval of our board of directors and prior notice to the Indiana Insurance Commissioner.

Our license agreements with the BCBSA require that our articles of incorporation contain certain provisions, including ownership limitations. The BCBSA ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for noninstitutional investors, both as defined in our articles of incorporation. In addition, no person may beneficially own shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest in our company. Our articles of incorporation prohibit ownership of our capital stock in excess of these BCBSA ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation).

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws:

- permit our board of directors to issue one or more series of preferred stock;
- divide our board of directors into three classes serving staggered three-year terms;
- restrict the maximum number of directors;
- limit the ability of shareholders to remove directors;
- impose restrictions on shareholders' ability to fill vacancies on our

board of directors;

- prohibit shareholders from calling special meetings of shareholders;
- impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and
- impose restrictions on shareholders' ability to amend our articles of incorporation and bylaws.

AVAILABLE INFORMATION

We have filed with the Securities and Exchange Commission in Washington, D.C., a registration statement on Form S-1 under the Securities Act of 1933 with respect to the common stock being offered by this prospectus. This prospectus which forms a part of the registration statement does not contain all the information set forth in the registration statement, certain parts of which are omitted in accordance with the rules and regulations of the Securities and Exchange Commission. For further information with respect to Anthem, Inc., our common stock and the units, we refer you to the registration statement and to the exhibits to the registration statement. Statements made in this prospectus describing the contents of any contract, agreement or other document referred to are not necessarily complete. With respect to these contracts, agreements or other documents filed as an exhibit to the registration statement, we refer you to the exhibit for a more complete description of the matter involved, and each statement is qualified in its entirety by this reference. The registration statement and the exhibits to the registration statement may be inspected and copied at the Securities and Exchange Commission's Public Reference Room at 450 Fifth Street, N.W., Washington, D.C. 20549, and at its regional offices located at 233 Broadway, The Woolworth Building, New York, New York 10279 and 500 West Madison Street, Suite 1400, Chicago, Illinois 60661-2511. The public may obtain information on the operation of the Public Reference Room by calling the Securities and Exchange Commission at 1-800-SEC-0330. The Securities and Exchange Commission maintains an Internet world wide web site at http://www.sec.gov that contains periodic and current reports, proxy and information statements, and other information regarding issuers that file electronically with the Securities and Exchange Commission.

As a result of Anthem Insurance's conversion to a stock insurance company, this offering and the offering of the units, we will become subject to the information reporting requirements of the Securities Exchange Act of 1934. We will fulfill our obligations with respect to such requirements by filing periodic and current reports, proxy statements and other information with the Securities and Exchange Commission. These reports, proxy statements and information may be inspected and copied at the public reference facilities maintained by the Securities and Exchange Commission referenced above. We intend to furnish holders of our common stock with annual reports that include our annual consolidated financial statements audited by an independent certified public accounting firm.

Our common stock has been approved for listing on the New York Stock Exchange, subject to official notice of issuance, under the symbol "ATH". The units have been approved for listing on the New York Stock Exchange, subject to official notice of issuance, under the symbol "ATV." Upon notice of issuance, copies of the registration statement, including all exhibits thereto, and periodic reports, proxy statements and other information will be available for inspection at the offices of the New York Stock Exchange, Inc. located at 20

Broad Street, New York, New York 10005.

INFORMATION PERTAINING TO FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements that reflect our views about future events and financial performance. When used in this prospectus, the words "may," "will," "should," "anticipate," "estimate," "expect," "plan," "believe," "predict," "potential," "intend" and similar expressions are intended to identify forward-looking statements. Forward-looking statements are subject to known and unknown risks and uncertainties that could cause actual results to differ materially from those projected. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us which attempt to advise interested parties of the factors which affect our business, including the discussion under the caption "Risk Factors" as well as our reports filed with the Securities and Exchange Commission from time to time.

Health benefits companies operate in a highly competitive, constantly changing environment that is significantly influenced by very large organizations that have resulted from business combinations, aggressive marketing and pricing practices of competitors and regulatory oversight. The following is a summary of factors, the results of which, either individually or in combination, if markedly different from our planning assumptions, could cause our results to differ materially from those expressed in any forward-looking statements contained in this prospectus:

- trends in health care costs and utilization rates;
- ability to secure sufficient premium rate increases;
- competitor pricing below market trends of increasing costs;
- increased government regulation of health benefits and managed care;
- significant acquisitions or divestitures by major competitors;
- introduction and utilization of new prescription drugs and technology;
- a downgrade in our financial strength ratings;
- litigation targeted at health benefits companies;
- ability to contract with providers consistent with past practice; and
- general economic downturns.

THE PLAN OF CONVERSION

The following summary discussion of the plan of conversion does not purport to be complete and is qualified in its entirety by reference to the complete text of the plan of conversion. A copy of the plan of conversion is filed as an exhibit to the registration statement of which this prospectus forms a part.

Background of the Demutualization

Mutual insurance companies, like Anthem Insurance, are not authorized to issue or sell capital stock and as a result are limited in their ability to raise capital. With increasing consolidation and competition in the health benefits industry, and the resulting need to develop new business opportunities, Anthem Insurance has examined alternative ways of raising capital.

On January 29, 2001, Anthem Insurance's board of directors authorized management to prepare a plan of conversion, whereby Anthem Insurance will convert from a mutual insurance company to a stock insurance company under the Indiana demutualization law, Indiana Code Section 27-15-1-1 et seq., and on June 18, 2001, Anthem Insurance's board of directors unanimously approved the plan of conversion. The principal reason for the demutualization is to increase our financial flexibility through improved access to capital, which will enhance our ability to expand existing business, develop new business opportunities and enhance our competitive position in the health benefits industry, and continue to improve service to our customers. In addition, if the plan of conversion becomes effective, the eligible statutory members will receive consideration in the form of Anthem, Inc. common stock or cash in exchange for the extinguishing of their membership interests in Anthem Insurance.

Exchange of Membership Interests

In general, holders of policies or certificates, including guaranty policies or certificates thereunder, as applicable, issued by Anthem Insurance, have rights as statutory members of Anthem Insurance, which in the context of demutualization are called membership interests. Membership interests consist principally of the right to vote on matters submitted to a vote of statutory members, including the election of directors, and the right to participate in any distribution of cash, stock or other consideration in the event of a conversion of Anthem Insurance to a stock insurance company under the Indiana demutualization law or a dissolution of Anthem Insurance. If the plan becomes effective, the membership interests of all statutory members will be extinguished and Anthem Insurance's eligible statutory members will receive consideration in the form of our common stock or cash.

Consideration

Eligible Statutory Members

If the plan becomes effective, Anthem Insurance's eligible statutory members will receive consideration in the form of our common stock or cash. Prior to the vote on the plan of conversion by Anthem Insurance's statutory members eligible to vote on the plan, they were given the opportunity to elect to receive common stock in the demutualization. Those eligible statutory members who failed to make a common stock election may be paid in cash. However, the amount of cash available for distribution to eligible statutory members will be limited, and a significant portion of eligible statutory members will likely receive Anthem, Inc. common stock even if they did not elect to receive common stock in the demutualization. The number of eligible statutory members for which cash will be available will depend on a number of factors, including market conditions, the size of this offering and the size of the offering of the units. We have agreed in the plan of conversion to use our best commercially reasonable efforts, consistent with our capital and liquidity needs and projections, to assure that funds sufficient to pay cash to a substantial number of eligible statutory members will be made available and used for these cash payments.

In general, an eligible statutory member is an Anthem Insurance statutory member who was the holder on June 18, 2001, of an in-force policy or certificate issued by Anthem Insurance and continues to be the holder of an in-force policy or certificate on the effective date of the plan. Of Anthem's more than seven million members or customers, under applicable law and the articles of incorporation and by-laws of Anthem Insurance, approximately one million are statutory members.

We have signed a definitive agreement with BCBS-KS, pursuant to which we will acquire BCBS-KS. See "Recent Developments--Pending Acquisition of Blue Cross and Blue Shield of Kansas." Policyholders of BCBS-KS will not become statutory members of Anthem Insurance and will not be eligible to receive any consideration as a result of our demutualization.

Allocation of Shares

The aggregate consideration to be distributed to Anthem Insurance's eligible statutory members in exchange for membership interests will consist of shares of our common stock or cash equal to the fair value of Anthem Insurance as determined under Indiana law. The amount of an eligible statutory member's consideration will be based on an allocation to that member of a number of shares of Anthem, Inc. common stock. The aggregate consideration distributed to eligible statutory members will be shares of common stock and cash equal in value to 100 million shares of our common stock. The method of allocation among eligible statutory members provides to each eligible statutory member a "fixed component" equal in value to 21 shares of Anthem, Inc. common stock and a "variable component," which may be zero. The variable component in general is based on an estimate of any positive contribution made by such member to Anthem Insurance's statutory surplus relative to the sum of such positive contributions made by all eligible statutory members. We anticipate that approximately 20% of the aggregate consideration distributed to eligible statutory members will represent the fixed component, and the balance will represent the variable component. We retained Daniel J. McCarthy, FSA, MAAA, Dale S. Hagstrom, FSA, MAAA, and Robert H. Dobson, FSA, MAAA, independent consulting actuaries associated with Milliman USA, Inc., an independent actuarial consulting firm, to advise us in connection with the actuarial matters involved in the plan of conversion and the allocation of consideration to eligible statutory members. The opinion of Messrs. McCarthy, Hagstrom and Dobson, dated June 18, 2001, states, in reliance upon the matters described in the opinion, that the principles, assumptions, methodologies and formulas used to allocate consideration among eligible statutory members in exchange for their membership interests are reasonable and appropriate and that the resulting allocation of consideration to eligible statutory members is fair and equitable. A copy of the opinion is attached as Annex A to this prospectus.

Cash Payment Amounts

For those eligible statutory members who receive cash in the demutualization, the amount of cash payments will be based on the initial public offering price of our common stock in this offering. The formula for calculation of cash payments includes a "top up" provision. If the average closing price of Anthem, Inc.'s common stock over the 20 consecutive trading days commencing with the date on which the demutualization is completed is more than 110% of the initial public offering price, eligible statutory members receiving cash will receive an additional payment equal to the amount by which the average closing price exceeds 110% of the initial public offering price, up to 120% of the initial public offering price.

Other Capital Raising Transaction

The plan requires us to make the initial public offering and to raise proceeds from the initial public offering, together with the offering of units,

to provide cash for the cash payments to be made to eligible statutory members under the plan, as well as to pay the fees and expenses we have incurred in connection with the demutualization. The plan also permits us to complete one or more

other specified capital raising transactions concurrently with the initial public offering. Concurrently with this offering, we are offering 4,000,000 equity security units for an aggregate offering of $200.0 million, plus up to an additional $30.0 million if the underwriters' option to purchase additional units is exercised in full. Each unit consists of (a) a contract to purchase shares of our common stock and (b) a subordinated debenture. For a description of the units, see "Description of the Equity Security Units."

Conditions to Effectiveness of the Plan

In order for the plan of conversion to become effective, the following approvals and conditions must be obtained and/or satisfied:

Approval by Statutory Members

One of the conditions for the plan of conversion and Anthem Insurance's Amended and Restated Articles of Incorporation to become effective is that they must be approved by a vote of Anthem Insurance's statutory members eligible to vote on the plan.

On June 18, 2001, the board of directors of Anthem Insurance unanimously approved the plan of conversion and Amended and Restated Articles of Incorporation, and recommended the plan and Amended and Restated Articles of Incorporation to Anthem Insurance's statutory members. Anthem Insurance's statutory members approved the plan and Amended and Restated Articles of Incorporation at a special meeting held on October 29, 2001.

Approval by the Indiana Insurance Commissioner

In order for the plan to become effective, the plan and Anthem Insurance's Amended and Restated Articles of Incorporation must be approved by the Indiana Insurance Commissioner.

The Indiana demutualization law requires the Indiana Insurance Commissioner to approve the plan and Anthem Insurance's Amended and Restated Articles of Incorporation if she finds that:

- the amount and form of consideration to be given to Anthem Insurance's eligible statutory members under the plan is fair in the aggregate and to each member class;

- the plan complies with the Indiana demutualization law and other applicable laws, is fair, reasonable and equitable to the eligible statutory members and will not prejudice the interests of Anthem Insurance's other statutory members or policyholders; and

- the total consideration provided to eligible statutory members under the plan is equal to or greater than Anthem Insurance's policyholders' surplus as determined in accordance with statutory accounting principles.

A public hearing on the demutualization was held at the Indiana Government Conference Center, Auditorium, 402 West Washington Street, Indianapolis, Indiana 46204 on October 2, 2001. The Indiana Insurance Commissioner approved

the plan of conversion and the Amended and Restated Articles of Incorporation on October 25, 2001.

Tax Opinion

Under the plan, an opinion of Anthem's tax advisor, Ernst & Young LLP, regarding certain federal income tax consequences of the plan must be received in order for the plan to become effective.

ERISA Exemption

Anthem Insurance will not cause or allow the demutualization to become effective unless, on or prior to the effective date of the plan:

- the Department of Labor has granted an exemption from Section 406 of the Employee Retirement Income Security Act of 1974, or ERISA, and Section 4975 of the Internal Revenue Code of 1986, as amended, or the Code, with respect to the receipt of consideration pursuant to the plan by employee benefit plans subject to the provisions of such sections; or

- Anthem has, upon advice of counsel, otherwise determined and reported to the Indiana Insurance Commissioner that the distribution of consideration will not have an adverse effect on eligible statutory members or on Anthem, or that the distribution of consideration will not constitute a prohibited transaction under ERISA or the Code; or

- the consideration payable to such employee benefit plans is placed in trust for up to six months, pending the receipt of the required exemptions.

Neither Anthem Insurance nor Anthem, Inc. nor their or their subsidiaries' employees, officers or directors are, or will be, eligible statutory members under any benefit or welfare plan established or maintained by Anthem Insurance, Anthem, Inc. or any of their subsidiaries for the benefit of such employees, officers or directors.

Initial Public Offering

Consummation of this offering is a condition to the effectiveness of the plan of conversion.

Other Approvals

In connection with the demutualization, we will need to obtain various regulatory approvals and the consent of the BCBSA.

Appeal Period

Section 27-15-15-2 of the Indiana demutualization law provides that any action challenging the validity of or arising out of acts taken or proposed to be taken under any order of the Indiana Insurance Commissioner in connection with the plan must be commenced within 30 days after the Indiana Insurance Commissioner issued the order or determination. The 30-day appeal period will not have expired prior to the effective date of the demutualization and this offering. In the event that the order of the Indiana Insurance Commissioner is challenged, a successful challenge could result in monetary damages, a modification of the plan or the Indiana Insurance Commissioner's approval of the plan being set aside. A successful challenge would likely result in substantial uncertainty relating to the terms and effectiveness of the plan,

including the demutualization of Anthem Insurance, payment of consideration and the extinguishing of membership interests. A substantial period of time might be required to reach a final determination. However, in order to challenge successfully the Indiana Insurance Commissioner's approval of the plan, the petitioner would have to sustain the burden of showing that such approval was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law, contrary to constitutional right, power, privilege or immunity, in excess of statutory jurisdiction, authority or limitations, or short of statutory right, without observance of procedure required by law or unsupported by substantial evidence. In addition, pursuant to the Indiana demutualization law, if certain claims have been asserted against Anthem Insurance and remain unresolved on the effective date of the demutualization, distribution of consideration to some or all eligible statutory members may be delayed by more than six months, by establishing one or more trusts for the purpose of holding assets on and following the effective date of the demutualization that are adequate to satisfy such claims.

Amendment or Withdrawal of the Plan; Corrections

The plan of conversion may be modified, amended, withdrawn or terminated only in a manner consistent with the provisions of the Indiana demutualization law and by action of a majority of Anthem Insurance's board of directors. Additionally, Anthem Insurance may make certain modifications, corrections of errors or omissions and clarifications to the plan as may be necessary under the plan, or as may be required by the Indiana Insurance Commissioner.

Effectiveness of the Plan

If the conditions to effectiveness of the plan are met, and upon Anthem Insurance's filing with the Indiana Department of Insurance and the Indiana Secretary of State the Amended and Restated Articles of Incorporation, the plan of conversion will go into effect. The plan provides that the effective date of the plan will occur upon the date and time of approval of Anthem Insurance's Amended and Restated Articles of Incorporation by the Indiana Secretary of State, unless a later date and time are specified in the Amended and Restated Articles of Incorporation, in which case the plan and those Articles will become effective at that later date and time. We anticipate that the plan will become effective on the closing date of this offering.

If the plan does not become effective for any reason, Anthem Insurance will remain a mutual insurance company, the interests of Anthem Insurance's statutory members will remain unchanged, no consideration will be paid to eligible statutory members, and no shares will be issued or sold in this offering and no units will be issued or sold in the units offering.

Tax Effect on Anthem

The following sections are a summary of the material federal income tax consequences to Anthem in connection with the plan, based on the opinion of Ernst & Young LLP, Anthem's tax advisor.

Demutualization of Anthem Insurance

The demutualization of Anthem Insurance from a mutual insurance company to a stock insurance company will be tax-free under the Code, and the holding company formation whereby Anthem Insurance will become a wholly-owned subsidiary of Anthem, Inc. will be tax-free to both Anthem Insurance and Anthem, Inc. under the Code.

Distribution of Cash to Eligible Statutory Members

Neither Anthem Insurance nor Anthem, Inc. will recognize gain or loss on Anthem, Inc.'s issuance of cash to those eligible statutory members who are to receive cash in lieu of Anthem, Inc. common stock under the plan.

Treatment of Anthem, Inc.

Anthem, Inc. will not recognize gain or loss on its receipt of cash in this offering.

Special Tax Rules Applicable to Blue Cross and Blue Shield Organizations

Under current law, Anthem currently enjoys certain federal income tax benefits as described below, including special tax deductions, as a Blue Cross or Blue Shield organization that was in existence on August 16, 1986. These special tax benefits continue for as long as Anthem does not undergo a "material change" in operations or structure. Current law does not address whether a

demutualization transaction will constitute a material change in the operations or structure of a Blue Cross or Blue Shield organization and, therefore, it is not clear what effect the plan will have on Anthem's ability to continue to qualify for such tax benefits.

As an existing Blue Cross and Blue Shield organization, Anthem is entitled to take advantage of special tax provisions. These provisions include a deduction based on the amount by which 25% of our claims and expenses exceed our adjusted surplus (the "Section 833(b) Deduction") and a deduction for increases to our unearned premium reserve that is higher than the deduction allowable to most insurance companies. Because of the current level of adjusted surpluses, Anthem has only one subsidiary that anticipates having a Section 833(b) Deduction in calendar year 2001.

If the plan is treated as effecting a "material change" to Anthem's structure or operations, Anthem would not be allowed the Section 833(b) Deduction. Anthem would also only be allowed to deduct 80% of our unearned premium reserve rather than 100%. This would have the impact of accelerating taxable income in the year in which the material change occurs.

In addition, as a Blue Cross or Blue Shield organization, Anthem was entitled to adjust the tax basis of assets that we owned on January 1, 1987 to their fair market value on that date. If we were deemed to undergo a material change as a result of the plan, it is possible that we would lose the remaining benefit of this special basis adjustment, which could cause an increase in our tax liability on any further disposition of certain assets owned on January 1, 1987.

Status as an Insurance Company

As long as Anthem does not undergo a material change, Anthem will be treated as an insurance company for federal income tax purposes. If Anthem were determined to have undergone a material change, Anthem's status as an insurance company would depend on whether its predominant business activities are considered to be those of an insurance company. Loss of insurance company status generally would preclude Anthem from taking into account deductions for additions to certain reserves that insurance companies are permitted to deduct for federal income tax purposes. The loss of these deductible reserves would, in general, cause acceleration of the payment of federal income tax on income

derived from Anthem's operations. However, we believe that Anthem should continue to qualify as an insurance company regardless of whether the demutualization is viewed as a material change.

ERISA Considerations

Prohibited Transaction Exemption

A significant percentage of the policies or certificates held by likely eligible statutory members are associated with welfare benefit plans subject to ERISA. The Department of Labor, or DOL, has taken the position that the stock or other consideration that is distributed in a demutualization with respect to ERISA plans generally is a "plan asset" under ERISA. Anthem may be considered to be a "party-in-interest" under ERISA with respect to these ERISA plans. Absent an exemption, the receipt of Anthem, Inc. common stock or cash by eligible statutory members whose policies or certificates are associated with ERISA plans could be viewed as a prohibited transaction under Section 406 of ERISA.

Anthem Insurance has received an individual prohibited transaction exemption from the DOL. The individual prohibited transaction exemption allows eligible statutory members with policies or certificates associated with ERISA plans to receive the Anthem, Inc. common stock or cash without application of the prohibited transaction rules. The DOL grants individual prohibited transaction exemptions if it determines that the exemption is administratively feasible, is in the interest of the ERISA plans and their participants and beneficiaries and is protective of the rights of participants and beneficiaries.

Large Holder Sale Program

Pursuant to the plan of conversion, shares of our common stock distributed to any of Anthem Insurance's eligible statutory members who receives and continues to hold 30,000 or more shares of our common stock may not be transferred or sold by such eligible statutory member until 180 days after the effective date of the demutualization, except for transfers that occur by operation of law, transfers with our written consent or sales in accordance with a large holder sale program that we will establish. After the 180 day period, these limitations will no longer apply.

The large holder sale program will be administered by EquiServe Trust Company, N.A. as the program agent. Under the large holder sale program procedures, if the aggregate number of shares of our common stock to be sold on the open market on any day on behalf of all holders who hold more than 30,000 shares exceeds the lesser of (i) 1/10th of 1% of the number of shares of our common stock outstanding or (ii) 25% of the average daily trading volume for the 20 consecutive trading days (or such shorter period, if fewer than 20 consecutive trading days have elapsed since the effective date of the demutualization) preceding such day, the designated broker-dealer will only process trades on the open market up to that limit for all holders who hold more than 30,000 shares. The designated broker-dealer will either defer the excess shares to the next trading day (which will be subject to the same volume limitations on that day) or sell the shares as principal through a block trade or through a nationally recognized brokerage firm that will sell the shares, as agent, at market clearing prices. The excess shares on any day may also be purchased by Anthem, subject to compliance with applicable regulatory requirements, but we have no obligation to purchase any excess shares.

Commission-Free Sales Program

Pursuant to the plan of conversion, we intend to establish a commission-free sales program that would commence no sooner than the first business day after the 180th day following, and no later than the last business day before the twelfth-month anniversary of, the effective date of the demutualization, and would continue for at least three months. Under this program, each of our shareholders who owns 99 or fewer shares of our common stock on the record date for the commission-free sales program would have the opportunity at any time during the term of the program to sell all, but not less than all, of those shares in one transaction at prevailing market prices without paying brokerage commissions or other similar expenses. We would also offer each shareholder eligible to participate in the commission-free sales program the opportunity to purchase shares of common stock as necessary to increase their holdings to 100 share round lots without paying brokerage commissions or other similar expenses. This stock purchase program would occur simultaneously and in conjunction with the commission-free sales program. The program may provide that we can repurchase shares of our common stock at prevailing market prices when, during any particular day of the program, the number of shares requested to be sold exceeds the number of shares requested to be purchased pursuant to round-up requests.

USE OF PROCEEDS

Gross proceeds to us from the offering will be $1,728.0 million. This reflects the sale of 48,000,000 shares of common stock by us, at an initial public offering price of $36.00 per share. From these gross proceeds, we estimate we will pay $1,434.0 million to Anthem Insurance's eligible statutory members who receive cash in lieu of shares of common stock in connection with the demutualization. We expect to pay from the gross proceeds $79.5 million for underwriting discounts and an estimated $32.0 million for other offering and additional demutualization expenses. We will use the estimated balance of approximately $182.5 million, plus an estimated additional $247.3 million of net proceeds if the underwriters exercise their over-allotment option in full, for general corporate purposes.

With respect to the concurrent offering of units, gross proceeds to us will be $200.0 million. We expect to pay from the gross proceeds approximately $9.0 million for underwriting discounts and offering expenses. From the resulting net proceeds of $191.0 million, together with estimated net proceeds of $1,616.5 million from this initial public offering of common stock (for estimated net proceeds from both offerings aggregating $1,807.5 million), payments totaling an estimated $1,625.0 million will be made to eligible statutory members of Anthem Insurance who receive cash instead of shares of Anthem, Inc. common stock in the demutualization. We will use the balance of the net proceeds from both offerings of approximately $182.5 million, plus an estimated additional $276.2 million of net proceeds if the underwriters exercise both over-allotment options in full, for general corporate purposes.

DIVIDEND POLICY

Our board of directors does not presently intend to declare cash dividends on our common stock. The declaration and payment of future dividends will be at the discretion of our board of directors and must comply with applicable law. Future dividend payments will depend upon our financial condition, results of operations, future liquidity needs, potential acquisitions, regulatory and capital requirements and other factors deemed relevant by our board of directors. In addition, following the effective date of the plan of conversion, we will be a holding company whose primary asset will be 100% of the capital stock of Anthem Insurance. Our ability to pay dividends to our shareholders will primarily depend upon the receipt of dividends from Anthem Insurance and

its receipt of dividends from our other regulated insurance subsidiaries.

In addition, the indenture governing the terms of the debentures to be issued in connection with the offering of units prohibits, with certain limited exceptions, the payment of dividends on our common stock during a deferral of interest payments on the debentures or an event of default under the indenture. We also have the option to defer contract fee payments on the purchase contracts. If we elect to defer contract fee payments, we cannot, with certain limited exceptions, pay dividends on our common stock during a deferral period.

CAPITALIZATION

The following table sets forth, as of June 30, 2001, Anthem's actual capitalization and Anthem, Inc.'s capitalization as adjusted to give effect to:

- the demutualization;
- the sale of 48,000,000 shares of common stock in this offering at an initial public offering price of $36.00 per share;
- the sale of 4,000,000 equity security units at an offering price of $50.00 per unit; and
- the application of estimated net proceeds from this offering and from the offering of the units as set forth under "Use of Proceeds."

	At June 30, 2001	
	Anthem Historical	Anthem, Inc. Pro forma
	(In Millions, except share data)	
Debt:		
9.00% surplus notes due 2027	$ 197.2	$ 197.2
9.125% surplus notes due 2010	295.7	295.7
5.95% debentures included in equity security units	--	191.0
Other	104.8	104.8
Total debt	597.7	788.7
Shareholders' equity(1):		
Preferred stock, without par value, shares authorized--100,000,000 shares issued and outstanding--none	$ --	$ --
Common stock, par value $0.01, shares authorized--900,000,000, shares issued and outstanding--none historically and 102,861,000 pro forma	--	1.0
Additional paid in capital	--	1,982.1
Retained earnings	1,991.6	--
Accumulated other comprehensive income	72.3	72.3
Total shareholders' equity(1)	2,063.9	2,055.4
Total capitalization	$2,661.6	$2,844.1

				========	========		

---

(1) Anthem historical amounts represent "Policyholders' surplus" prior to demutualization.

SELECTED CONSOLIDATED FINANCIAL AND OTHER DATA

In the table below, we provide selected consolidated financial data of Anthem. We prepared this information using our unaudited consolidated financial statements for the six-month periods ended June 30, 2001 and 2000 and our consolidated financial statements for each of the years in the five-year period ended December 31, 2000, which have been audited by Ernst & Young LLP. You should read this selected consolidated financial data together with our audited consolidated financial statements and notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this prospectus. In our opinion, the selected consolidated financial data for the six-month periods ended June 30, 2001 and 2000 include all adjustments, consisting of only normal recurring adjustments, necessary for a fair presentation of that data. The selected consolidated financial and other data do not necessarily indicate the results to be expected in the future.

	As of and for the Six Months Ended June 30,		As of and for the Year Ended December 31,				
	2001(1)	2000(1)	2000(1)	1999(1)	1998	1997	1996
	(unaudited)		($ in Millions)				
Income Statement Data							
Revenues							
Premiums	$4,542.8	$3,589.3	$7,737.3	$5,418.5	$4,739.5	$4,581.4	$4,445.9
Administrative fees	430.3	356.5	755.6	611.1	575.6	445.9	452.9
Other revenue	22.6	18.9	50.6	51.0	74.6	82.7	108.5
Total operating revenue	4,995.7	3,964.7	8,543.5	6,080.6	5,389.7	5,110.0	5,007.3
Net investment income	109.0	95.0	201.6	152.0	136.8	125.2	141.9
Net realized gains (losses) on investments	(10.9)	6.5	25.9	37.5	155.9	97.0	73.3
Gain on sale of subsidiary operations	25.0	--	--	--	--	--	--
	5,118.8	4,066.2	8,771.0	6,270.1	5,682.4	5,332.2	5,222.5
Expenses							
Benefit expense	3,870.8	3,080.6	6,551.0	4,582.7	3,934.2	3,833.3	3,715.1
Administrative expense(2)	991.6	817.5	1,808.4	1,469.4	1,420.1	1,358.9	1,268.7
Interest expense	28.0	27.0	54.7	30.4	27.9	23.7	19.5
Amortization of goodwill and other intangible assets	15.7	11.4	27.1	12.7	12.0	9.6	10.7
Demutualization							

expenses.....	3.0	--	--	--	--	--	--
Endowment of non-profit foundations(3).....	--	--	--	114.1	--	--	--
	4,909.1	3,936.5	8,441.2	6,209.3	5,394.2	5,225.5	5,014.0
Income from continuing operations before income taxes and minority interest.....	209.7	129.7	329.8	60.8	288.2	106.7	208.5
Income taxes.....	68.6	38.9	102.2	10.2	110.9	24.1	53.0
Minority interest (credit).....	(1.9)	0.5	1.6	(0.3)	(1.1)	3.5	15.0
Income from continuing operations.....	143.0	90.3	226.0	50.9	178.4	79.1	140.5
Discontinued operations, net of income taxes							
Loss from discontinued operations prior to disposal.....	--	--	--	--	(3.9)	(125.1)	(44.4)
Loss on disposal of discontinued operations.....	--	--	--	(6.0)	(2.1)	(113.0)	--
Net income (loss).....	$ 143.0	$ 90.3	$ 226.0	$ 44.9	$ 172.4	$ (159.0)	$ 96.1

	As of and for the Six Months Ended June 30,		As of and for the Year Ended December 31,				
	2001(1)	2000(1)	2000(1)	1999(1)	1998	1997	1996
	(unaudited)		($ in Millions, except ratios)				
Other Data-unaudited(4)							
Operating revenue and premium equivalents(5).....	$6,883.1	$5,559.0	$11,800.1	$8,691.6	$7,987.4	$7,269.3	$6,772.3
Benefit expense ratio...	85.2%	85.8%	84.7%	84.6%	83.0%	83.7%	83.6%
Administrative expense ratio:							
Calculated using operating revenue.....	19.8%	20.6%	21.2%	24.2%	26.3%	26.6%	25.3%
Calculated using operating revenue and premium equivalents...	14.4%	14.7%	15.3%	16.9%	17.8%	18.7%	18.7%
Return on revenue.....	2.8%	2.2%	2.6%	0.7%	3.0%	(3.0)%	1.8%
Return on revenue-- continuing operations..	2.8%	2.2%	2.6%	0.8%	3.1%	1.5%	2.7%
Return on equity.....	N/A	N/A	12.6%	2.7%	10.7%	(10.1)%	6.0%
Members (000s).....	7,779	7,030	7,270	6,265	5,167	5,261	4,078
Ratio of earnings to fixed charges(6).....	8.49	5.80	7.03	3.00	11.33	5.50	11.69

Pro forma ratio of earnings to fixed charges(6)(7).....	6.78	--	5.52	--	--	--	--
Balance Sheet Data							
Cash and investments....	$4,029.6	$3,418.4	$ 3,714.6	$2,972.4	$2,805.1	$2,415.6	$2,123.4
Total assets.....	5,838.0	5,364.0	5,708.5	4,816.2	4,359.2	4,131.9	4,085.8
Policy liabilities.....	1,593.8	1,625.5	1,698.3	1,431.1	1,118.1	1,143.9	1,231.5
Debt.....	597.7	597.5	597.7	522.2	302.1	305.9	245.9
Total policyholders' surplus(8).....	2,063.9	1,756.3	1,919.8	1,660.9	1,702.5	1,524.7	1,625.2

---

(1) On October 27, 1999 and November 16, 1999 Anthem acquired New Hampshire-Vermont Health Service, formerly d/b/a Blue Cross Blue Shield of New Hampshire, and Rocky Mountain Hospital and Medical Service, Inc., formerly d/b/a Blue Cross and Blue Shield of Nevada/Colorado. On June 5, 2000, Anthem acquired Associated Hospital Service of Maine, formerly d/b/a Blue Cross and Blue Shield of Maine. These acquisitions were accounted for as purchases and the net assets and results of operations have been included in our consolidated financial statements from the respective purchase dates. Below is information for the six months ended June 30, 2001 and 2000 and for the years ended December 31, 2000 and 1999 that is included in Anthem's consolidated financial statements for the acquisitions that were completed in those periods:

	As of and for the Six Months Ended June 30,							
	2001				2000			
	Total Revenues	Operating Gain	(000s) Assets	(000s) Members	Total Revenues	Operating Loss	(000s) Assets	(000s) Members
BCBS-ME.....	$ 457.6	$ 3.0	$ 326.4	496	$ 59.6	$(2.5)	$264.8	468

	As of and for the Year Ended December 31,							
	2000				1999			
	Total Revenues	Operating Gain	(000s) Assets	(000s) Members	Total Revenues	Operating Loss	(000s) Assets	(000s) Members
BCBS-NH.....	$ 591.0	$11.6	$ 316.8	479	$ 77.9	$ (0.3)	$250.6	366
BCBS-CO/NV.....	678.6	6.5	545.8	595	76.9	(3.4)	521.5	486
BCBS-ME.....	489.4	8.7	339.5	487	--	--	--	--
Total.....	$1,759.0	$26.8	$1,202.1	1,561	$154.8	$ (3.7)	$772.1	852

Operating gain (loss) consists of operating revenue less benefit expense and administrative expense.

(2) The 1999 administrative expense includes a non-recurring charge of $41.9

million related to the settlement agreement with the Office of Inspector General. See Note 14 to our audited consolidated financial statements.

(3) During 1999, Anthem reached agreements with the states of Kentucky, Ohio and Connecticut to resolve any questions as to whether Anthem or the predecessor/successor entities were in possession of property that was impressed with a charitable trust. The endowment of non-profit foundations reflects contributions made for the benefit of charitable foundations in these states. See Note 3 to our audited consolidated financial statements.

(4) The benefit expense ratio represents benefit expense as a percentage of premium revenue. The administrative expense ratio represents administrative expense as a percentage of operating revenue and has also been presented as a percentage of operating revenue and premium equivalents. Return on revenue represents net income (loss) as a percentage of total revenues. Return on revenue--continuing operations represents income from continuing operations as a percentage of total revenues. Return on equity, which is only presented for annual periods, represents net income (loss) as a percentage of the average of the sum of policyholders' surplus at the beginning and the end of the period.

(5) Operating revenue and premium equivalents is a measure of the volume of business serviced by Anthem that is commonly used in the health benefits industry to allow for a comparison of operating efficiency among companies. It is calculated by adding to premiums, administrative fees and other revenue the amount of claims attributable to non-Medicare, self-funded health business where Anthem provides a complete array of customer service, claims administration and billing and enrollment services. The self-funded claims included for the six months ended June 30, 2001 and 2000 were $1,887.4 million and $1,594.3 million, respectively, and for the years ended December 31, 2000, 1999, 1998, 1997 and 1996 were $3,256.6 million, $2,611.0 million, $2,597.7 million, $2,159.3 million and $1,765.0 million, respectively.

(6) For purposes of this computation, earnings are defined as pretax earnings from continuing operations before adjustment for minority interest, plus interest expense, and amortization of debt discount and expense related to indebtedness. Fixed charges are interest expense, including amortization of debt discount and expense on indebtedness.

(7) For purposes of the pro forma ratio of earnings to fixed charges, fixed charges also reflect interest payments on the debentures included in the units at a rate of 5.95% ($11.9 million and $6.0 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively) and amortization of underwriting discounts and estimated unit offering expenses ($3.0 million and $1.5 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively). The pro forma ratio of earnings to fixed charges has been presented to give effect to the additional fixed charges related to the issuance of the units. The pro forma ratio does not give effect to any pro forma earnings resulting from the use of the net proceeds from the units offering.

(8) Policyholders' surplus represents shareholders' equity prior to demutualization.

UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION

The unaudited pro forma consolidated financial information presented below gives effect to (i) the demutualization, including the issuance of 54,861,000 shares of common stock to Anthem Insurance's eligible statutory members (net of 45,139,000 shares for which eligible statutory members receive cash in lieu of shares), (ii) the offering of 48,000,000 shares of Anthem, Inc. common stock at the initial public offering price of $36.00 per share (before deducting the estimated underwriting discount and offering expenses payable by us), and (iii) the offering of 4,000,000 units at $50.00 per unit, as if the demutualization

and the offerings had occurred as of June 30, 2001 for purposes of the unaudited pro forma consolidated balance sheet, and as of January 1, 2000 for purposes of the unaudited pro forma consolidated income statements for the year ended December 31, 2000 and the six months ended June 30, 2001. Prior to the demutualization, "shareholders' equity" represents consolidated policyholders' surplus of Anthem.

The pro forma information does not take into account the sale of up to 7,200,000 shares of our common stock and up to 600,000 units which the underwriters in the offerings have the option to purchase from us to cover over-allotments. The pro forma information also assumes that no additional cash payments (which could be up to a maximum of $162.5 million, at the initial public offering price of $36.00 per share) will be made to eligible statutory members pursuant to the cash "top up" provisions of the plan of conversion.

The pro forma information reflects gross proceeds of $1,728.0 million and estimated net proceeds of $182.5 million that we expect to receive from this offering. From the gross proceeds, we estimate that we will pay $1,434.0 million to eligible statutory members in cash in lieu of shares that would otherwise be issued to such eligible statutory members in the demutualization, $79.5 million will be applied to underwriting discounts and $32.0 million as other offering and additional demutualization expenses. We will retain the balance of the net proceeds from this offering for general corporate purposes. The pro forma information also reflects gross proceeds of $200.0 million from the issuance of units, less underwriting discounts and estimated offering expenses aggregating $9.0 million, resulting in net proceeds from the offering of units of $191.0 million, all of which would be used for cash payments to eligible statutory members in the demutualization. See "Use of Proceeds."

We will account for the demutualization using the historical carrying values of Anthem's assets and liabilities.

We based the pro forma information on available information and on assumptions that management believes are reasonable and that reflect the effects of these transactions. We provide the pro forma information for informational purposes only and this information should not be construed to be indicative of our consolidated financial position or our consolidated results of operations had these transactions been consummated on the dates assumed. This information does not represent a projection or forecast of our consolidated financial position or consolidated results of operations for future dates or periods. You should read the pro forma information in conjunction with the historical consolidated financial statements of Anthem beginning on page F-1 and with the information set forth under "The Plan of Conversion," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "The Business of Anthem" included elsewhere in this prospectus.

UNAUDITED PRO FORMA

CONSOLIDATED STATEMENTS OF INCOME
($ in Millions, except share data)

	Six Months Ended June 30, 2001				Year Ended De	
	Anthem	The Demutualization and Initial	The Unit	Anthem Pro	Anthem	The Demutualiza and Initi

	Historical	Public Offering	Offering	Forma	Historical	Public Offe
Revenues						
Premiums.....	$4,542.8	$ --	$ --	$ 4,542.8	$7,737.3	$ --
Administrative fees.....	430.3	--	--	430.3	755.6	--
Other revenue.....	22.6	--	--	22.6	50.6	--
Total operating revenue.....	4,995.7	--	--	4,995.7	8,543.5	--
Net investment income.....	109.0	-- (1)	--	109.0	201.6	-- (
Net realized gains (losses) on investments.....	(10.9)	--	--	(10.9)	25.9	--
Gain on sale of subsidiary operations.....	25.0	--	--	25.0	--	--
	5,118.8	--	--	5,118.8	8,771.0	--
Expenses						
Benefit expense...	3,870.8	--	--	3,870.8	6,551.0	--
Administrative expense.....	991.6	--	--	991.6	1,808.4	--
Interest expense..	28.0	--	7.5 (2)	35.5	54.7	--
Amortization of goodwill and other intangible assets.....	15.7	--	--	15.7	27.1	--
Demutualization expenses.....	3.0	(3.0)(3)	--	--	--	--
	4,909.1	(3.0)	7.5	4,913.6	8,441.2	--
Income before income taxes and minority interest..	209.7	3.0	(7.5)	205.2	329.8	--
Income taxes (credit).....	68.6	--	(2.6)(2)	66.0	102.2	--
Minority interest (credit).....	(1.9)	--	--	(1.9)	1.6	--
Net income	$ 143.0	$ 3.0	$(4.9)	$ 141.1	$ 226.0	$ --
Income per share..				$ 1.37		
Shares used in calculating per share amount.....				102,861,000(4)		

See accompanying notes.

UNAUDITED PRO FORMA

CONSOLIDATED BALANCE SHEET

($ in Millions)

	June 30, 2001				
	Anthem Historical	The Demutualization	As Adjusted for The Demutualization	The Initial Public Offering	The Unit Offering
Assets					
Current assets:					
Investments	$3,790.7	$ --	$ 3,790.7	$ --	$ --
Cash and cash equivalents	238.9	(1,625.0)(5)	(1,386.1)	1,616.5 (6)	191.0(7
Premium and self funded receivables	498.5	--	498.5	--	--
Reinsurance receivables	78.9	--	78.9	--	--
Other receivables	194.5	--	194.5	--	--
Income tax receivables	7.4	--	7.4	--	--
Other current assets	33.4	--	33.4	--	--
Total current assets	4,842.3	(1,625.0)	3,217.3	1,616.5	191.0
Other noncurrent investments	13.1	--	13.1	--	--
Restricted cash and investments	51.1	--	51.1	--	--
Property and equipment	409.6	--	409.6	--	--
Goodwill and other intangible assets	480.4	--	480.4	--	--
Other noncurrent assets	41.5	--	41.5	--	--
Total assets	$5,838.0	$(1,625.0)	$ 4,213.0	$1,616.5	$191.0
Liabilities and shareholders' equity					
Liabilities					
Current liabilities:					
Total policy liabilities	$1,593.8	$ --	$ 1,593.8	$ --	$ --
Unearned income	321.2	--	321.2	--	--
Accounts payable and accrued expenses	269.0	22.0 (8)	291.0	(22.0)(6)	--
Bank overdrafts	281.6	--	281.6	--	--
Income taxes payable	34.6	--	34.6	--	--
Other current liabilities	283.7	--	283.7	--	--
Total current liabilities	2,783.9	22.0	2,805.9	(22.0)	--
Long term debt, less current portion	597.5	--	597.5	--	--
Debentures included in units	--	--	--	--	191.0(7
Retirement benefits	187.5	--	187.5	--	--
Other noncurrent liabilities	205.2	--	205.2	--	--

Total liabilities...	3,774.1	22.0	3,796.1	(22.0)	191.0
Shareholders' equity					
Common stock.....	--	0.5 (9)	0.5	0.5 (6)	--
Additional paid in capital.....	--	344.1 (9)	344.1	1,638.0 (6)	--
Retained earnings.....	1,991.6	(1,991.6)(9)	--	--	--
Accumulated other comprehensive income...	72.3	--	72.3	--	--
Total shareholders' equity.....	2,063.9(10)	(1,647.0)	416.9	1,638.5	--
Total liabilities and shareholders' equity.....	$5,838.0	$(1,625.0)	$ 4,213.0	$1,616.5	$191.0

See accompanying notes.

NOTES TO UNAUDITED PRO FORMA

CONSOLIDATED FINANCIAL STATEMENTS

(1) Although such data is not reflected within the pro forma income statement, the initial public offering net proceeds of $182.5 million would have generated some level of net investment income during the income statement periods shown.

(2) The charge to interest expense in the pro forma consolidated statement of income reflects interest payments on the debentures included in the units at a rate of 5.95% ($11.9 million and $6.0 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively) and amortization of underwriting discounts and estimated unit offering expenses ($3.0 million and $1.5 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively). The income tax benefit related to such charges is $5.2 million and $2.6 million for the year ended December 31, 2000 and for the six months ended June 30, 2001, respectively.

(3) The demutualization expenses of $3.0 million incurred during the six months ended June 30, 2001 have been eliminated as they resulted directly from the demutualization and will not have a continuing impact on operations. In addition, subsequent to the demutualization, we will incur additional expenses associated with servicing our shareholder base, including mailing and printing fees. As these expenses are not directly related to the transaction, they have not been reflected within the unaudited pro forma consolidated statements of income.

(4) Estimated total shares of common stock outstanding after the initial public offering is calculated as follows:

	Number of Shares

Shares allocated to eligible statutory members	100,000,000
Less: estimated shares allocated to eligible statutory members who receive cash in lieu of shares	45,139,000
Shares issued to eligible statutory members	54,861,000
Shares issued in the offering	48,000,000
Total shares of common stock outstanding	102,861,000

(5) Represents estimated $1,625.0 million cash paid to certain eligible statutory members who receive cash in lieu of shares of common stock.

(6) Represents the gross proceeds of $1,728.0 million from the issuance of 48,000,000 shares of common stock in the offering at the initial public offering price of $36.00 per share less underwriting discounts of $79.5 million and estimated other offering and additional demutualization expenses of $32.0 million.

(7) Represents gross proceeds of $200.0 million from the issuance of the units, less underwriting discounts and estimated unit offering expenses aggregating $9.0 million. The debentures included in the units are shown as a separate caption on our pro forma consolidated balance sheet. The proceeds from the units will be allocated to the underlying purchase contracts and debentures based on their relative fair values at the offering date.

(8) Represents estimated additional nonrecurring expenses of $22.0 million for demutualization costs and expenses to be incurred at the date of the unaudited pro forma consolidated balance sheet. We have shown the additional nonrecurring expenses as a liability and a decrease to

retained earnings within the unaudited pro forma consolidated balance sheet. The additional nonrecurring demutualization expenses have not been reflected within the unaudited pro forma statements of income as they will not have a continuing impact and will be recorded as expense from continuing operations when actually incurred.

(9) Represents reclassification of retained earnings of the mutual insurance company to reflect the demutualization as follows (in millions):

Historical retained earnings	$1,991.6
Less cash used to fund payments to eligible statutory members in lieu of issuing shares	1,625.0
Less additional demutualization expenses--see Note 8	22.0
Retained earnings related to eligible statutory members receiving common stock	$ 344.6

(10) Anthem historical amounts represent "Policyholders' Surplus" prior to demutualization.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF
FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Introduction

We are one of the nation's largest health benefits companies and an independent licensee of the Blue Cross Blue Shield Association, or BCBSA. We offer Blue Cross Blue Shield, or BCBS, branded products to over seven million members throughout Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada.

Our reportable segments are strategic business units delineated by geographic areas within which we offer similar products and services. We manage our business units with a local focus to address each geographic region's unique market, regulatory and health care delivery characteristics. The regions are: Midwest, which includes Indiana, Kentucky and Ohio; East, which includes Connecticut, New Hampshire and Maine; and West, which includes Colorado and Nevada.

In addition to our three geographic regions, we operate a Specialty segment and an Other segment. Our Specialty segment includes business units providing group life and disability insurance benefits, pharmacy benefit management, dental administration services and third party occupational health services. Our Other segment includes primarily AdminaStar Federal, a subsidiary which administers Medicare programs in Indiana, Illinois, Kentucky and Ohio. The Other segment also includes Anthem Alliance Health Insurance Company, a subsidiary which primarily provided health care benefits and administration in nine states for the Department of Defense's TRICARE program for military families prior to our sale of the TRICARE operations on May 31, 2001. Additionally, the Other segment includes intersegment revenue and expense eliminations and corporate expenses not allocated to reportable segments.

We offer a diversified mix of managed care products, including Health Maintenance Organizations or HMOs, Preferred Provider Organizations or PPOs, and Point of Service or POS plans, as well as traditional indemnity products. We also offer a broad range of managed care services and partially insured products for self-funded employers, including underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, claims processing and other administrative services. Our operating revenue consists primarily of premiums from fully insured contracts, where we indemnify our policyholders against loss, and administrative fees from self-funded contracts, where our contract holders are wholly or partially self-insured. Fees received for administration of Medicare programs are also included in our administrative revenue. Other revenue consists primarily of fees generated by our pharmacy benefit management company. Our benefit expense consists primarily of outpatient and inpatient care costs, as well as pharmacy benefit costs. All three components are affected both by unit costs (for example, the cost of outpatient medical procedures and inpatient hospital stays, and prescription drug prices) and utilization rates, which vary due to the age and health of our members, as well as due to broader social and lifestyle factors in the population as a whole.

Our results in 1999 and 2000 were significantly impacted by the acquisitions of Blue Cross and Blue Shield of New Hampshire, or BCBS-NH, which we completed on October 27, 1999, Blue Cross and Blue Shield of Colorado and Nevada, or BCBS-CO/NV, which we completed on November 16, 1999, and Blue Cross and Blue Shield of Maine, or BCBS-ME, which we completed on June 5, 2000. The acquisitions were accounted for as purchases and the net assets and results of operations have been included in our consolidated financial statements from the respective dates of purchase. The following represents the contribution to our

total revenues, operating gain, assets and membership for the six months ended June 30, 2001 and 2000 and for the years ended December 31, 2000 and 1999 of the acquisitions that were completed in those periods.

	As of and for the Six Months Ended June 30,							
	2001				2000			
	Total Revenues	Operating Gain	Assets	(000s) Members	Total Revenues	Operating Loss	Assets	(000s) Members
	($ in Millions)				($ in Millions)			
BCBS-ME....	$457.6	$3.0	$326.4	496	$59.6	$(2.5)	$264.8	468

	As of and for the Year Ended December 31,							
	2000				1999			
	Total Revenues	Operating Gain	Assets	(000s) Members	Total Revenues	Operating Loss	Assets	(000s) Members
	($ in Millions)				($ in Millions)			
BCBS-NH.....	$ 591.0	$11.6	$ 316.8	479	$ 77.9	$(0.3)	$250.6	366
BCBS-CO/NV.....	678.6	6.5	545.8	595	76.9	(3.4)	521.5	486
BCBS-ME.....	489.4	8.7	339.5	487	--	--	--	--
Total.....	$1,759.0	$26.8	$1,202.1	1,561	$154.8	$(3.7)	$772.1	852

Operating gain (loss) consists of operating revenue less benefit expense and administrative expense.

We sold our TRICARE operations to a subsidiary of Humana, Inc. on May 31, 2001. The results of our TRICARE operations are reported in our Other segment (for Anthem Alliance Health Insurance Company), and in our Midwest business segment, which assumed a portion of the TRICARE risk from May 1, 1998 to December 31, 2000. The operating results for our TRICARE operations for 2000, 1999, and 1998 were as follows and include both the Anthem Alliance Health Insurance Company and Midwest business segment results:

	Year Ended December 31,		
	2000	1999	1998
	($ in Millions)		
Operating revenue.....	$353.9	$292.4	$240.7

Operating gain.....	3.9	5.1	5.4

On May 30, 2001, we signed a definitive agreement with BCBS-KS, pursuant to which BCBS-KS will become a subsidiary of ours. Subject to the approval of BCBS-KS policyholders, the approval of the BCBSA, the approval of the Kansas Department of Insurance and other regulatory approvals, the transaction is expected to close in early 2002. The operating results for BCBS-KS for 2000, 1999 and 1998 were as follows:

	Year Ended December 31,		
	2000	1999	1998
	($ in Millions)		
Total revenues.....	$1,026.0	$920.0	$851.0
Net income (loss).....	5.8	(7.0)	40.2

You should read this "Management's Discussion and Analysis of Financial Condition and Results of Operations" in conjunction with our audited consolidated financial statements and accompanying notes for the years ended December 31, 2000, 1999 and 1998 and our unaudited consolidated financial statements and accompanying notes for the periods ended June 30, 2001 and 2000, both included in this prospectus.

MEMBERSHIP--Six Months Ended June 30, 2001 Compared to Six Months Ended June 30, 2000

Our membership data presented below are unaudited and in certain instances include management's estimates of the number of members represented by each contract at the end of the period rounded to the nearest thousand.

Of our customer types listed below, "Large group" consists of those customers with 51 or more eligible employees, while "Small group" consists of those customers with one to 50 employees. Individual members include those in our under age 65 business and our Medicare Supplement (age 65 and over) business. Our National customers consist of employer groups which have multi-state locations and require partnering with other Blue Cross and Blue Shield plans for administration and/or access to non-Anthem provider networks. Included within the National business are our "Blue Card" customers who represent enrollees of health plans marketed by other Blue Cross and Blue Shield Plans who receive health care services in Anthem's Blue Cross and Blue Shield licensed markets. Under this arrangement, Anthem, as the "host plan," receives fees from the "home plan" for providing claims and other administrative services for these members. Medicare + Choice members have enrolled in coverages that are managed care alternatives for the Medicare program. The Federal Employee Program, or FEP, provides health insurance coverage to United States government employees and their dependents. Medicaid members have enrolled in coverages that are managed care alternatives for the Medicaid program. Our TRICARE program provided managed care services to active and retired military personnel and their dependents. The TRICARE business was sold to Humana, Inc. on May 31, 2001. At June 30, 2000, our TRICARE membership totaled 125,000, was fully insured and included in our Midwest region.

Blue Card membership is calculated based on the amount of Blue Card administrative fees we receive from the Blue Card members' home plans. Generally, the administrative fees we receive are based on the number and type of claims processed and a portion of the network discount on those claims. The administrative fees are then divided by an assumed per member per month, or PMPM, factor in order to calculate the number of members. The assumed PMPM factor is based on an estimate of Anthem's experience and BCBSA guidelines.

Self-funded products are offered to customers, generally larger employers, with the ability and desire to retain some or all of the risk associated with their employees' health care costs.

The following table presents membership data by region, customer type and funding type as of June 30, 2001 and June 30, 2000.

MEMBERSHIP

	Total June 30, 2001	Total June 30, 2000	Total Change	Total % Change
	(In Thousands)			
Region				
Midwest	4,826	4,496	330	7.3%
East	2,216	1,952	264	13.5
West	737	582	155	26.6
Total	7,779	7,030	749	10.7%
Customer Type				
Large group	2,786	2,547	239	9.4%
Small group	807	731	76	10.4
Individual	674	647	27	4.2
National	2,877	2,367	510	21.5
Medicare + Choice	101	103	(2)	(1.9)
Federal Employee Program	426	411	15	3.6
Medicaid	108	99	9	9.1
TRICARE	--	125	(125)	(100.0)
Total	7,779	7,030	749	10.7%
Funding Type				
Fully insured	3,740	3,682	58	1.6%
Self-funded	4,039	3,348	691	20.6
Total	7,779	7,030	749	10.7%

Membership increased 749,000, or 10.7%, primarily due to growth in National business, including a significant increase in enrollment in BlueCard programs. Excluding TRICARE, membership increased 12.7%. Large group membership increased 239,000, or 9.4%, with growth in all regions primarily reflecting the success of our PPO products, as more employer groups desire the additional choices our PPO product offers. The 76,000, or 10.4%, growth in Small group business from

June 30, 2000 reflects management initiatives to increase Small group membership, including revised commission structures, product offerings, brand promotion and enhanced relationships with our brokers. Small group business generally has higher profit margins than Large group business.

Medicare + Choice membership decreased as we withdrew from the Medicare + Choice program in Connecticut effective January 1, 2001 due to losses in this line of business in that market. At June 30, 2000 and December 31, 2000, membership in Medicare + Choice in Connecticut was 24,000 and 18,000, respectively. Offsetting this decrease was growth in Medicare + Choice membership in Ohio, where many competitors have left the market and we are one of the few remaining companies offering this product. We decided to remain in selected markets for Medicare + Choice in Ohio because we believe that with a critical mass of membership in those selected markets in Ohio, we can achieve improved results.

Individual membership increased primarily due to additional Medicare Supplement business in our East region and additional individual (under age 65) business in our Midwest region. Medicare Supplement sales increased as a result of approximately 6,000 members converting from our Medicare + Choice product, which was terminated effective January 1, 2001 in Connecticut, to one of our Medicare Supplement products in Connecticut.

Self-funded membership increased primarily due to the increase in BlueCard utilization. Fully insured membership, excluding TRICARE, grew by 183,000 members, or 5.1%, due to growth in both Large and Small group businesses.

Midwest membership, excluding TRICARE, grew 10.4% primarily from growth in BlueCard utilization, Large group and National account sales. East membership grew primarily due to increased sales of Small group and growth in BlueCard utilization. West's membership growth was primarily due to increased BlueCard utilization.

Results of Operations for the Six Months Ended June 30, 2001 Compared to the Six Months Ended June 30, 2000

The following table presents our consolidated results of operations for the six months ended June 30, 2001 and 2000:

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents (1)	$6,883.1	$5,559.0	$1,324.1	23.8%
Premiums	$4,542.8	$3,589.3	$ 953.5	26.6%
Administrative fees	430.3	356.5	73.8	20.7%
Other revenue	22.6	18.9	3.7	19.6%
Total operating revenue	4,995.7	3,964.7	1,031.0	26.0%
Benefit expense	3,870.8	3,080.6	790.2	25.7%
Administrative expense	991.6	817.5	174.1	21.3%

Total operating expense.....	4,862.4	3,898.1	964.3	24.7%
Operating gain.....	133.3	66.6	66.7	100.2%
Net investment income.....	109.0	95.0	14.0	14.7%
Net realized gains (losses) on investments.....	(10.9)	6.5	(17.4)	NM (2)
Gain on sale of subsidiary operations (TRICARE).....	25.0	--	25.0	NM (2)
Interest expense.....	28.0	27.0	1.0	3.7%
Amortization of intangibles.....	15.7	11.4	4.3	37.7%
Demutualization expenses.....	3.0	--	3.0	NM (2)
Income before taxes and minority interest.....	209.7	129.7	80.0	61.7%
Income taxes.....	68.6	38.9	29.7	76.3%
Minority interest (credit).....	(1.9)	0.5	(2.4)	NM (2)
Net income.....	$ 143.0	$ 90.3	$ 52.7	58.4%
Benefit expense ratio (3).....	85.2%	85.8%		(60) bp(4)
Administrative expense ratio: (5)				
Calculated using operating revenue (6).....	19.8%	20.6%		(80) bp(4)
Calculated using operating revenue and premium equivalents (7).....	14.4%	14.7%		(30) bp(4)
Operating margin (8).....	2.7%	1.7%		100 bp(4)

---

(1) Operating revenue and premium equivalents is a measure of the volume of business commonly used in the health insurance industry to allow for a comparison of operating efficiency among companies. It is calculated by adding to premiums, administrative fees and other revenue the amount of claims attributable to non-Medicare, self-funded health business where we provide a complete array of customer service, claims administration and billing and enrollment services. Self-funded claims included in operating revenue and premium equivalents for the six months ended June 30, 2001 were $1,887.4 million and for the six months ended June 30, 2000 were $1,594.3 million.

(2) NM = Not meaningful.

(3) Benefit expense ratio = Benefit expense / Premiums.

(4) bp = basis point, one hundred basis points = 1%.

(5) While we include two calculations of administrative expense ratio, we believe that administrative expense ratio including premium equivalents is a better measure of efficiency as it eliminates changes in the ratio caused by changes in our mix of insured and self-funded business. All discussions and explanations related to administrative expense ratio will be related to administrative expense ratio including premium equivalents.

(6) Administrative expense / Operating revenue.

(7) Administrative expense / Operating revenue and premium equivalents.

(8) Operating margin = Operating gain / Total operating revenue.

Premiums increased $953.5 million, or 26.6%, to $4,542.8 million in 2001 in part due to the acquisition of BCBS-ME in June 2000 and the additional risk recaptured as of January 1, 2001 by Anthem Alliance Health Insurance Company for their TRICARE business. Prior to January 1, 2001, the TRICARE business had been partially reinsured with other insurance companies. On January 1, 2001 Anthem Alliance Health Insurance Company retained 90% of the total risk for the contract. The TRICARE business was sold on May 31, 2001. Excluding the

acquisition of BCBS-ME and the sale of our TRICARE business, premiums increased $422.1 million, or 12.0%, primarily due to premium rate increases and higher membership in the Midwest and East regions. Midwest premiums increased $266.6 million, or 13.0%, while East premiums increased $119.2 million, or 10.6%. Midwest premiums increased primarily due to higher membership and premium rate increases in our group accounts (both Large group and Small group) and higher membership in Medicare + Choice. East premiums increased primarily due to premium rate increases and higher membership in group business.

Administrative fees increased $73.8 million, or 20.7%, from $356.5 million in 2000 to $430.3 million in 2001, with $30.7 million of this increase from the acquisition of BCBS-ME. Excluding acquisitions and dispositions, administrative fees increased $47.1 million, or 16.9%, primarily from membership growth in National self-funded business. Excluding acquisitions and divestitures, other revenue increased $2.3 million, or 12.2%, primarily due to higher mail order revenues at Anthem Prescription Management, or APM. APM is our pharmacy benefit manager and provides its services to other Anthem affiliates. These services include contracting with retail pharmacies and providing mail order pharmacy services.

Benefit expense increased $790.2 million, or 25.7%, in 2001 primarily due to the acquisition of BCBS-ME and the additional risk assumed by Anthem Alliance Health Insurance Company for TRICARE on January 1, 2001. Excluding acquisitions and dispositions, benefit expense increased $304.8 million, or 10.2%, due to higher average membership and increasing cost of care. Cost of care trends were driven primarily by higher utilization of outpatient services and higher prescription drug costs. Our benefit expense ratio decreased 60 basis points from 85.8% in 2000 to 85.2% in 2001 primarily because premium rates increased at a higher rate than benefit costs. Excluding acquisitions and dispositions, our benefit expense ratio decreased 140 basis points from 85.6% in 2000 to 84.2% in 2001.

Outpatient cost increases have varied among regions and products and have generally ranged from 15% to 20% in the first six months of 2001 over the first six months of 2000. These increases have resulted from both increased utilization and higher unit costs. Increased utilization reflects an industry-wide trend towards a broader range of medical procedures being performed without overnight hospital stays, as well as an increasing customer awareness of, and demand for, diagnostic procedures such as magnetic resonance imagings, or MRI's. In addition, improved medical technology has allowed more complicated medical procedures to be performed on an outpatient basis rather than on an inpatient (hospitalized) basis, increasing both utilization rates and unit costs.

Prescription drug cost increases have varied among regions and by product, but generally ranged from 10% to 15% in the first six months of 2001 over the first six months of 2000, primarily due to introduction of new, higher cost drugs as well as higher overall utilization as a result of increases in direct-to-consumer advertising by pharmaceutical companies. In response to increasing prescription drug costs, we have implemented a "three-tiered" drug program and expanded use of formularies for our members. "Three-tiered" drug programs reflect benefit designs that have three co-payment levels which depend on the drug selected. Generic drugs have the lowest co-payment, brand name drugs included in the drug formulary have a higher co-payment, and brand name drugs not included in the drug formulary have the highest co-payment. Drug formularies are a list of prescription drugs that have been reviewed and selected for their quality and efficacy by a committee of practicing physicians and clinical pharmacists. Through our pharmacy benefit design, we encourage use of these listed brand name and generic drugs to ensure members receive quality and cost-effective medication.

While growth in inpatient costs has been flat or in low single digits for several years, we cannot guarantee that this trend will continue. Hospitals have taken a more aggressive stance in their contracting with health insurance companies as a result of reduced hospital reimbursements from Medicare and pressure to recover the costs of additional investments in new medical technology and facilities.

Administrative expense increased $174.1 million, or 21.3%, in 2001 primarily due to the acquisition of BCBS-ME. Excluding acquisitions and dispositions, administrative expense increased $111.7 million, or 15.3%, primarily due to higher commissions and premium taxes, which vary with premium, additional costs associated with higher membership and investments in technology.

Our administrative expense ratio decreased 30 basis points primarily due to operating revenue increasing faster than administrative expense. Excluding acquisitions and dispositions, our administrative expense ratio would have increased 30 basis points largely due to increased mail order prescription volumes at APM in 2001 and the cost of temporary help to reduce health claim inventory in the West in the first quarter of 2001.

Net investment income increased $14.0 million, or 14.7%, primarily due to higher overall investment portfolio balances. The higher portfolio balances included net cash generated from operations, as well as cash generated from improved balance sheet management, such as quicker collection of receivables and sales of non-core assets. Excluding acquisitions and dispositions, net investment income increased $9.1 million, or 9.8%.

During 2001, our investment portfolio generated a net yield of 5.90% compared with a net yield of 5.96% in 2000. We define our net yield as earned income divided by the amortized cost of our investments. The decrease of six basis points was primarily due to lower returns on our fixed maturity securities portfolio, in line with overall market conditions. As returns on fixed maturity portfolios are dependent on market interest rates and changes in interest rates are not easily predictable, there is no certainty that past investment performance will be repeated in the future.

Net realized capital gains (losses) changed from $6.5 million in 2000 to $(10.9) million in 2001 primarily due to $28.9 million in unrealized losses on equity securities being recognized as other than temporary impairment. These losses were partially offset by gains resulting from higher turnover in the fixed maturity portfolio, which benefited from lower interest rates in 2001. Net realized capital losses from sale and other than temporary loss recognition of equity securities were $22.3 million in 2001 versus net realized capital gains of $19.3 million in 2000. Net realized capital gains from sale of fixed maturity securities were $11.4 million in 2001 versus net realized capital losses of $12.8 million in 2000. Net gains or losses on investments are influenced by market conditions when an investment is sold, and will vary from year to year. We and our equity portfolio managers make decisions regarding equity investments to ensure that the portfolios mirror the S&P 400 and S&P 500 indices, excluding in each case tobacco stocks.

Gain on sale of subsidiary operations of $25.0 million relates to the sale of our TRICARE business to Humana on May 31, 2001.

Interest expense increased $1.0 million, or 3.7%, primarily reflecting increased net borrowings following our private placement of $300.0 million principal amount of surplus notes in January 2000.

Amortization of intangibles increased $4.3 million, or 37.7%, primarily due to amortization expense associated with the acquisition of BCBS-ME.

Demutualization expenses of $3.0 million were incurred in the first six months of 2001 in connection with our plan to demutualize.

Income before taxes and minority interest increased $80.0 million, or 61.7%, as a result of improvement in operating results in all business segments.

Income tax expense increased $29.7 million, or 76.3%, due to higher income before taxes. Our effective income tax rate in 2001 was 32.7% versus 30.0% in 2000. The rate is lower than statutory effective tax rate in both periods primarily as a result of changes in our deferred tax valuation allowance. The effective tax rate increased in 2001 primarily due to the effect of higher income before taxes and slightly higher state income tax rates. As the amount of income before taxes increases, the effect of permanent tax differences on our income tax rate is reduced.

Net income increased $52.7 million, or 58.4%, primarily due to the improvement in operating results, gain on sale of subsidiary operations, and higher investment income and was partially offset by net realized investment losses, all as described above. Excluding the gain on sale of subsidiary operations ($16.3 million after tax) and the acquisition of BCBS-ME, net income increased $30.0 million, or 32.6%.

Midwest

The following table presents the Midwest region's results of operations for the six months ended June 30, 2001 and 2000:

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$3,797.0	$3,360.9	$436.1	13.0%
Premiums	$2,313.0	$2,046.4	$266.6	13.0%
Administrative fees	152.8	123.7	29.1	23.5%
Other revenue	0.9	1.3	(0.4)	(30.8)%
Total operating revenue	2,466.7	2,171.4	295.3	13.6%
Benefit expense	1,952.8	1,748.7	204.1	11.7%
Administrative expense	428.9	386.5	42.4	11.0%
Total operating expense	2,381.7	2,135.2	246.5	11.5%
Operating gain	$ 85.0	$ 36.2	$ 48.8	134.8%
Benefit expense ratio (1)	84.4%	85.5%		(110) bp(2)
Administrative expense ratio:				
Calculated using operating revenue (3)	17.4%	17.8%		(40) bp(2)
Calculated using operating revenue and premium equivalents (4)	11.3%	11.5%		(20) bp(2)

Operating margin (5).....	3.4%	1.7%	170 bp(2)
Membership (in thousands).....	4,826	4,496	7.3%

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point, one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Our Midwest region assumed a portion of the risk for Anthem Alliance Health Insurance Company's TRICARE contract until December 31, 2000. Effective January 1, 2001, Anthem Alliance Health Insurance Company reassumed this risk. For the first six months of 2000, our Midwest region received $55.3 million of premium income, no administrative fees and other income, incurred $53.2 million of benefit expense and $3.8 million of administrative expense, resulting in a $1.7 million operating loss on the TRICARE contract. There were also 125,000 TRICARE members included in Midwest region's membership at June 30, 2000 and no members at June 30, 2001.

Premiums increased $266.6 million, or 13.0%, in 2001. Excluding TRICARE, premiums increased $321.9 million, or 16.2%, in 2001 primarily due to higher premiums PMPM that accounted for $209.9 million of the increase and the effect of higher average membership throughout the year. Excluding TRICARE, premiums PMPM increased from $166.29 in 2000 to $188.23 in 2001 primarily due to premium rate increases in group (both Large group and Small group) and Medicare + Choice businesses. Increases in group and Medicare + Choice premiums accounted for $258.2 million, or 80.2%, of the increase in premiums. Group PMPM premiums increased 13.9% from $153.58 in 2000 to $174.97 in 2001 primarily due to premium rate increases. Average insured group membership was essentially flat. Medicare + Choice PMPM premiums increased 8.3% from $458.66 in 2000 to $496.69 in 2001 due to the aging of our Medicare + Choice population, resulting in higher premiums. We received higher premiums starting in March 2001 as a result of the Benefit Improvement and Protection Act of 2000, or BIPA. BIPA increased the level of reimbursements from the government to payors that participate in the Medicare + Choice program. Average Medicare + Choice membership increased 41.5% to 90,000 due to reduced competition in the Ohio marketplace as a result of competitors discontinuing their participation in this product.

Administrative fees increased 23.5% from $123.7 million in 2000 to $152.8 million in 2001, primarily due to increased membership in both our National and BlueCard business and our Large group Administrative Services Only, or ASO, business. National business benefited from higher sales while our Large group business benefited from growth in existing accounts.

Benefit expense increased $204.1 million, or 11.7%, in 2001. Excluding TRICARE, benefit expense increased $257.3 million, or 15.2%, primarily due to higher benefit expense PMPM (12.2%) and the effect of higher average membership throughout the year. Excluding TRICARE, benefit expense PMPM increased from $141.61 in 2000 to $158.91 in 2001, primarily due to higher outpatient costs and higher prescription drug costs. Outpatient cost increases averaged approximately 15% in 2001 due to continued trends of shifting services to outpatient settings versus inpatient/facility based services. These cost increases have come from both increased utilization and higher unit costs. Improved medical technology has allowed more complicated medical procedures, such as cardiac catheterization and angioplasties, to be performed on an outpatient basis.

Prescription drug costs increased approximately 13% in 2001 primarily due to

introduction of new, higher cost drugs and increases in direct-to-consumer advertising by pharmaceutical companies. We believe that utilization of a three-tiered drug program for our members has helped contain the increase in prescription drug costs.

While outpatient and prescription drug costs increased significantly in 2000, inpatient costs increased approximately 7%. Admissions per 1,000 members increased less than 2%, while average length of stay was generally unchanged. These factors were slightly offset by modest reimbursement increases under the terms of our hospital contracting agreements.

Midwest's benefit expense ratio decreased 110 basis points from 85.5% in 2000 to 84.4% in 2001. Excluding TRICARE, the benefit expense ratio decreased 80 basis points as the growth in premium PMPM of 13.2% exceeded growth in benefit expense PMPM of 12.2% as discussed above.

Administrative expense increased $42.4 million, or 11.0%, in 2001. Excluding TRICARE, administrative expense increased $46.2 million, or 12.1%, primarily due to higher commission and premium taxes related to higher premiums, as well as costs associated with higher membership and incentive compensation costs related to above target financial performance. The administrative expense ratio decreased 20 basis points primarily due to higher premiums as discussed above.

East

The following table presents our East region's results of operations for the six months ended June 30, 2001 and 2000. BCBS-ME is included from its acquisition date of June 5, 2000.

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$2,285.0	$1,596.5	$688.5	43.1%
Premiums	$1,658.3	$1,175.6	$482.7	41.1%
Administrative fees	99.6	57.9	41.7	72.0%
Other revenue	0.8	2.5	(1.7)	(68.0)%
Total operating revenue	1,758.7	1,236.0	522.7	42.3%
Benefit expense	1,418.1	1,012.2	405.9	40.1%
Administrative expense	292.2	189.7	102.5	54.0%
Total operating expense	1,710.3	1,201.9	508.4	42.3%
Operating gain	$ 48.4	$ 34.1	$ 14.3	41.9%
Benefit expense ratio (1)	85.5%	86.1%		(60) bp(2)
Administrative expense ratio:				
Calculated using operating revenue (3)	16.6%	15.3%		130 bp(2)
Calculated using operating				

revenue and premium equivalents (4)	12.8%	11.9%	90 bp(2)
Operating margin (5)	2.8%	2.8%	--
Membership (in thousands)	2,216	1,952	13.5%

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point, one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Premiums increased $482.7 million, or 41.1%, primarily due to the acquisition of BCBS-ME in June 2000 ($363.5 million). Excluding the effect of acquisitions and the exit from the Medicare + Choice business on December 31, 2000, premiums increased $204.9 million, or 19.8%, in 2001 due to premium rate increases in group business and higher average membership. Group PMPM premiums increased 12.1% from $203.93 in 2000 to $228.69 in 2001 primarily due to premium rate increases in Large group. Average insured group membership increased approximately 15% in 2001.

Administrative fees increased $41.7 million, or 72.0%, from $57.9 million in 2000 to $99.6 million in 2001. The BCBS-ME acquisition contributed $29.1 million of this increase. Excluding the effect of acquisitions, administrative fees increased $12.6 million, or 23.7%, primarily due to higher ASO membership.

Benefit expense increased $405.9 million, or 40.1%, primarily due to the acquisition of BCBS-ME. The BCBS-ME acquisition contributed $316.7 million of this increase. Excluding the effect of acquisitions and Medicare + Choice business, benefit expense increased $158.3 million, or 17.7%, in 2001 primarily due to higher average membership (12%) and to a lesser extent higher benefit expense PMPM.

Benefit expense PMPM, excluding acquisitions and Medicare + Choice business, increased 5.3% from $168.21 in 2000 to $177.10 in 2001. Prescription drug costs and professional costs were the

biggest drivers of increased benefit expense PMPM. Prescription drug PMPM costs increased over 10% due to introduction of new, higher cost drugs and increases in direct to consumer advertising by pharmaceutical companies. We believe utilization of a three-tiered drug program for our members has helped contain prescription drug costs. Professional PMPM costs increased approximately 10% primarily due to increased utilization resulting from direct to consumer drug advertising which drives physician office visits and increased awareness of preventive medicine.

Inpatient PMPM costs decreased approximately 1% due to lower admissions per 1,000 members and shorter average length of stay and the effect of hospital recontracting. Outpatient PMPM costs increased about 6% primarily due to higher utilization caused by the continuing shift of services from an inpatient basis to an outpatient setting. While a decrease in inpatient utilization helped contain increases in benefit expense PMPM, there is no guarantee that our East region will experience these favorable trends in the future. Hospitals have taken a more aggressive stance during contract negotiations to recover reduced hospital reimbursements from Medicare and the costs of additional investments in new medical technology and facilities.

On an overall basis, the benefit expense ratio decreased 60 basis points

from 86.1% in 2000 to 85.5% in 2001, however, excluding acquisitions and Medicare + Choice, the benefit expense ratio decreased 150 basis points. This decrease was primarily due to premium PMPM growth of 7.1% outpacing benefit expense PMPM growth of 5.3%, as discussed above.

Administrative expense increased $102.5 million, or 54.0%, and the administrative expense ratio increased 90 basis points primarily due to the acquisition of BCBS-ME. Excluding acquisitions, administrative expense increased $31.5 million, or 17.7%, and the administrative expense ratio increased 40 basis points primarily due to higher commissions and premium taxes, systems consolidation costs, investments in technology and higher incentive compensation costs related to above target financial performance.

West

The following table presents our West region's results of operations for the six months ended June 30, 2001 and 2000:

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$384.7	$343.7	$41.0	11.9%
Premiums	$327.3	$278.1	$49.2	17.7%
Administrative fees	29.6	24.9	4.7	18.9%
Other revenue	--	0.1	(0.1)	(100.0)%
Total operating revenue	356.9	303.1	53.8	17.7%
Benefit expense	275.3	240.2	35.1	14.6%
Administrative expense	78.5	61.6	16.9	27.4%
Total operating expense	353.8	301.8	52.0	17.2%
Operating gain	$ 3.1	$ 1.3	$ 1.8	138.5%
Benefit expense ratio (1)	84.1%	86.4%		(230) bp(2)
Administrative expense ratio:				
Calculated using operating revenue (3)	22.0%	20.3%		170 bp(2)
Calculated using operating revenue and premium equivalents (4)	20.4%	17.9%		250 bp(2)
Operating margin (5)	0.9%	0.4%		50 bp(2)
Membership (in thousands)	737	582		26.6%

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point, one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

West entered into an agreement with Sloan's Lake HMO in Colorado for the conversion of Sloan's Lake HMO business effective January 1, 2001. The terms of the agreement include payment to Sloan's Lake for each member selecting Anthem's product at the group's renewal date and continuing as an Anthem member for a minimum of nine months. Through June 30, 2001, we added approximately 31,000 members from Sloan's Lake, most of which were added in May and June. Premiums and benefit expense associated with Sloan's Lake members were approximately $6.3 million and $5.3 million, respectively, for the first six months of 2001.

Premiums increased $49.2 million, or 17.7%, primarily due to increased sales and premium rate increases in group business and membership from Sloan's Lake. Group premiums PMPM increased 29.8% from $124.99 in 2000 to $162.29 in 2001 primarily due to rate increases to offset increasing benefit expense. Average group insured membership increased 11.1%. Offsetting the group premium PMPM increase was a 4.3% decline in FEP premium PMPM from $216.69 in 2000 to $207.42 in 2001 primarily due to a decrease in FEP claims paid. FEP premiums vary with claim payment level. Also lowering the growth in West premiums PMPM was a change in the mix of business with lower Medicare + Choice membership, which has higher premium PMPM, and higher National business which has lower premium PMPM. Average insured membership increased 12.0% in 2001.

Administrative fees increased $4.7 million, or 18.9%, from $24.9 million in 2000 to $29.6 million in 2001 primarily due to growth in BlueCard revenues.

Benefit expense increased $35.1 million, or 14.6%, primarily due to higher membership and higher benefit expense PMPM in our group business. Benefit expense PMPM for group business increased 23.6% from $106.69 in 2000 to $131.91 in 2001 reflecting higher outpatient and professional costs. Overall benefit expense PMPM increased 2.4% as lower benefit expense for FEP business and better claims experience in Medicare + Choice offset the increase in group benefit expense PMPM.

Outpatient costs increased over 33% primarily due to increased utilization and higher unit costs as medical services were moved from an inpatient to an outpatient setting. Outpatient utilization increased over 20%. In response to these escalating costs, we have implemented new contracts with providers, particularly in high cost areas such as radiology and oncology, to better contain the growth in outpatient costs. Professional costs have increased approximately 14% primarily due to increased utilization and new fee schedules reflecting higher reimbursement to physicians.

Inpatient PMPM costs increased 2% reflecting shorter lengths of stay, offsetting an increase in hospital admissions. Pharmacy PMPM costs increased 3% reflecting the West's switch to APM from a third party pharmacy benefit manager early in 2001. Based on national pharmacy trends, we cannot guarantee that future pharmacy costs for West will not increase.

Administrative expense increased $16.9 million, or 27.4%, and administrative expense ratio increased 250 basis points primarily due to higher membership, higher commission costs, higher temporary help costs and higher incentive compensation costs. Commission costs increased due to both higher membership and costs associated with implementation of a broker retention program. Temporary help costs were incurred in early 2001 in order to reduce claims inventory. Incentive compensation costs increased as West became fully integrated into Anthem's incentive compensation program as of January 1, 2001.

Specialty

Our Specialty segment includes business units providing group life insurance benefits, pharmacy benefit management, third party occupational health and dental administration services.

The following table presents our Specialty segment's results of operations for the six months ended June 30, 2001 and 2000:

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$188.4	$165.0	$ 23.4	14.2%
Premiums from life and disability	$ 47.4	$ 64.3	$(16.9)	(26.3)%
Administrative fees	18.0	14.8	3.2	21.6%
Other revenue	120.1	82.3	37.8	45.9%
Total operating revenue	185.5	161.4	24.1	14.9%
Benefit expense	31.8	51.2	(19.4)	(37.9)%
Administrative expense	137.8	100.4	37.4	37.3%
Total operating expense	169.6	151.6	18.0	11.9%
Operating gain	$ 15.9	$ 9.8	$ 6.1	62.2%
Benefit expense ratio (1)	67.1%	79.6%		(1,250) bp (2)
Administrative expense ratio:				
Calculated using operating revenue (3)	74.3%	62.2%		1,210 bp (2)
Calculated using operating revenue and premium equivalents (4)	73.1%	60.8%		1,230 bp (2)
Operating margin (5)	8.6%	6.1%		250 bp (2)

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point, one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Life and disability premiums decreased $16.9 million, or 26.3%, primarily due to the termination of a large life group on December 31, 2000. This group accounted for $20.2 million of life and disability premiums for the first six months of 2000. Excluding this group, life and disability premiums would have increased $3.3 million, or 7.5%, primarily due to growth in new sales in our Midwest and West regions. Administrative fees increased $3.2 million, or 21.6%, primarily due to increased membership served by APM.

Other revenue increased $37.8 million, or 45.9%, primarily from APM. In 2001, APM began to provide pharmacy benefit management services to BCBS-ME, BCBS-CO and BCBS-CT. Excluding these new agreements, other revenue increased primarily due to higher mail and retail volumes related to increased membership and utilization from existing Anthem customers. In total, mail service

membership increased 47% while retail service membership increased 90%. Mail service prescription volume increased 36% and retail prescription volume increased 37%.

Benefit expense decreased $19.4 million, or 37.9%, due to the termination of the large life group discussed above. This group accounted for $21.2 million of benefit expense for the first six months of 2000. Excluding this group, benefit expense would have increased $1.8 million, or 6.0%, primarily due to additional life membership. The benefit expense ratio was 67.1% in 2001, a significant

decrease from 2000 primarily due to the termination of the large life group. Excluding this group, the benefit expense ratio decreased 90 basis points from 68.0% in 2000 primarily due to improved underwriting results in our West life business.

Administrative expense increased $37.4 million, or 37.3%, primarily due to increased membership serviced by APM. Administrative expense ratio increased significantly due to APM comprising a larger percentage of Anthem's specialty business segment. APM incurs a higher administrative expense ratio than our life and disability operations.

Other

Various ancillary business units (reported with the Other segment) include AdminaStar Federal which administers Medicare Parts A and B programs in Indiana, Illinois, Kentucky and Ohio, and Anthem Alliance Health Insurance Company which provided health care benefits and administration in nine states for the Department of Defense's TRICARE program for military families. The TRICARE operations were sold on May 31, 2001 and are included in the results below. The Other segment also includes intersegment revenue and expense eliminations plus corporate expenses not allocated to reportable segments.

The following table presents the results of operations for the Other segment for the six months ended June 30, 2001 and 2000:

	Six Months Ended June 30,			
	2001	2000	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$228.0	$ 92.9	$135.1	145.4%
Premiums	$196.8	$ 24.9	$171.9	690.4%
Administrative fees	130.3	135.2	(4.9)	(3.6)%
Other revenue (expense)	(99.2)	(67.3)	(31.9)	47.4%
Total operating revenue	227.9	92.8	135.1	145.6%
Benefit expense	192.8	28.3	164.5	581.3%
Administrative expense	54.2	79.3	(25.1)	(31.7)%
Total operating expense	247.0	107.6	139.4	129.6%
Operating loss	$(19.1)	$(14.8)	$ (4.3)	29.1%

====== ====== ====== =====

Premiums increased $171.9 million, or 690%, due to higher premiums at Anthem Alliance Health Insurance Company. This increase was primarily related to our assumption of additional risk under our TRICARE contract with the Department of Defense. Also, we received additional premiums from the Department of Defense in connection with a global settlement related to a series of bid price adjustments, requests for equitable adjustments and change orders filed during the past two years under our TRICARE contract. Predominantly all premiums received in our Other segment relate to the TRICARE business which was sold on May 31, 2001 ($196.5 million in 2001 and $28.6 million in 2000).

Administrative fees decreased $4.9 million, or 3.6%, primarily due to TRICARE business. Excluding the effect of TRICARE, administrative fees increased $1.2 million, or 1.9%, due to AdminaStar Federal performing additional customer service activities for Medicare beneficiaries. Excluding the elimination of intersegment revenues in 2001 and 2000 of $96.9 million and $67.9 million, respectively, other revenue decreased $2.9 million to a $2.3 million loss in 2001 from $0.6 million in 2000 primarily due to a write-off of $3.0 million of previously capitalized systems development costs.

53

Benefit expense increased $164.5 million, or 581%, primarily due to the assumption of additional risk under our TRICARE contract. Also, we incurred additional benefit expense related to the global settlement under our TRICARE contract as mentioned above. Benefit expense associated with the global settlement offset most of the increase in premiums associated with the global settlement and bid price adjustments.

Excluding intersegment administrative expense eliminations in 2001 and 2000 of $92.8 million and $70.9 million, respectively, administrative expense decreased $3.2 million, or 2.1%, primarily due to TRICARE business being included for five months in 2001 and six months in 2000. Excluding TRICARE, administrative expense increased $9.8 million, or 12.9%, primarily due to increased unallocated corporate expenses in 2001.

Certain corporate expenses are not allocated to our business segments. These unallocated expenses accounted for $23.6 million in 2001 and $9.5 million in 2000, and primarily included such items as unallocated incentive compensation. Excluding unallocated corporate expenses, operating gain was $4.5 million in 2001 versus a $5.3 million operating loss in 2000. Most of the improvement was related to additional revenues from the global settlement with the Department of Defense.

54

MEMBERSHIP--Year Ended December 31, 2000 Compared to Year Ended December 31, 1999

Our membership data presented below are unaudited and in certain instances include management's estimates of the number of members at the end of the period rounded to the nearest thousand.

The following table presents membership data by region, customer type and funding type as of December 31, 2000 and 1999, comparing total and "same store" membership respectively. We define "same store" membership as our membership at a given year-end in a region or for a particular customer or funding type, after excluding the impact of members obtained through acquisitions or

combinations during such year. As such, we believe that "same store" membership data best captures the rate of organic growth of our operations year over year.

MEMBERSHIP

	Total 2000	BCBS-ME Acquisition	Same Store 2000	Total 1999	Total Change	Total %	Same Store Change	Same Store %
			(In Thousands)					
Region								
Midwest	4,582	--	4,582	4,382	200	4.6%	200	4.6%
East	2,093	487	1,606	1,397	696	49.8	209	15.0
West	595	--	595	486	109	22.4	109	22.4
Total	7,270	487	6,783	6,265	1,005	16.0%	518	8.3%
Customer Type								
Large group	2,634	278	2,356	2,249	385	17.1%	107	4.8%
Small group	775	62	713	637	138	21.7	76	11.9
Individual	650	84	566	586	64	10.9	(20)	(3.4)
National	2,468	32	2,436	2,106	362	17.2	330	15.7
Medicare + Choice	106	--	106	96	10	10.4	10	10.4
Federal Employee Program	407	31	376	362	45	12.4	14	3.9
TRICARE	128	--	128	129	(1)	(0.8)	(1)	(0.8)
Medicaid	102	--	102	100	2	2.0	2	2.0
Total	7,270	487	6,783	6,265	1,005	16.0%	518	8.3%
Funding Type								
Fully insured	3,789	360	3,429	3,354	435	13.0%	75	2.2%
Self-funded	3,481	127	3,354	2,911	570	19.6	443	15.2
Total	7,270	487	6,783	6,265	1,005	16.0%	518	8.3%

Same store membership increased 518,000, or 8.3%, from 1999 to 2000, primarily due to growth in National business, including a significant increase in enrollment in BlueCard programs. Small group business generally has higher profit margins than Large group business. The 76,000, or 11.9%, growth in Small group business in 2000 reflects management initiatives to increase Small group membership, including revised commission structures, product offerings, brand promotion and enhanced relationships with our brokers.

Medicare + Choice membership increased mostly due to growth in Ohio, where many competitors have left the market and we are one of the few remaining companies offering this product. We decided to remain in selected markets for Medicare + Choice in Ohio because we believe that with a critical mass of membership in those markets in Ohio, we can achieve improved results.

Individual membership dropped primarily due to a reduction in Medicare Supplement business in our Midwest region. This block of business, which has traditionally generated high profit margins, is shrinking due to terminations of grandfathered policies, primarily mortality related, exceeding new sales.

Effective on January 1, 1992, CMS, then known as HCFA, required that new sales of Medicare Supplement coverages be sold in the form of one of 10 standardized policies, while persons with existing Medicare Supplement coverages could retain their existing Medicare Supplement products, which generally had higher profit margins than the new products. Since that time, our Medicare Supplement membership has, through terminations of grandfathered policies and sales of new policies, reached the point where at December 31, 2000, approximately 50% of our Medicare Supplement membership in the Midwest was in the old plans and 50% in the new plans. During 2001, we are introducing a line of competitive Medicare Supplement policies in the Midwest in order to improve the growth of this business and have modified the premium rate structures to improve the attractiveness of these products in the marketplace.

Self-funded membership increased primarily due to the increase in BlueCard utilization, while fully insured membership grew primarily as a result of the growth in Small group membership sales.

Midwest membership grew in 2000 primarily from the growth in BlueCard utilization discussed above, Large group and National account sales. East membership grew primarily due to increased sales of Small group and growth in BlueCard. Small group sales in our East region increased primarily due to the withdrawal of two of our largest competitors from the New Hampshire market. West membership growth was primarily due to higher BlueCard utilization.

We withdrew from the Medicare + Choice program in Connecticut effective January 1, 2001 due to losses in this line of business. At December 31, 2000, membership in the Medicare + Choice program in Connecticut was 18,000.

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

The following table presents our consolidated results of operations for the years ended December 31, 2000 and 1999:

	Year Ended December 31,			
	2000	1999	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents(1)	$11,800.1	$8,691.6	$3,108.5	35.8%
Premiums	$ 7,737.3	$5,418.5	$2,318.8	42.8%
Administrative fees	755.6	611.1	144.5	23.6%
Other revenue	50.6	51.0	(0.4)	(0.8)%
Total operating revenue	8,543.5	6,080.6	2,462.9	40.5%
Benefit expense	6,551.0	4,582.7	1,968.3	43.0%
Administrative expense	1,808.4	1,469.4	339.0	23.1%
Total operating expense	8,359.4	6,052.1	2,307.3	38.1%
Operating gain	184.1	28.5	155.6	NM(2)
Net investment income	201.6	152.0	49.6	32.6%
Net realized gains on				

investments	25.9	37.5	(11.6)	(30.9)%
Interest expense	54.7	30.4	24.3	79.9%
Amortization of intangibles	27.1	12.7	14.4	113.4%
Endowment of non-profit foundations	--	114.1	(114.1)	(100.0)%
Income from continuing operations before taxes and minority interest	329.8	60.8	269.0	NM(2)
Income taxes	102.2	10.2	92.0	NM(2)
Minority interest (credit)	1.6	(0.3)	1.9	NM(2)
Income from continuing operations	226.0	50.9	175.1	NM(2)
Discontinued operations, net of income taxes Loss on disposal of discontinued operations	--	(6.0)	6.0	NM(2)
Net income	$ 226.0	$ 44.9	$ 181.1	NM(2)
Benefit expense ratio(3)	84.7%	84.6%		10 bp(4)
Administrative expense ratio:				
Calculated using operating revenue(5)	21.2%	24.2%		(300) bp(4)
Calculated using operating revenue and premium equivalents(6)	15.3%	16.9%		(160) bp(4)
Operating margin(7)	2.2%	0.5%		170 bp(4)

---

(1) Self-funded claims included in operating revenue and premium equivalents for the year ended December 31, 2000 were $3,256.6 million and for the year ended December 31, 1999 were $2,611.0 million.
(2) NM = Not meaningful.
(3) Benefit expense ratio = Benefit expense / Premiums.
(4) bp =basis point; one hundred basis points = 1%.
(5) Administrative expense /Operating revenue.
(6) Administrative expense / Operating revenue and premium equivalents.
(7) Operating margin = Operating gain / Total operating revenue.

Premiums increased by $2,318.8 million, or 42.8%, to $7,737.3 million in 2000 primarily due to the acquisitions of BCBS-NH and BCBS-CO/NV in the fourth quarter of 1999 and BCBS-ME in June 2000. Excluding these acquisitions, premiums increased by $870.5 million, or 16.5%, primarily due to premium rate increases and higher membership in the Midwest and East regions. Midwest premiums increased $473.8 million, or 12.7%, while East premiums increased $353.4 million, or 24.9%. Midwest premiums increased primarily due to higher membership and premium rate increases in our group accounts (both Large group and Small group) and higher membership in Medicare + Choice. East premiums increased primarily due to premium rate increases and higher membership in group business, as well as the conversion of the State of Connecticut account to fully insured from self-funded status in mid-1999.

Administrative fees increased $144.5 million, or 23.6%, from $611.1 million in 1999 to $755.6 million in 2000, with $135.3 million of this increase resulting from acquisitions of BCBS-NH, BCBS-CO/NV and BCBS-ME. In July 1999, we sold two non-strategic businesses which combined had 1999 revenues of $12.8 million. Excluding acquisitions and divestitures, administrative fees increased $20.6 million, or 3.5%, primarily from membership growth in National business.

Excluding acquisitions and divestitures, other revenue increased $6.0 million, or 14.0%, primarily due to Anthem Alliance Health Insurance Company assuming additional administrative functions under the TRICARE program.

Benefit expense increased $1,968.3 million, or 43.0%, in 2000, primarily due to acquisitions. Excluding acquisitions, benefit expense increased $729.9 million, or 16.4%, due to increasing cost of care and the effect of higher average membership throughout the year. Cost of care trends were driven primarily by higher utilization of outpatient services and higher prescription drug costs. Our benefit expense ratio increased 10 basis points from 84.6% in 1999 to 84.7% in 2000 due to the acquisition of BCBS-ME in 2000, which had a higher benefit expense ratio than our other operations. Excluding acquisitions, our benefit expense ratio remained constant at 84.6% in 2000 and 1999.

Outpatient cost increases ranged from 15% to 20% in 2000 over 1999. These increases have resulted from both increased utilization and higher unit costs. Increased utilization reflects an industry-wide trend towards a broader range of medical procedures being performed without overnight hospital stays, as well as an increasing customer awareness of and demand for diagnostic procedures such as MRI's. In addition, improved medical technology has allowed more complicated medical procedures to be performed on an outpatient basis rather than on an inpatient basis, increasing both utilization rates and unit costs.

Prescription drug cost increases have varied among regions and by product, but generally ranged from 12% to 20% in 2000 over 1999, primarily due to introduction of new, higher cost drugs as well as higher overall utilization as a result of increases in direct-to-consumer advertising by pharmaceutical companies. In response to increasing prescription drug costs, we have implemented a "three-tiered" drug program and expanded use of formularies for our members.

Administrative expense increased $339.0 million, or 23.1%, in 2000, primarily due to the acquisitions of BCBS-NH, BCBS-CO/NV and BCBS-ME. Administrative expense in 1999 included $41.9 million resulting from a settlement with the Office of Inspector General, or OIG, Health and Human Services to resolve an investigation into alleged misconduct in the Medicare fiscal intermediary operations in Connecticut during periods preceding BCBS-CT's merger with Anthem. Excluding acquisitions and the effect of the OIG settlement, administrative expense increased $75.6 million, or 5.4%, primarily due to higher commissions and premium taxes, which vary with premium and higher incentive compensation costs. Additionally, in December 2000, we made a $20.0 million contribution to the newly formed Anthem Foundation, Inc., which is a charitable and educational not-for-proft corporation. Excluding these costs, administrative expense would have been down slightly in 2000 due to productivity improvements resulting from ongoing efforts to identify and implement more efficient processes in our customer service and claims operations.

Our administrative expense ratio decreased 160 basis points primarily due to operating revenues increasing more than administrative expense. Excluding acquisitions and the effect of the OIG settlement, our administrative expense ratio would have decreased 120 basis points.

Net investment income increased $49.6 million, or 32.6%, primarily due to higher rates of investment returns earned on our fixed income portfolio and higher overall portfolio balances. The higher portfolio balances included net cash resulting from acquisitions, net proceeds of $295.9 million from our surplus note issuance in January 2000, as well as cash generated from operations and from improved balance sheet management, such as more rapid

collection of receivables and sales of non-core assets. Excluding acquisitions, net investment income increased $24.9 million, or 16.6%.

During 2000, our investment portfolio generated a net yield of 5.91% compared with a net yield of 5.60% in 1999. We define our net yield as earned income divided by the amortized cost of our investments. The increase of 31 basis points was primarily due to higher returns on our fixed income security portfolio, in line with overall market conditions.

Net realized capital gains decreased $11.6 million, or 30.9%, in 2000. Included in net realized capital gains in 1999 are capital losses of $20.5 million related to the sale of several non-core businesses. Excluding the effect of the capital losses on dispositions, net realized capital gains decreased $32.1 million, or 55.3%, primarily due to lower turnover in the portfolio resulting in fewer capital gains. Net realized capital gains from equities decreased 37.2% ($43.5 million in 2000 versus $69.3 million in 1999). Net realized capital losses from fixed income securities increased 55.8% ($17.6 million loss in 2000 versus $11.3 million loss in 1999). Acquisitions had no material effect on net realized capital gains. Net gains or losses on investments are influenced by market conditions when an investment is sold, and will vary from year to year as sales of investments are determined by cash flow needs, as well as portfolio allocation decisions.

Interest expense increased $24.3 million, or 79.9%, primarily reflecting increased net borrowings following our private placement of $300.0 million principal amount of surplus notes in January 2000. The proceeds of our new surplus notes were used to retire short-term borrowings which had been incurred to finance the purchases of BCBS-NH and BCBS-CO/NV in late 1999 and to bolster liquidity as a part of our Year 2000 readiness effort.

Amortization of intangibles increased $14.4 million, or 113.4%, primarily due to amortization of goodwill associated with the acquisitions of BCBS-NH, BCBS-CO/NV and BCBS-ME.

The endowment of non-profit foundations of $114.1 million in 1999 represented the expense of settlement of charitable asset claims brought by the Attorneys General of the states of Ohio, Kentucky and Connecticut.

Income before taxes and minority interest increased $269.0 million as a result of improvement in operating results in all business segments, and the non-recurring endowment of non-profit foundations during 1999.

Income tax expense increased $92.0 million due to higher income before taxes. Our effective income tax rate in 2000 was 31.0% versus 16.7% in 1999. The rate is lower than the statutory effective tax rate in both periods primarily as a result of changes in our deferred tax valuation allowance.

Excluding the after-tax endowment of non-profit foundations in 1999, net income increased $109.3 million, or 93.7%, primarily due to the improvement in operating results, acquisitions and higher investment income described above.

Midwest

The following table presents our Midwest region's results of operations for the years ended December 31, 2000 and 1999:

Year Ended

	December 31,			
	2000	1999	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$6,816.9	$5,892.2	$924.7	15.7%
Premiums	$4,203.1	$3,729.3	$473.8	12.7%
Administrative fees	254.8	242.8	12.0	4.9%
Other revenue	2.6	3.4	(0.8)	(23.5)%
Total operating revenue	4,460.5	3,975.5	485.0	12.2%
Benefit expense	3,555.4	3,162.2	393.2	12.4%
Administrative expense	817.3	776.9	40.4	5.2%
Total operating expense	4,372.7	3,939.1	433.6	11.0%
Operating gain	$ 87.8	$ 36.4	$ 51.4	141.2%
Benefit expense ratio(1)	84.6%	84.8%		(20)bp(2)
Administrative expense ratio:				
Calculated using operating revenue(3)	18.3%	19.5%		(120)bp(2)
Calculated using operating revenue and premium equivalents(4)	12.0%	13.2%		(120)bp(2)
Operating margin(5)	2.0%	0.9%		110bp(2)
Membership (in thousands)	4,582	4,382		4.6%

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point; one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Premiums increased $473.8 million, or 12.7%, primarily due to higher premiums PMPM, which accounted for 12.2% of the increase, and the effect of higher average membership throughout the year. Premiums PMPM increased from $147.57 in 1999 to $165.08 in 2000 primarily due to premium rate increases in group (both Large group and Small group) and Medicare + Choice businesses. The increases in group and Medicare + Choice premiums accounted for $368.9 million, or 77.9%, of the increase in premiums. Group premiums PMPM increased 12.9% from $140.60 in 1999 to $158.76 in 2000 primarily due to premium rate increases. Average insured group membership was essentially flat. Medicare + Choice PMPM premiums increased 5.3% from $438.24 in 1999 to $461.58 in 2000 due to the aging of our insured Medicare + Choice population in 2000, resulting in higher premiums. We receive higher premiums from CMS as our Medicare + Choice population ages. In addition, we received a premium rate increase from CMS of approximately 3% at the beginning of 2000. Average Medicare + Choice membership increased 27.7% due to reduced competition in the Ohio marketplace as a result of competitors discontinuing their participation in the Medicare + Choice product.

Administrative fees increased 4.9% from $242.8 million in 1999 to $254.8 million in 2000. In mid-1999, we sold our worker's compensation third party administration business and a physician's group practice. Most of this increase was from membership growth in National business. Excluding these dispositions in 1999, administrative fees would have increased $23.4 million or 10.1%.

Benefit expense increased $393.2 million, or 12.4%, in 2000 primarily due to higher benefit expense PMPM (11.9%) and the effect of higher average membership (0.5%) throughout the year. Benefit expense PMPM increased from $125.13 in 1999 to $140.06 in 2000 primarily due to higher outpatient costs and higher prescription drug costs. Outpatient cost increases averaged approximately 16% in 2000 due to continued trends of shifting services to outpatient settings versus inpatient/facility based services. These cost increases have come from both increased utilization and higher unit costs. Improved medical technology has allowed more complicated medical procedures, such as cardiac catheterization and angioplasties, to be performed on an outpatient basis.

Prescription drug costs increased about 13% in 2000 primarily due to introduction of new, higher cost drugs and increases in direct to consumer advertising by pharmaceutical companies. Utilization of a three-tiered drug program for our members has helped contain the increase in prescription drug costs.

While outpatient and prescription drug costs increased significantly in 2000, inpatient costs increased approximately 3%. Admissions per 1,000 members were generally unchanged, while average length of stay declined slightly in 2000. These factors were slightly offset by modest reimbursement increases under the terms of our hospital contracting agreements.

Midwest's benefit expense ratio decreased 20 basis points from 84.8% in 1999 to 84.6% in 2000 as the growth in premium PMPM of 12.2% exceeded growth in benefit expense PMPM of 11.9% as discussed above.

Administrative expense increased $40.4 million, or 5.2%, in 2000 primarily due to higher commission and premium taxes related to higher premiums, as well as incentive compensation costs related to above-target financial performance and a contribution of $15.0 million to create the Anthem Foundation. Excluding the additional incentive compensation and foundation contribution costs, administrative expense was flat in 2000. The administrative expense ratio decreased 120 basis points primarily due to higher premiums as discussed above.

East

The following table presents our East region's results of operations for the years ended December 31, 2000 and 1999. BCBS-NH is included from its October 27, 1999 acquisition date and BCBS-ME is included from its June 5, 2000 acquisition date.

	Year Ended December 31,			
	2000	1999	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$3,751.2	$2,272.8	$1,478.4	65.1%
Premiums	$2,768.9	$1,495.4	$1,273.5	85.2%
Administrative fees	144.1	99.7	44.4	44.5%

Other revenue	8.9	3.8	5.1	134.2%
Total operating revenue	2,921.9	1,598.9	1,323.0	82.7%
Benefit expense	2,332.4	1,259.9	1,072.5	85.1%
Administrative expense	485.7	339.9	145.8	42.9%
Total operating expense	2,818.1	1,599.8	1,218.3	76.2%
Operating gain (loss)	$ 103.8	$ (0.9)	$ 104.7	NM(1)
Benefit expense ratio(2)	84.2%	84.3%	(10)	bp(3)
Administrative expense ratio:				
Calculated using operating revenue(4)	16.6%	21.3%	(470)	bp(3)
Calculated using operating revenue and premium equivalents(5)	12.9%	15.0%	(210)	bp(3)
Operating margin(6)	3.6%	(0.1)%	370	bp(3)
Membership (in thousands)	2,093	1,397	49.8%	

---

(1) NM = Not meaningful.
(2) Benefit expense ratio = Benefit expense / Premiums.
(3) bp = basis point; one hundred basis points = 1%.
(4) Administrative expense / Operating revenue.
(5) Administrative expense / Operating revenue and premium equivalents.
(6) Operating margin = Operating gain / Total operating revenue.

Premiums increased $1,273.5 million, or 85.2%, primarily due to the acquisitions of BCBS-NH in October 1999 ($474.6 million) and BCBS-ME in June 2000 ($445.4 million) and the conversion of the State of Connecticut account from self-funded to fully insured status in July 1999 ($197.8 million). Due to the State of Connecticut's conversion, 2000 included a full year of premiums versus six months of premiums (July through December) in 1999, since the new funding arrangement was changed effective July 1999. For the first six months of 1999, we recorded administrative fees for the State of Connecticut account, which is consistent with accounting practices for Self-funded business. Excluding the effect of acquisitions and the conversion of the State of Connecticut account, premiums increased $155.7 million, or 12.5%, in 2000 due to premium rate increases in group business and higher average membership.

Administrative fees increased $44.4 million, or 44.5%, from $99.7 million in 1999 to $144.1 million in 2000. The BCBS-NH and BCBS-ME acquisitions contributed $66.6 million of this increase, while the conversion of the State of Connecticut account resulted in a decline in administrative fees of approximately $13.0 million. Excluding the effect of acquisitions and the conversion of the State of Connecticut account, administrative fees decreased $9.8 million, or 11.7%, primarily due to lower fees from Self-funded business and our decision to discontinue our contract as the Medicare Part A

processor in Connecticut as of January 1, 2000. Self-funded administrative fees fell $8.8 million, or 12.9%, primarily due to our focus on growing Fully insured business. Medicare Part A fees were $3.0 million in 1999.

Benefit expense increased $1,072.5 million, or 85.1%, primarily due to the acquisitions of BCBS-NH and BCBS-ME and the conversion of the State of Connecticut account from self-funded to fully insured status in July 1999. Excluding the effect of these acquisitions, benefit expense increased $285.7 million, or 23.9%, in 2000 due to the conversion of the State of Connecticut

account ($163.3 million) and higher average membership.

Benefit expense PMPM, excluding acquisitions, increased 5.1% in 2000. Prescription drug PMPM costs increased over 8% due to the introduction of new, higher cost drugs and increases in direct to consumer advertising by pharmaceutical companies. Utilization of a three-tiered drug program for our members has helped contain prescription drug costs.

Inpatient, outpatient and professional PMPM cost increases were 1.8%, 5.7% and 5.1%, respectively. Utilization in all of these areas increased due to higher respiratory and cardiology medical conditions, which resulted in both higher admissions and increased additional follow-up treatment visits. The increase in inpatient PMPM costs was also impacted by a slightly longer average length of stay, offset by a decline in the average cost per inpatient visit.

On an overall basis, the benefit expense ratio decreased 10 basis points from 84.3% in 1999 to 84.2% in 2000; however, excluding acquisitions, the benefit expense ratio decreased 60 basis points. Excluding acquisitions, the decrease in benefit expense ratio was primarily due to the effect of the relatively modest trends discussed above.

Administrative expense increased $145.8 million, or 42.9%, primarily due to the acquisitions of BCBS-NH and BCBS-ME. Excluding these acquisitions, administrative expense decreased $35.0 million, or 10.8%, primarily due to a one-time expense of $41.9 million in 1999 associated with the settlement of a claim with respect to Medicare Part A claims processing related to activities prior to Anthem's merger with BCBS-CT as discussed above. Excluding acquisitions and the Medicare settlement, administrative expense increased $6.9 million, or 2.4%, primarily due to higher commissions and premium taxes, investments in e-business technology development, higher incentive compensation costs related to above-target financial performance and a contribution to create the Anthem Foundation.

The administrative expense ratio in 2000 decreased 210 basis points primarily due to the effect of the Medicare Part A settlement described above (184 basis points). Excluding acquisitions and the Medicare settlement, the administrative expense ratio decreased 80 basis points primarily due to higher premiums as discussed above and productivity improvements implemented in the last half of 1999. These productivity improvements are a result of ongoing efforts to identify and implement more efficient processes in customer service and claims operations.

West

Our Anthem West region was established in November 1999 following the acquisition of BCBS-CO/NV. Results of this segment have been recorded in the consolidated results from that date forward. The 1999 results include approximately one and one-half months activity, while the 2000 results include twelve months of results.

The following table presents our West region's results of operations for the years ended December 31, 2000 and 1999:

	Year Ended December 31,		
	2000	1999(1)	$ Change

	($ in Millions)		
Operating revenue and premium equivalents	$686.9	$86.9	$600.0
Premiums	$569.6	$64.2	$505.4
Administrative fees	52.8	1.7	51.1
Other revenue	--	6.8	(6.8)
Total operating revenue	622.4	72.7	549.7
Benefit expense	491.7	55.0	436.7
Administrative expense	128.2	21.2	107.0
Total operating expense	619.9	76.2	543.7
Operating gain (loss)	$ 2.5	$(3.5)	$ 6.0
Benefit expense ratio(2)	86.3%	85.7%	
Administrative expense ratio:			
Calculated using operating revenue(3)	20.6%	29.2%	
Calculated using operating revenue and premium equivalents(4)	18.7%	24.4%	
Operating margin(5)	0.4%	(4.8)%	
Membership (in thousands)	595	486	

---

(1) Includes one and one-half months of activity in 1999.
(2) Benefit expense ratio = Benefit expense / Premiums.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Operating results in the West improved in 2000, primarily due to reduced administrative expense as a result of integration savings and cost reduction programs as well as higher membership. Membership increased 22.4% due to higher sales and better retention of business. These cost reduction programs included reducing levels of management and improving productivity in customer service and claims operations. The administrative expense ratio declined 570 basis points as a result of lower administrative expenses and higher membership.

Benefit expense PMPM increased approximately 16% in 2000, primarily due to higher outpatient and inpatient costs, reflecting increased utilization and unit costs for both outpatient and inpatient services. In response to these trends, our West region is seeking to implement new contracts with providers. The improvement in the administrative expense ratio more than offset increased benefit expense, resulting in a $6.0 million increase in operating results.

Specialty

The following table presents our Specialty segment's results of operations for the years ended December 31, 2000 and 1999:

Year Ended December 31,			
2000	1999	$ Change	% Change
($ in Millions)			

Operating revenue and premium equivalents	$338.7	$255.3	$83.4	32.7%
Premiums from life and disability	$123.7	$ 96.3	$27.4	28.5%
Administrative fees	31.8	14.6	17.2	117.8%
Other revenue	176.8	138.2	38.6	27.9%
Total operating revenue	332.3	249.1	83.2	33.4%
Benefit expense	92.6	73.8	18.8	25.5%
Administrative expense	214.8	159.1	55.7	35.0%
Total operating expense	307.4	232.9	74.5	32.0%
Operating gain	$ 24.9	$ 16.2	$ 8.7	53.7%
Benefit expense ratio(1)	74.9%	76.6%		(170) bp(2)
Administrative expense ratio:				
Calculated using operating revenue(3)	64.6%	63.9%		70 bp(2)
Calculated using operating revenue and premium equivalents(4)	63.4%	62.3%		110 bp(2)
Operating margin(5)	7.5%	6.5%		100 bp(2)

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point; one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Life and disability premiums increased $27.4 million, or 28.5%, primarily due to the acquisition of Rocky Mountain Life or RML, an affiliate of BCBS-CO/NV. Excluding the acquisition of RML, premiums increased $4.5 million, or 4.8%, due to higher life sales in our Midwest region. Administrative fees increased $17.2 million, or 117.8%, due to the acquisitions of Occupational Healthcare Management Services, Inc., a worker's compensation third party administration company, and Health Management Systems, Inc., a dental benefits third party administration company, both subsidiaries of BCBS-CO/NV. Excluding these acquisitions, administrative fees were essentially flat.

Other revenue increased $38.6 million, or 27.9%, primarily from APM. In 2000, APM began to provide pharmacy benefit management services to both BCBS-NH and Anthem Alliance Health Insurance Company. These new markets for APM generated an additional $3.5 million of other revenue in 2000. Excluding new markets, other revenue increased primarily due to higher mail and retail volumes related to increased membership and utilization. Mail service membership increased 26% while retail service membership increased 80%. Mail service prescription volume increased 15% and retail prescription volume increased 39%.

Benefit expense increased $18.8 million, or 25.5%, due to the acquisition of RML. Excluding the acquisition of RML, benefit expense increased $3.9 million, or 5.4%, in line with the increase in life and disability premiums. The benefit expense ratio was 74.9% in 2000, a 170 basis point decrease from 1999 primarily due to the acquisition of RML, which generates a lower benefit expense ratio than our other life business. Our other life business includes two large customers that generate

higher benefit expense ratios as these two customers are retrospectively experience rated. These higher benefit expense ratios are offset by a lower administrative expense ratio on these two customers. One of these customers terminated at the end of 1999, although this group had a small profit margin and its termination should not impact future results.

Administrative expense increased $55.7 million, or 35.0%, as a result of the acquisitions mentioned above and APM. Excluding acquisitions, administrative expense increased $33.9 million, or 21.4%, primarily due to increased membership and volume at APM. Administrative expense ratio increased 110 basis points, primarily due to costs at APM associated with adding additional customers in 2001.

Other

The following table presents the results of operations for our Other segment for the years ended December 31, 2000 and 1999:

	Year Ended December 31,			
	2000	1999	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$ 206.4	$ 184.4	$ 22.0	11.9%
Premiums	$ 72.0	$ 33.3	$ 38.7	116.2%
Administrative fees	272.1	252.3	19.8	7.8%
Other revenue (expense)	(137.7)	(101.2)	(36.5)	36.1%
Total operating revenue	206.4	184.4	22.0	11.9%
Benefit expense	78.9	31.8	47.1	148.1%
Administrative expense	162.4	172.3	(9.9)	(5.7)%
Total operating expense	241.3	204.1	37.2	18.2%
Operating loss	$ (34.9)	$ (19.7)	$(15.2)	NM(1)

---

(1) NM = Not meaningful

Premiums increased $38.7 million, or 116.2%, primarily due to higher premiums at Anthem Alliance Health Insurance Company related to amounts received from the Department of Defense. These amounts were received in connection with a global settlement related to a series of bid price adjustments, requests for equitable adjustments and change orders filed during the past two years with the Department of Defense under the TRICARE program. Other administrative fees increased $19.8 million, or 7.8%, primarily due to increased revenues at AdminaStar Federal related to performing additional customer service activities for Medicare beneficiaries. Excluding intersegment revenues in 2000 of $145.7 million and in 1999 of $104.3 million, other revenue increased $4.9 million, or 158.1%, due to Anthem Alliance Health Insurance Company's assuming additional administrative services related to the TRICARE contract during 2000.

Benefit expense increased $47.1 million, or 148.1%, primarily due to the services provided and risks assumed related to the global settlement received by Anthem Alliance Health Insurance Company. Benefit expense associated with

the global settlement offset most of the increase in premiums associated with the global settlement and bid price adjustments.

Excluding intersegment administrative expenses in 2000 of $154.1 million and in 1999 of $112.1 million, administrative expense increased $32.1 million, or 11.3%, primarily due to expenses associated with AdminaStar Federal's additional customer service activities and Anthem Alliance Health Insurance Company's assuming additional administrative services.

Certain corporate expenses are not allocated to our business segments. These unallocated expenses account for $39.9 million in 2000 and $26.7 million in 1999, and primarily include such items as unallocated incentive compensation and other expenses associated with discontinued

operations. Excluding unallocated corporate expenses, operating gain was $5.0 million in 2000, $2.0 million, or 28.6%, less than in 1999. Most of the decrease is due to higher non-reimbursable administrative expense at AdminaStar Federal.

MEMBERSHIP--Year Ended December 31, 1999 Compared to Year Ended December 31, 1998

Our membership data presented below are unaudited and include estimates based upon the number of contracts in place at the period-end date and an actuarial estimate of the number of members represented by each contract. The following table presents membership by region, customer type and funding type as of December 31, 1999 and 1998, comparing total and "same store" (after removing the impact of acquisitions) membership, respectively:

MEMBERSHIP

	Total 1999	Acquisitions*	Same Store 1999	Total 1998	Total Change	Total %	Same Store Change	Same Store %
			(In Thousands)					
Region								
Midwest	4,382	--	4,382	4,199	183	4.4%	183	4.4%
East	1,397	366	1,031	968	429	44.3	63	6.5
West	486	486	--	--	486	--	--	--
Total	6,265	852	5,413	5,167	1,098	21.3%	246	4.8%
Customer Type								
Large group	2,249	349	1,900	1,852	397	21.4%	48	2.6%
Small group	637	76	561	559	78	14.0	2	0.4
Individual	586	108	478	478	108	22.6	0	0.0
National	2,106	213	1,893	1,696	410	24.2	197	11.6
Medicare + Choice	96	13	83	81	15	18.5	2	2.5
Federal Employee Program	362	89	273	268	94	35.1	5	1.9
TRICARE	129	--	129	153	(24)	(15.7)	(24)	(15.7)
Medicaid	100	4	96	80	20	25.0	16	20.0
Total	6,265	852	5,413	5,167	1,098	21.3%	246	4.8%

Funding Type								
Fully insured.....	3,354	552	2,802	2,791	563	20.2%	11	0.4%
Self-funded.....	2,911	300	2,611	2,376	535	22.5	235	9.9
Total.....	6,265	852	5,413	5,167	1,098	21.3%	246	4.8%

---

* Represents acquisitions of BCBS-NH and BCBS-CO/NV.

Most of our membership growth in 1999 was due to the acquisitions of BCBS-NH and BCBS-CO/NV.

Same store membership increased 246,000, or 4.8%, primarily due to a significant increase in National BlueCard activity and growth in Large group and Medicaid membership, which more than offset a decline in TRICARE membership. Membership growth in group businesses was 50,000, or 2.1%, and reflects the impact of both significant premium rate increases implemented to improve profitability and severe price competition in several of our key markets. TRICARE membership fell primarily due to more military personnel selecting military primary care providers instead of civilian primary care providers. Only those military personnel selecting civilian primary care providers from Anthem's network are included in our membership data.

Self-funded membership increased primarily due to an increase in BlueCard utilization. Fully insured membership decreased primarily due to lower retention of Large group insured business following our January 1999 renewals and lower TRICARE membership. Midwest membership grew in 1999 primarily from growth in BlueCard utilization, reflecting greater overall membership in the BCBS systems nationwide, as well as higher claims activity by BlueCard members in Anthem's "host" territories. East membership showed strong growth primarily due to higher BlueCard membership and Small group sales in Connecticut.

Results of Operations for the Year Ended December 31, 1999 Compared to the Year Ended December 31, 1998

The following table presents our consolidated results of operations for the years ended December 31, 1999 and 1998:

	Year Ended December 31,			
	1999	1998	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents(1).....	$8,691.6	$7,987.4	$ 704.2	8.8%
Premiums.....	$5,418.5	$4,739.5	$ 679.0	14.3%
Administrative fees.....	611.1	575.6	35.5	6.2%
Other revenue.....	51.0	74.6	(23.6)	(31.6)%
Total operating revenue.....	6,080.6	5,389.7	690.9	12.8%
Benefit expense.....	4,582.7	3,934.2	648.5	16.5%
Administrative expense.....	1,469.4	1,420.1	49.3	3.5%

Total operating expense.....	6,052.1	5,354.3	697.8	13.0%
Operating gain.....	28.5	35.4	(6.9)	(19.5)%
Net investment income.....	152.0	136.8	15.2	11.1%
Net realized gains on investments.....	37.5	155.9	(118.4)	(75.9)%
Interest expense.....	30.4	27.9	2.5	9.0%
Amortization of intangibles.....	12.7	12.0	0.7	5.8%
Endowment of non-profit foundations.....	114.1	--	114.1	NM(2)
Income from continuing operations before taxes and minority interest.....	60.8	288.2	(227.4)	(78.9)%
Income taxes.....	10.2	110.9	(100.7)	(90.8)%
Minority interest (credit).....	(0.3)	(1.1)	0.8	NM(2)
Income from continuing operations.....	50.9	178.4	(127.5)	(71.5)%
Discontinued operations, net of income taxes				
Loss from discontinued operations prior to disposal..	--	(3.9)	3.9	NM(2)
Loss on disposal of discontinued operations.....	(6.0)	(2.1)	(3.9)	NM(2)
Net income.....	$ 44.9	$ 172.4	$(127.5)	(74.0)%
Benefit expense ratio(3).....	84.6%	83.0%		160 bp(4)
Administrative expense ratio:				
Calculated using operating revenue(5).....	24.2%	26.3%		(210) bp(4)
Calculated using operating revenue and premium equivalents(6).....	16.9%	17.8%		(90) bp(4)
Operating margin(7).....	0.5%	0.7%		(20) bp(4)

---

(1) The self-funded claims included in Operating revenue and premium equivalents for the years ended December 31, 1999 and 1998 were $2,611.0 and $2,597.7, respectively.
(2) NM = Not meaningful.
(3) Benefit expense ratio = Benefit expense / Premiums.
(4) bp = basis point; one hundred basis points = 1%.
(5) Administrative expense / Operating revenue.
(6) Administrative expense / Operating revenue and premium equivalents.
(7) Operating margin = Operating gain / Total operating revenue.

Premiums increased $679.0 million, or 14.3%, in 1999. The acquisitions of BCBS-NH and BCBS-CO/NV, which were both accounted for using the purchase accounting method during the last quarter of 1999, accounted for $140.7 million of the overall increase. Midwest and East, excluding the impact of the BCBS-NH acquisition, accounted for $196.0 million and $333.6 million of the increase, respectively. The increase in the Midwest was a result of both rate increases and increased enrollment. East's increase was attributable to the conversion of the State of Connecticut account to a fully insured arrangement in July 1999 from a self-insured status for all of 1998, as well as rate increases and enrollment growth. These increases are explained more fully in the Midwest and

East discussions that follow.

Administrative fees increased 6.2% from $575.6 million in 1998 to $611.1 million in 1999. Most of this increase was from higher BlueCard membership and revenues. The acquisitions of BCBS-NH and BCBS-CO/NV had relatively little effect ($5.5 million) on the increase in administrative fees. Other revenue decreased $23.6 million, or 31.6%, primarily due to the sale of two non-core businesses during 1998. Excluding the sale of these businesses and the acquisitions of BCBS-NH and BCBS-CO/NV, other revenue decreased $8.1 million, or 15.5%, primarily due to a one-time fee received in 1998 related to the termination of a large block of group life business.

Benefit expense increased $648.5 million, or 16.5%, in 1999 due to increases in costs of care, growth in membership and the acquisitions of BCBS-NH and BCBS-CO/NV. Midwest accounted for $239.3 million of the increase, resulting from both enrollment growth and increased costs. East, excluding the impact of the BCBS-NH acquisition, increased by $296.0 million. Conversion of the State of Connecticut account to fully insured from self-insured status and increased outpatient and prescription drug costs contributed to these increases. These factors are discussed more fully in the Midwest and East discussions that follow.

Administrative expense increased $49.3 million, or 3.5%, in 1999 primarily due to acquisitions and a $41.9 million expense resulting from a settlement agreement with the OIG to resolve an investigation into alleged misconduct in the Medicare fiscal intermediary operations of BCBS-CT. The events giving rise to this investigation occurred prior to the merger of BCBS-CT with Anthem. After taking the acquisitions and OIG settlement increases into account, overall administrative expense decreased by $30.1 million, or 2.1%, from 1998. Simultaneously, same store membership increased by 4.8%. Midwest expenses decreased by $20.8 million, or 2.6%, primarily as a result of divestiture of two small non-core businesses in 1999 (1998 included a full year of expenses associated with these businesses while 1999 included only a partial year). East expenses, excluding the impact of BCBS-NH and the OIG settlement, decreased by $12.1 million, or 4.1%. This decrease was primarily as a result of various cost control initiatives being implemented in late 1998 and early 1999, primarily related to installation of more efficient processes in our customer service and claims operations.

Net investment income increased by $15.2 million, or 11.1%, to $152.0 million in 1999 from $136.8 million in 1998. During the first half of 1998, we completed a portfolio restructuring that resulted in increasing the allocation of our investment in fixed income securities in our portfolio and reducing the amount of equity securities. Equities with a market value of $437.3 million were sold as part of this restructuring and reinvested in fixed income securities, reducing the equity allocation in

the portfolio from 33% to 18%. This, coupled with rising interest rates, resulted in higher investment income in 1999, as we had a higher portion of the investment portfolio in fixed income securities for a full year in 1999 compared to only three quarters in 1998. Net realized gains on investments were $37.5 million in 1999, a decrease of $118.4 million, or 75.9%, from net gains of $155.9 million in 1998. As discussed above, we executed a restructuring of the portfolio in 1998 to allocate a higher portion of our investments to fixed income securities. This restructuring generated approximately $80.0 million of realized capital gains during the year ended December 31, 1998. The remaining $38.4 million of the 1999 decrease resulted from gains realized through normal trading during robust market conditions in 1998.

Interest expense increased $2.5 million, or 9.0%, in 1999 as we borrowed $220.0 million in the fourth quarter of 1999 to partially fund the acquisitions of BCBS-NH and BCBS-CO/NV in the fourth quarter of 1999.

Amortization of intangibles increased $0.7 million, or 5.8%, in 1999. The increase in amortization was primarily due to goodwill created from the acquisitions of BCBS-NH and BCBS-CO/NV in late 1999.

The endowment of non-profit foundations of $114.1 million in 1999 arose from the settlements of charitable asset claims brought by Attorneys General of the states of Kentucky, Ohio and Connecticut. In 1999, contributions of $45.0 million, $28.0 million and $41.1 million were made for the benefit of charitable foundations in Kentucky, Ohio and Connecticut, respectively.

Income tax expense was $10.2 million in 1999, compared to $110.9 million in 1998. The higher tax expense in 1998 reflected the higher pre-tax income recognized in that period. Also, the effective tax rate for the year ended December 31, 1999 was 16.7%, while the rate for the same period in 1998 was 38.5%. The decrease in our effective tax rate was primarily due to a reduction in the valuation allowance on deferred tax assets. The effective rate for the year ended December 31, 1998 was higher than the combined statutory rates primarily due to state and local taxes. A reconciliation to the statutory rate for both years is included in Note 10 to our audited consolidated financial statements.

Net income in 1999 was $44.9 million, a $127.5 million, or 74%, decrease from $172.4 million for the prior year. As discussed above, the primary reasons for the lower net income were reduced realized capital gains, the endowment of non-profit foundations and the OIG settlement, offset in part by lower income taxes and improved administrative expense ratios.

Midwest

The following table presents our Midwest region's results of operations for the years ended December 31, 1999 and 1998:

	Year Ended December 31,			
	1999	1998	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$5,892.2	$5,681.8	$210.4	3.7%
Premiums	$3,729.3	$3,533.3	$196.0	5.5%
Administrative fees	242.8	234.8	8.0	3.4%
Other revenue	3.4	3.0	0.4	13.3%
Total operating revenue	3,975.5	3,771.1	204.4	5.4%
Benefit expense	3,162.2	2,922.9	239.3	8.2%
Administrative expense	776.9	797.7	(20.8)	(2.6)%
Total operating expense	3,939.1	3,720.6	218.5	5.9%
Operating gain	$ 36.4	$ 50.5	$(14.1)	(27.9)%

Benefit expense ratio(1).....	84.8%	82.7%		210 bp(2)
Administrative expense ratio:				
Calculated using operating revenue(3).....	19.5%	21.2%		(170) bp(2)
Calculated using operating revenue and premium equivalents(4).....	13.2%	14.0%		(80) bp(2)
Operating margin(5).....	0.9%	1.3%		(40) bp(2)
Membership (in thousands).....	4,382	4,199		4.4%

---

(1) Benefit expense ratio = Benefit expense /Premiums.
(2) bp = basis point; one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Premiums increased $196.0 million, or 5.5%, primarily due to higher premiums PMPM, which more than offset the effect of lower average membership throughout the year. Premiums PMPM increased 10.7% from $133.32 in 1998 to $147.57 in 1999, primarily due to rate increases in group and National businesses. Group premiums PMPM increased 10.2% from $127.54 in 1998 to $140.60 in 1999, reflecting premium rate increases averaging 15% in response to increasing claim trends. Average insured group membership fell 4.6%, primarily due to competitive pressures in Kentucky and Ohio. National PMPM premiums increased 14.6% from $137.99 in 1998 to $158.15 in 1999, due to rate increases implemented in response to increasing claim trends. Average National insured membership decreased 9.1% or 9,600 members, primarily due to non-renewals at the beginning of 1999.

Administrative fees increased 3.4% from $234.8 million in 1998 to $242.8 million in 1999. Most of this increase was from membership growth in National self-funded business which more than offset reductions arising from the sale of our worker's compensation third party administration subsidiary and a physician's group practice during 1999. Excluding the administrative fees from the divested businesses, administrative fees increased $20.1 million, or 9.5%, to $231.4 million in 1999 due to membership growth in National self-funded business.

Benefit expense increased $239.3 million, or 8.2%, in 1999 primarily due to higher benefit expense PMPM, which was offset by the effect of lower average membership throughout the year.

Benefit expense PMPM increased 13.0% from $110.69 in 1998 to $125.13 in 1999 primarily due to higher outpatient costs and higher prescription drug costs. Increases in outpatient costs were primarily due to continued shifting of services to outpatient settings versus inpatient service, which has increased both utilization and unit costs. Improved medical technology has also allowed more complicated medical procedures to be performed on an outpatient basis, thus increasing unit costs.

Prescription drug cost increases accelerated in 1999 primarily due to introduction of new, higher cost drugs and increases in direct-to-consumer advertising by pharmaceutical companies. Midwest utilized several strategies to optimize prescription drug benefits, including expanded use of drug formularies and expansion of a three-tiered drug program for our members.

The benefit expense ratio increased 210 basis points from 82.7% in 1998 to

84.8% in 1999, as the growth in premium PMPM of 10.7% was not sufficient to cover the growth in benefit expense PMPM of 13.0% as discussed above. Ohio group, National business and Medicare + Choice were the primary drivers of the deterioration in benefit expense ratio. Ohio group and National were impacted by increasing outpatient and prescription drug costs, while Medicare + Choice was impacted by provider risk share write-offs and claim reserve increases. Provider risk share agreements were used in Medicare + Choice business in Ohio in order to share the risk of claim costs with providers. Midwest implemented corrective pricing actions late in 1999 that were targeted at improving underwriting results.

Administrative expense decreased $20.8 million, or 2.6%, in 1999, primarily due to the sale of a worker's compensation third party administration company and physicians' group practice in July 1999, and the effect of expense reduction programs initiated in 1998. Most of the benefit of these programs occurred in 1999. These expense reduction programs included process improvements in claims and customer service operations and reduction in the number of levels of management. The administrative expense ratio decreased 80 basis points from 14.0% in 1998 to 13.2% in 1999 primarily due to higher premiums and the reduced administrative expense discussed above.

East

The following table presents our East region's results of operations for the years ended December 31, 1999 and 1998. BCBS-NH results are included from October 27, 1999:

	Year Ended December 31,			
	1999	1998	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$2,272.8	$1,871.5	$401.3	21.4%
Premiums	$1,495.4	$1,088.3	$407.1	37.4%
Administrative fees	99.7	91.4	8.3	9.1%
Other revenue	3.8	11.2	(7.4)	(66.1)%
Total operating revenue	1,598.9	1,190.9	408.0	34.3%
Benefit expense	1,259.9	901.9	358.0	39.7%
Administrative expense	339.9	294.6	45.3	15.4%
Total operating expense	1,599.8	1,196.5	403.3	33.7%
Operating loss	$ (0.9)	$ (5.6)	$ 4.7	NM(1)
Benefit expense ratio(2)	84.3%	82.9%	140	bp(3)
Administrative expense ratio:				
Calculated using operating revenue(4)	21.3%	24.7%	(340)	bp(3)
Calculated using operating revenue and premium equivalents(5)	15.0%	15.7%	(70)	bp(3)

Operating margin(6).....	(0.1)%	(0.5)%	40 bp(3)
Membership (in thousands)....	1,397	968	44.3%

---

(1) NM = Not meaningful.
(2) Benefit expense ratio = Benefit expense / Premiums.
(3) bp = basis point; one hundred basis points = 1%.
(4) Administrative expense / Operating revenue.
(5) Administrative expense / Operating revenue and premium equivalents.
(6) Operating margin = Operating gain / Total operating revenue.

Premiums increased $407.1 million, or 37.4%, primarily due to the conversion of the State of Connecticut account from self-funded to fully insured in July 1999 and the acquisition of BCBS-NH in October 1999. Excluding the effect of $73.5 million in premiums from the acquisition, premiums increased 30.7%. The State of Connecticut account accounted for $175.0 million, or 52.5%, of the increase. Excluding the effect of the acquisition and the conversion of the State of Connecticut account, premiums increased $158.6 million, or 14.6%, primarily due to premium rate increases in group business and higher average membership.

Administrative fees increased $8.3 million, or 9.1%, from $91.4 million in 1998 to $99.7 million in 1999. The acquisition of BCBS-NH accounted for $3.8 million of the increase. Conversion of the State of Connecticut account from self-funded to fully insured caused a $10.6 million reduction in administrative fees in 1999. Excluding the effect of the acquisition of BCBS-NH and the conversion of the State of Connecticut account, administrative fees increased $15.1 million, or 22.1%, to $83.5 million in 1999. This increase in administrative fees was primarily due to higher sales of self-funded business in Connecticut. Other revenue decreased $7.4 million, or 66.1%, in 1999 primarily due to the sale of a small real estate subsidiary at the end of 1998.

Benefit expense increased $358.0 million, or 39.7%, primarily due to the conversion of the State of Connecticut account from self-funded to fully insured in July 1999 and the acquisition of BCBS-NH

in October 1999. Excluding the effect of $62.0 million of benefit expense from BCBS-NH, benefit expense increased $296.0 million, or 32.8%, in 1999 primarily due to the conversion of the State of Connecticut account, which accounted for $154.1 million, or 52.1%, of the increase. Excluding the effect of the acquisition and the conversion of the State of Connecticut account, benefit expense increased $141.9 million, or 15.7%, due to increasing cost of care trends and higher average membership.

The benefit expense ratio increased 140 basis points from 82.9% in 1998 to 84.3% in 1999. However, excluding the effect of the conversion of the State of Connecticut account, benefit expense ratio increased 80 basis points to 83.7%. The acquisition of BCBS-NH had no effect on the benefit expense ratio in 1999.

Administrative expense increased $45.3 million, or 15.4%, primarily due to a one-time expense of $41.9 million in 1999 associated with a settlement of claims brought by the OIG, alleging overpayment for Medicare Part A claims prior to Anthem's merger with BCBS-CT. Excluding this settlement and the acquisition of BCBS-NH, administrative expense decreased $12.1 million, or 4.1%, as a result of the implementation of cost savings initiatives in Connecticut designed to identify duplication of administrative services and improve efficiency in the services we provide our customers. Excluding acquisitions and the Medicare settlement, the administrative expense ratio improved 270 basis points to 13.0% in 1999.

West

The following table presents our West region's results of operations for the period ended December 31, 1999:

	Period Ended December 31, 1999
	($ in Millions)
Operating revenue and premium equivalents	$86.9
Premiums	$64.2
Administrative fees	1.7
Other revenue	6.8
Total operating revenue	72.7
Benefit expense	55.0
Administrative expense	21.2
Total operating expense	76.2
Operating loss	$(3.5)
Benefit expense ratio(1)	85.7%
Administrative expense ratio:	
Calculated using operating revenue(2)	29.2%
Calculated using operating revenue and premium equivalents(3)	24.4%
Operating margin(4)	(4.8)%
Membership (in thousands)	486

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) Administrative expense / Operating revenue.
(3) Administrative expense / Operating revenue and premium equivalents.
(4) Operating margin = Operating gain / Total operating revenue.

Anthem West was established with the acquisition of BCBS-CO/NV on November 16, 1999. Results of operations for this segment have been included in our consolidated financial statements

since the purchase date. This transaction was accounted for as a purchase and, accordingly, 1999 includes only a partial year with no results reported for 1998. At the time of the acquisition, we began to fully implement our turnaround strategy for West. We implemented cost reduction programs, including reducing layers of management, integrating certain administrative functions into existing Anthem operations and instituting appropriate pricing discipline and customer service standards.

Specialty

The following table presents our Specialty segment's results of operations for the years ended December 31, 1999 and 1998:

	Year Ended December 31,			
	1999	1998	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$255.3	$248.0	$ 7.3	2.9%
Premiums from life and disability	$ 96.3	$ 90.3	$ 6.0	6.6%
Administrative fees	14.6	21.1	(6.5)	(30.8)%
Other revenue	138.2	130.2	8.0	6.1%
Total operating revenue	249.1	241.6	7.5	3.1%
Benefit expense	73.8	76.1	(2.3)	(3.0)%
Administrative expense	159.1	142.3	16.8	11.8%
Total operating expense	232.9	218.4	14.5	6.6%
Operating gain	$ 16.2	$ 23.2	$(7.0)	(30.2)%
Benefit expense ratio (1)	76.6%	84.3%	(770) bp(2)	
Administrative expense ratio:				
Calculated using operating revenue (3)	63.9%	58.9%	500 bp(2)	
Calculated using operating revenue and premium equivalents (4)	62.3%	57.4%	490 bp(2)	
Operating margin (5)	6.5%	9.6%	(310) bp(2)	

---

(1) Benefit expense ratio = Benefit expense / Premiums.
(2) bp = basis point; one hundred basis points = 1%.
(3) Administrative expense / Operating revenue.
(4) Administrative expense / Operating revenue and premium equivalents.
(5) Operating margin = Operating gain / Total operating revenue.

Premiums increased $6.0 million, or 6.6%, primarily due to higher group life sales that offset the sale of a small block of unprofitable non-core health business. Administrative fees decreased $6.5 million, or 30.8%, primarily due to loss of third party business at APM. Other revenue increased $8.0 million, or 6.1%, primarily due to growth in business with other Anthem companies.

Benefit expense decreased $2.3 million, or 3.0%, primarily due to the sale of the non-core block of group life and health business in California. The effect of this sale on the benefit expense ratio in 1999 was a reduction of 490 basis points. The benefit expense ratio fell an additional 280 basis points primarily due to a change in the funding arrangement with a major group in California. Until October 1998, we held the assets of this group's retirement funding account and utilized investment income from these assets to subsidize the group's life insurance premiums. In October 1998, the retirement funding account was returned to the group. Since investment income was no longer available to subsidize the life insurance premiums, the premiums paid by the group increased, resulting in a lower benefit expense ratio.

Administrative expense increased primarily at APM due to higher mail order volume, costs associated with switching third party claims processing vendors, as well as costs incurred in anticipation of adding the business of BCBS-NH and

BCBS-CO/NV.

Operating gain decreased $7.0 million, or 30.2%, primarily due to the loss of a large customer in 1999 and an increase in drug rebates shared with our Midwest region.

Other

The following table presents our Other segment's results of operations for the years ended December 31, 1999 and 1998:

	Year Ended December 31,			
	1999	1998	$ Change	% Change
	($ in Millions)			
Operating revenue and premium equivalents	$ 184.4	$186.1	$ (1.7)	(0.9)%
Premiums	$ 33.3	$ 27.6	$ 5.7	20.7%
Administrative fees	252.3	228.3	24.0	10.5%
Other revenue (expense)	(101.2)	(69.8)	(31.4)	45.0%
Total operating revenue	184.4	186.1	(1.7)	(0.9)%
Benefit expense	31.8	33.3	(1.5)	(4.5)%
Administrative expense	172.3	185.5	(13.2)	(7.1)%
Total operating expense	204.1	218.8	(14.7)	(6.7)%
Operating loss	$ (19.7)	$(32.7)	$ 13.0	NM(1)

(1) NM = Not meaningful.

Premiums increased $5.7 million, or 20.7%, primarily due to additional premiums from non-core business that was subsequently disposed of in 1999. The business that was sold generated $11.4 million of premiums in 1999 versus $2.2 million in 1998. Excluding this business, premiums decreased $3.5 million, or 13.8%, due to lower membership at Anthem Alliance Health Insurance Company, as more military personnel opted to use military primary care physicians instead of civilian primary care physicians. Administrative fees increased $24.0 million, or 10.5%, primarily due to increased business at AdminaStar Federal. Excluding intersegment other revenue of $104.3 million and $105.8 million in 1999 and 1998, respectively, other revenue decreased $32.9 million, or 91.4%, to $3.1 million in 1999 primarily due to the transfer of document management operations to our Midwest region at the beginning of 1999 and the sale of non-core businesses.

Benefit expense decreased $1.5 million, or 4.5%, primarily due to lower membership at Anthem Alliance Health Insurance Company as discussed above.

Excluding intersegment administrative expense of $112.1 million and $116.3 million in 1999 and 1998 respectively, administrative expense decreased $17.4 million, or 5.8%, primarily due to sale of non-core businesses during 1998, transfer of document management operations and lower unallocated corporate

expenses. Excluding the sale of non-core businesses, administrative expense decreased $1.1 million, or 0.4%, to $284.4 million in 1999.

Almost all of our operating loss reported in our Other segment relates to unallocated corporate expenses. In 1999, unallocated corporate expenses were $26.7 million versus $32.1 million in 1998, primarily due to higher employee benefit cost allocations in 1999.

Income Taxes

Statement of Financial Accounting Standards No. 109, "Accounting for Income Taxes," requires, among other things, the separate recognition, measured at currently enacted tax rates, of deferred tax assets and deferred tax liabilities for the tax effect of temporary differences between the financial reporting and tax reporting. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may not be realized. See Note 10 to the audited consolidated financial statements for additional information.

We believe we will be able to realize the benefit of the net deferred tax asset of $2.7 million as of June 30, 2001. This net deferred tax asset is comprised of a gross tax asset of $484.5 million, less a valuation allowance of $262.2 million and a deferred tax liability of $219.6 million. We believe that the allowance is sufficient and at each quarterly financial reporting date, we evaluate each of our gross deferred tax assets based on each of the five key elements that follow:

- the types of temporary differences making up our gross deferred tax asset;
- the anticipated reversal periods of those temporary differences;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the forecasted near term future taxable income; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

As an entity taxed under Internal Revenue Code Section 833, at June 30, 2001, we have tax temporary differences of approximately $206.6 million for net operating loss carry-forwards and alternative minimum tax credits. Due to uncertainty of the realization of these deferred tax assets, we have provided a valuation allowance included above of $188.1 million for these amounts. This amount is part of the total valuation allowance of $262.2 million at June 30, 2001.

Liquidity and Capital Resources

Anthem Cash Flow

Our cash collections consist primarily of premiums and administrative fees, investment income and proceeds from the sale or maturity of our investment securities. Cash disbursements result mainly from policyholder benefit payments, administrative expenses and taxes. We also use cash for purchases of investment securities, capital expenditures and acquisitions. Cash outflows can fluctuate because of uncertainties regarding the amount and timing of settlement of our liabilities for unpaid benefit claims and the timing of

payments of operating expenses. Our investment strategy is to make prudent investments, consistent with insurance statutes and other regulatory requirements, with the main objective of preserving our asset base. Management believes that cash flow from operations, together with the portfolio, will continue to provide sufficient liquidity to meet general operations needs, special needs arising from changes in financial position and changes in financial markets. We also maintain a bank line of credit and a commercial paper program to provide additional liquidity.

Six Months Ended June 30, 2001 and 2000

Net cash flow provided by operating activities was $261.1 million in 2001, as compared to $365.4 million in 2000. Net cash flow provided by operating activities decreased as the 2000 period included the initial results of improved balance sheet management in which we converted certain operating assets, such as receivables and investments in non-strategic assets, to cash. These activities contributed additional operating cash above levels in 2000. Also, in 2001, higher payments were made related to incentive compensation that had been accrued in previous years. These items

offset significant growth in the amount of net income, increased depreciation and amortization expense related to acquisitions. Net cash used in investing activities was $225.5 million in 2001 compared to cash used in investing activities of $320.9 million in 2000. The net cash received from the sale of our TRICARE business and other purchase price adjustments paid in respect of prior acquisitions in 2001 resulted in a decrease of approximately $105.5 million in cash used in investing activities as compared to 2000 when we purchased BCBS-ME.

There were no financing activities in the first six months of 2001. Net cash provided by financing activities was $75.3 million for 2000, which constituted the net proceeds received from the issuance of $295.3 million of surplus notes on a discounted basis less $220.0 million repayment of bank debt.

Twelve Months Ended December 31, 2000 and 1999

Net cash flow provided by operating activities was $684.5 million in 2000, as compared to $219.8 million in 1999. Significant growth occurred in the amount of net income, increased depreciation and amortization expense related to acquisitions, amortization of a new claims and administration system in our Midwest region and better balance sheet management. The 1999 period included non-recurring disbursements of $156.0 million related to payments for the settlement of charitable asset claims in the states of Ohio, Kentucky and Connecticut and the $41.9 million settlement with the OIG with respect to BCBS-CT. Additionally, during 2000, through improved balance sheet management, we converted certain operating assets, such as receivables and investments in non-strategic assets, to cash. These activities contributed $256.4 million of additional operating cash in 2000. Net cash used in investing activities was $761.1 million in 2000 compared to cash used in investing activities of $356.8 million in 1999. As a result of the increased operating cash flow discussed above and the increased cash from financing activities discussed below, we purchased significantly more investment securities in 2000 accounting for $596.8 million of the total increase in cash used in investing activities. Additionally, the net cash paid to acquire BCBS-ME and other purchase price adjustments paid in respect of prior acquisitions in 2000 resulted in a decrease of approximately $161.7 million in cash used for investing activities, as compared to 1999 when we purchased BCBS-NH and BCBS-CO/NV. Offsetting these increases was a decrease of $23.4 million in capital expenditures from the prior year. Capital expenditures decreased in 2000 primarily due to lower

capitalization of software costs related to the new Midwest claims and administration system and lower purchases of computer equipment.

Net cash provided by financing activities was $75.5 million for 2000, as compared to $220.1 million for 1999. The cash provided in 2000 was the net proceeds received from the issuance of $295.9 million of surplus notes on a discounted basis less $220.4 million repayment of bank debt.

Twelve Months Ended December 31, 1999 and 1998

Net cash provided by operating activities was $219.8 million in 1999 and $119.9 million in 1998, an increase of $99.9 million, or 83.3%. The 1999 period included non-recurring disbursements of $156.0 million relating to payments for the settlement of charitable asset claims in the states of Ohio, Connecticut and Kentucky and the $41.9 million settlement with the OIG with respect to BCBS-CT. After eliminating the effect of these one-time disbursements, the increase in 1999 operating cash flow from 1998 was $255.9 million. This increase was primarily attributable to improved operating cash flow resulted from a net increase in policy liabilities of $145.9 million. Additionally, during 1999 through balance sheet management, we converted certain operating assets such as receivables to cash. Finally, net cash used in discontinued operations declined between the two years as obligations related to the sales of these operations were nearing completion.

Net cash used in investing activities increased $248.0 million, to $356.8 million during 1999 from $108.8 million in 1998. Anthem acquired BCBS-NH and BCBS-CO/NV in the fourth quarter of 1999, which accounted for most of the increased usage. During 1999, we had fewer net investment purchases than in 1998, primarily due to the restructuring of the investment portfolio in 1998

described earlier. Net investment sales and purchases tend to fluctuate from year to year as other sources and uses of cash, such as financing or acquisitions, affect changes in the portfolio. Capital expenditures increased $7.5 million to $96.7 million primarily due to purchases of personal computers as part of our desktop standardization program.

Net cash provided by financing activities was $220.1 million in 1999, a $223.9 million increase from the $3.8 million cash used in financing activities during 1998. During 1999, we utilized our revolving credit lines to partially finance the acquisition of BCBS-NH and BCBS-CO/NV, while no such borrowings occurred in 1998.

Anthem, Inc.

Following this offering, the units offering and the effective date of the plan to convert from a mutual into a stock insurance company, Anthem Insurance will become a wholly owned subsidiary and the primary asset of Anthem, Inc. From the net proceeds of the offerings, it is estimated that $1,625.0 million will be paid to certain of Anthem Insurance's eligible statutory members in lieu of shares that would otherwise be issued to such members in the demutualization.

Our future liquidity needs may include acquisitions, operating expenses, capital contributions to our subsidiaries and dividend payments, and will include interest and contract fee payments on the units being offered in the units offering. On an ongoing basis, we will rely upon dividends from our subsidiary, Anthem Insurance, to meet liquidity needs. Although Anthem Insurance and its insurance subsidiaries are subject to capitalization requirements, as well as restrictions and limitations on the amounts of

dividends or distributions that can be made, we believe, based on historical results of Anthem Insurance and its subsidiaries, that we will have the liquidity needed.

The ability of our 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 or lesser (depending on state statute) of the prior year's statutory net income or 10% of statutory surplus. Dividends in excess of this amount are classified as extraordinary and require prior approval of the respective departments of insurance. Further, an insurance company may not pay a dividend unless, after such payment, its surplus to policyholders is reasonable in relation to its outstanding liabilities and adequate to meet its financial needs, as determined by the department of insurance. In connection with our acquisitions of BCBS-ME and BCBS-NH, further limitations were imposed on their ability to pay dividends. Until June 2005, BCBS-ME may not declare any dividend without the prior approval of the department of insurance of Maine. BCBS-NH may not pay any dividends for as long as the New Hampshire department of insurance permits BCBS-NH to continue to use certain accounting practices permitted prior to the acquisition. The maximum dividend payable by Anthem Insurance's licensed insurance company subsidiaries without prior approval in 2001 is $185.0 million. The dividends paid by such regulated subsidiaries in 2000 was $71.3 million. The amount of dividends that could be paid by Anthem Insurance to Anthem, Inc. in 2001, based upon the foregoing standards, is $190.7 million.

Anthem Insurance currently has a $300 million commercial paper program available for general corporate purposes. Commercial paper notes are short term in nature, with a maturity not to exceed 270 days from date of issuance. The notes bear interest at then available market rates. The commercial paper program is supported by the revolving credit agreement discussed below. Anthem Insurance had no commercial paper outstanding at June 30, 2001.

Anthem Insurance has a $300 million multi-year revolving credit agreement with a syndicate of banks. The facility is available for general corporate purposes and support of the commercial paper program. Borrowings under the credit facility bear interest at rates determined by reference to the banks' base rate or to the London Interbank Offered Rate, or LIBOR, plus a margin determined by reference to Anthem Insurance's then current claims paying ability ratings issued by certain specified rating agencies. The agreement requires payment of quarterly facility fees, again determined by the then current claims paying ability ratings of Anthem Insurance. The agreement contains certain

financial covenants, including limits on minimum net worth, maximum consolidated debt and maximum asset dispositions annually. We are currently in compliance with all such covenants. The facility matures on October 22, 2002. No borrowings were outstanding as of June 30, 2001.

Anthem Insurance intends to replace its current $300 million credit facility. Anthem Insurance has entered into a commitment letter with respect to senior unsecured revolving credit facilities in the aggregate principal amount of $750 million, which Anthem Insurance may request be increased to up to $1.0 billion in the event of oversubscription by the syndicate of banks. The commitment letter also provides that the facilities would consist of one 364-day facility and one five-year facility. Subject to final documentation and other conditions, we expect the new facilities to be in place shortly after the completion of this offering. Subject to the effectiveness of the demutualization, Anthem, Inc. will guarantee all obligations of Anthem Insurance under the facilities. Anthem, Inc. also will be permitted to be a

borrower under the facilities, if the Indiana Insurance Commissioner approves Anthem Insurance's guaranty of Anthem, Inc.'s obligations.

We will pay for the BCBS-KS acquisition with currently available funds. We plan to utilize our investment portfolio, current capacity of existing borrowing facilities, new bank borrowings, equity or debt offerings or operating cash flow to fund any future acquisitions. The source of financing would be determined at the time of any future transaction, based on market conditions at that time. Any proceeds from previously issued debt, not used for acquisitions, are currently invested as part of our investment portfolio. See Note 4 of our audited consolidated financial statements for information related to our investment portfolio.

Risk-Based Capital

Our subsidiaries' states of domicile have statutory risk-based capital or RBC requirements for health and other insurance companies based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers, taking into account the risk characteristics of an insurer's investments and products. The RBC Model Act sets forth the formula for calculating the RBC requirements which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under these laws, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, as of the end of the previous calendar year.

Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation.

Anthem's risk based capital as of June 30, 2001 continues to be substantially in excess of all mandatory RBC thresholds.

Quantitative and Qualitative Disclosure About Market Risk

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on Anthem's financial positions as of June 30, 2001. Actual results could vary significantly from these estimates.

Our primary objective is the preservation of the asset base and the maximization of total return given an acceptable level of risk. Our portfolio is exposed to three primary sources of risk: (1) interest rate risk, (2) credit risk, and (3) market valuation risk for equity holdings. As of June 30, 2001, the fair value of fixed income securities and equity securities represented approximately 88% and 12% of the securities available for sale, respectively. Since June 30, 2001, we have increased the percentage of fixed income securities to approximately 95% and decreased equity securities to approximately 5% of the securities available for sale.

The primary risks associated with our fixed maturity securities are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit downgrade to an individual fixed income security and the potential loss attributable to that downgrade. We manage this risk through our investment

policy, which establishes credit quality limitations on the overall portfolio as well as dollar limits for individual issuers. Since we are advised immediately of circumstances surrounding credit rating downgrades, we are able to promptly avoid or minimize exposure to losses by selling the subject security. The result is a well-diversified portfolio of fixed income securities, with an average credit rating of approximately double-A. Interest rate risk is defined as the potential for economic losses on fixed-rate securities, due to an adverse change in market interest rates. Our fixed maturity portfolio consists exclusively of U.S. dollar-denominated assets, invested primarily in U.S. government securities, corporate bonds, asset-backed bonds and mortgage-related securities, all of which represent an exposure to changes in the level of market interest rates. We manage interest rate risk by maintaining a duration commensurate with our insurance liabilities and policyholders' surplus. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value. Further, we do not engage in the use of derivatives to manage interest rate risk, as they are prohibited in our investment policy.

Our portfolio consists of corporate securities (approximately 34% of the total fixed income portfolio) which are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed income portfolio. This risk is managed externally by our money managers--through fundamental credit analysis, diversification of issuers and industries, and an average credit rating of the corporate fixed income portfolio of approximately double-A.

The equity portfolio is exposed to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation and consumer confidence. These systematic risks cannot be managed through diversification. However, unsystematic risks, such as stock/industry specific risks, are managed by investing in index mutual funds that replicate the risk and performance of the S&P 500 and S&P 400 indices (78% and 22% respectively), resulting in a diversified equity portfolio.

All of our investments are classified as available-for-sale. As of June 30, 2001, approximately 88% of these were fixed maturity securities. Market risk is addressed by actively managing the duration, allocation and diversification of the investment portfolio. We have evaluated the impact on the fixed income portfolio's fair value considering a 100 basis point change in interest rates over the next twelve-month period. A 100 basis point increase in interest rates would result in an approximate $166.8 million decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $164.9 million increase in fair value. This analysis includes the assumption that the 100 basis point change occurs evenly throughout the 12-month period. The analysis also assumes investment income earned is reinvested into the portfolio thus mitigating the effects of change in fair value. As of June 30, 2001, no portion of our fixed income portfolio was invested in non-US dollar denominated investments.

We also maintain a diverse portfolio of large capitalization equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of $43.9 million. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of $43.9 million. No portion of our equity portfolio was invested in non-US dollar denominated investments as of June 30, 2001. As of June 30, 2001, we held no derivative financial or commodity-based instruments.

During the six months ended June 30, 2001, $28.9 million of unrealized investment losses were charged to income as equity securities declines in value

were determined to be other than temporary.

RECENT DEVELOPMENTS

Pending Acquisition of Blue Cross and Blue Shield of Kansas

General

On May 30, 2001, we signed a definitive agreement with Blue Cross and Blue Shield of Kansas, Inc., or BCBS-KS, pursuant to which we have agreed to acquire BCBS-KS, which will become a wholly owned subsidiary of ours.

Under the proposed transaction, BCBS-KS will convert from a mutual insurance company to a stock insurance company through a process known as a sponsored demutualization. Under the agreement, BCBS-KS policyholders eligible to receive consideration in its demutualization will be entitled to receive $190.0 million, which we will pay in cash to the escrow described below at the closing of the transaction and which amount thereafter may be reduced as described below. However, we and BCBS-KS may agree to place less than the full $190.0 million in the escrow account, in which case the portion of the $190.0 million not placed in escrow will be distributed directly to eligible BCBS-KS policyholders. The amount placed in the escrow account will be held in escrow pending the resolution of a matter involving a subpoena dated February 28, 2001, received by BCBS-KS from the OIG. The subpoena seeks documents related to an investigation of possible improper claims against Medicare. The amount held in escrow will be used to pay costs, expenses and liabilities related to the OIG investigation, and to pay costs and expenses of the escrow, with any remaining amount to be distributed to eligible BCBS-KS members following final resolution of the matter. In addition, at or prior to the closing, BCBS-KS will declare a special distribution payable after the closing to its eligible policyholders in an amount equal to the excess of BCBS-KS' consolidated closing book value over $155.0 million.

The transaction is expected to close in early 2002, subject to the approval of BCBS-KS policyholders, the approval of the BCBSA, the approval of the Kansas Department of Insurance and other regulatory approvals. Once the transaction is completed, we will market our health benefits products in Kansas under the Anthem Blue Cross and Blue Shield name. The acquisition will be accounted for as a purchase and the net assets and results of operations will be included in our consolidated financial statements from the purchase date.

Policyholders of BCBS-KS will not become statutory members of Anthem Insurance and will not be eligible to receive any consideration as a result of Anthem Insurance's demutualization.

BCBS-KS

BCBS-KS is the largest health insurer in Kansas. BCBS-KS provides insurance coverage or self-insured administration services to more than 715,000 individuals in all Kansas counties except Johnson and Wyandotte, two counties near Kansas City. BCBS-KS also administers Medicare and Medicaid government programs.

BCBS-KS offers a wide range of health benefit products including traditional indemnity products and HMO, POS and PPO managed care products. BCBS-KS also offers claims administration and stop-loss coverage for employer self-funded plans, as well as underwriting, actuarial services, provider network access, and medical cost management. Additionally, BCBS-KS offers several specialty insurance products, including group life, disability, dental and long-term

care.

BCBS-KS provides its products to a diverse customer base, including non-group, small group, large group national accounts, federal employees and government programs. BCBS-KS markets its products primarily through its captive sales force and contracts with independent agents and brokers on only a limited basis.

BCBS-KS has various subsidiaries, including a majority-owned HMO operated in partnership with two hospitals and a majority-owned company licensed to sell life insurance in 38 states.

For the year ended December 31, 2000, BCBS-KS had revenue of $1,026.0 million and net income of $5.8 million and, at December 31, 2000, assets of $730.8 million and surplus of $328.5 million.

Escrow of Funds; Certain Liabilities

Pursuant to the definitive agreement, we will place the $190.0 million purchase price (or a lesser amount, if so agreed upon by us and BCBS-KS) in an escrow account, to be held pending resolution of all matters relating to the subpoena received from the OIG seeking documents related to an investigation of possible improper claims against Medicare. The amount held in escrow will be used to pay fees and costs attributable to the OIG investigation, certain related tax costs and other related costs, expenses and liabilities of the escrow. Any amounts remaining in the escrow account, including any interest on the escrow funds, following the final resolution of the matter and the payment of such costs, expenses and liabilities will be distributed to eligible BCBS-KS policyholders. However, if the amount that we have placed in escrow is not enough to cover the costs, expenses and liabilities relating to the OIG investigation and the escrow, then those remaining costs, expenses and liabilities would reduce the value of BCBS-KS.

Disposition of TRICARE Operations

Under a contract between our subsidiary, Anthem Alliance Health Insurance Company, or Alliance, and the United States Department of Defense, Alliance managed and administered the TRICARE Managed Care Support Program for military families from May 1, 1998 through May 31, 2001. TRICARE administration is outside of our focus on core Blue Cross and Blue Shield health benefits business and on those specialty businesses that enable us to offer a broad line of products to health plan customers. Accordingly, a decision was made to sell the TRICARE operations.

On April 18, 2001, along with Alliance, we entered into an Agreement and Plan of Merger to sell the TRICARE operations of Alliance to a subsidiary of Humana, Inc. for $45.0 million. The transaction, which closed on May 31, 2001, resulted in a gain on sale of subsidiary operations of $25.0 million, net of selling expenses.

Nine Months Financial Information

	Nine Months Ended September 30,	
	2001	2000

	($ in Millions)	
Operating revenue and premium equivalents (1)	$10,428.6	$8,666.8
Total operating revenue	$ 7,525.9	$6,225.9
Benefit expense	5,847.6	4,831.3
Administrative expense	1,465.9	1,274.7
Operating gain	212.4	119.9
Net investment income	170.4	147.2
Net realized gains on investments (2)	86.2	13.1
Interest and amortization expense	65.6	59.4
Demutualization expenses	16.6	--
Income before income taxes and minority interest	386.8	220.8
Income taxes	133.2	66.3
Minority interest (credit)	(0.9)	0.7
Net income	$ 254.5	$ 153.8
Adjusted net income (3)	$ 215.0	$ 145.3
Membership (000s)	7,834	7,136

(1) Operating revenue and premium equivalents is a measure of the volume of business serviced by Anthem that is commonly used in the health benefits industry to allow for a comparison of operating efficiency among companies. It is calculated by adding to premiums, administrative fees and other revenue the amount of claims attributable to non-Medicare, self-funded health business where Anthem provides a complete array of customer service, claims administration and billing and enrollment services.
(2) Includes gain on sale of subsidiary operations (TRICARE) of $25.0 million in 2001.
(3) Excludes net realized gains on investments and demutualization expenses, less tax expense of $30.1 million and $4.6 million, in 2001 and 2000, respectively.

Net income increased 65.5% to $254.5 million for the first nine months of 2001 compared with net income of $153.8 million for the first nine months of 2000. Net income excluding net realized gains on investments and demutualization expenses was $215.0 million for the first nine months of 2001, a 48.0% increase compared with $145.3 million for the first nine months of 2000. Earnings improved in 2001 compared with 2000 primarily due to increased membership, improved underwriting performance and administrative expense management.

Medical membership reached 7.8 million at September 30, 2001, a 9.9% increase compared with September 30, 2000. Operating revenue increased 20.9% to $7.5 billion for the first nine months of 2001. The increase was primarily due to increased membership, premium rate increases and the acquisition of BCBS-ME during the second quarter of 2000.

The benefit expense ratio was 85.2% for the first nine months of 2001, a 50 basis point improvement compared with the first nine months of 2000. The change was primarily due to improved underwriting results which more than offset the impact of approximately $21.0 million of net adjustments to benefit expense recorded during the third quarter of 2001. Excluding these adjustments, the

benefit expense ratio would have improved 80 basis points over the comparable 2000 period. These adjustments were principally to strengthen reserves in the Midwest and East regions during the third quarter of 2001. The benefit expense ratio in our Midwest and East regions increased for the three months ended September 30, 2001, compared to the three months ended June 30, 2001, by 80 basis points and 20 basis points, respectively, including the effect of these adjustments. The benefit expense ratio would have improved sequentially and year over year in each of the regions without these adjustments. At September 30, 2001, days in claims payable totaled 63.5 days as compared to 62.8 days at June 30, 2001.

The administrative expense ratio, calculated using operating revenue and premium equivalents, was 14.1% for the first nine months of 2001, a 60 basis point improvement compared with the first nine months of 2000, and was related mostly to cost containment efforts and the 20.9% increase in operating revenue.

Net realized capital gains, excluding the gain on sale of subsidiary operations, for the nine months ended September 30, 2001 were $61.2 million compared with net realized capital gains of $13.1 million for the nine months ended September 30, 2000. Included in net realized capital gains in 2001 was $65.2 million of gains resulting from restructuring the equity portfolio into fixed maturity securities and equity index funds during the third quarter.

Net investment income increased 15.8%, to $170.4 million, in the first nine months of 2001, primarily due to growth in the investment portfolio. Income before taxes and minority interest increased 75.2%, to $386.8 million, in the first nine months of 2001, primarily due to improved operating results and higher net realized capital gains.

All adjustments, including normal recurring adjustments, necessary for a fair presentation of the financial information for the nine months ended September 30, 2001 and 2000, have been recorded.

THE BUSINESS OF ANTHEM

General Business Description

We are one of the nation's largest health benefits companies, serving over seven million members, or customers, primarily in Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. We hold the leading market position in seven of these eight states and own the exclusive right to market our products and services using the Blue Cross Blue Shield, or BCBS, names and marks in all eight states under license agreements with the Blue Cross Blue Shield Association, or BCBSA, an association of independent BCBS plans. We seek to be a leader in our industry by offering a broad selection of flexible and competitively priced health benefits products.

Our product portfolio includes a diversified mix of managed care products, including HMO, PPO, and POS plans, as well as traditional indemnity products. We also offer a broad range of administrative and managed care services and partially insured products for employer self-funded plans. These services and products include underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, claims processing and other administrative services. In addition, we offer our customers several specialty products including group life, disability, prescription management, workers compensation, dental and vision. Our products allow our customers to choose from a wide array of funding alternatives. For our insured products, we charge a premium and assume all or a majority of the health care risk. Under our self-

funded and partially insured products, we charge a fee for services, and the employer or plan sponsor reimburses us for all or a majority of the health care costs. Of our 2000 operating revenue, 90.6% was derived from fully insured products, while 9.4% was derived from administrative services and other revenues.

Our customer base primarily includes large groups (contracts with 51 or more eligible employees), individuals and small groups (one to 50 employees), each of which accounted for 36.8%, 19.0% and 17.0% of our 2000 operating revenue, respectively. Other major customer categories include National accounts, Medicare recipients, federal employees and other federally funded programs. We principally market our products through an extensive network of independent agents and brokers who are compensated on a commission basis for new sales and retention of existing business.

Our managed care plans and products are designed to encourage providers and members to select quality, cost-effective health care by utilizing the full range of our innovative medical management services, quality initiatives and financial incentives. Our leading market shares enable us to realize the long-term benefits of investing in preventive and early detection programs. We further improve our ability to provide cost-effective health benefits products and services through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. These measures have allowed us to achieve significant growth in membership (78%), revenue (68%), and net income (135%) from 1996 through 2000.

We intend to continue to expand through a combination of organic growth and strategic acquisitions in both existing and new markets. Our growth strategy is designed to enable us to take advantage of the additional economies of scale provided by increased overall membership. In addition, we believe geographic diversity reduces our exposure to local or regional economic, regulatory and competitive pressures and provides us with increased opportunities for expansion. While the majority of our growth has been the result of strategic mergers and acquisitions, we have also achieved growth in our existing markets by providing excellent service, offering competitively priced products and effectively capturing the brand strength of the Blue Cross and Blue Shield names and marks.

Industry Overview

The health benefits industry has experienced significant change in recent years. The increasing focus on health care costs by employers, the government and consumers has led to the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans, incorporating features of each, are among the various forms of managed care products that have developed in recent years. Through these types of products, the cost of health care is contained by negotiating contracts with hospitals, physicians and other providers to deliver health care at favorable rates. These products also can feature medical management and other quality and cost containment measures such as pre-admission review and approval for non-emergency hospital services, pre-authorization of outpatient surgical procedures, and network credentialing to determine that network doctors and hospitals have the required certifications and expertise. In addition, providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. HMO, PPO and POS enrollees generally are charged periodic, pre-paid premiums, and pay co-payments or deductibles when they receive services. PPO and POS plans allow out-of-network usage, typically at higher out-of-pocket costs to members. HMO members generally select one of the network's primary care physicians who then assumes responsibility for

coordinating their health care services. Typically, there is no out-of-network benefit for HMO members. PPOs and other open access plans generally allow members to select non-network providers without coordination through a primary care physician, but at a higher out-of-pocket cost. Hybrid plans, such as POS plans, typically involve the selection of primary care physicians similar to HMOs, but allow members to self refer or to choose non-network providers at higher out-of-pocket costs similar to those of PPOs.

Recently, economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger, more extensive networks, more member choice related to coverage and the ability to self refer within those networks. There is also a growing preference for greater flexibility to assume larger deductibles and co-payments in exchange for lower premiums. We believe we are well positioned in each of our regions to respond to these market preferences. Our PPO products, which contain most or all of the features noted above, have experienced significant growth over the past few years.

The Blue Cross Blue Shield Association, or BCBSA, has also undergone significant change in recent years. Historically, most states had at least one Blue Cross (hospital coverage) and a separate Blue Shield (physician coverage) company. Prior to the mid 1980s there were more than 125 separate Blue Cross or Blue Shield companies. Many of these organizations have merged, reducing the number of independent licensees to under 50 as of December 2000. We expect this trend to continue, with plans merging or affiliating to address capital needs and other competitive pressures.

Each of the BCBS plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large multi-state employer groups. As a result of this cooperation, each plan is able to take advantage of other member plans' substantial provider networks and discounts when any member from one state works or travels outside of the state in which the policy is written. We receive a substantial and growing source of revenue under this "BlueCard" program for providing member services in our states for individuals who are customers of other BCBS plans.

Our Strategy

Our strategic objective is to be among the best and biggest in our industry with the size and scale to deliver the best product value with the best people.

To achieve these goals, we offer a broad selection of flexible and competitively priced products and seek to establish leading market positions. We believe that increased scale in each of our regional markets will provide us competitive advantages, cost efficiencies and greater opportunities to sustain profitable growth. The key to our ability to deliver this growth is our commitment to work with providers to optimize the cost and quality of care while improving the health of our members and improving the quality of our service.

Promote Quality Care

We believe that our ability to help our members receive quality, cost-effective health care will be key to our success. We promote the health of our members through education and through products that cover prevention and early detection programs that help our members and their providers manage illness before higher cost intervention is required. To help develop those programs, we collaborate with the providers in our networks to promote improved quality of care for our members. The following policies and programs are key to improving

the quality of care that our members receive:

- Selection and continued assessment of provider networks: We select for our networks providers who meet and maintain our standards of medical education, training and professional experience.

- Disease management: We develop disease management programs that educate members on actions they can take to help monitor and better control their illnesses and to manage diseases such as diabetes, asthma and congestive heart failure.

- Prevention measures: We work with providers and members to promote preventive measures such as childhood and adult immunizations, as well as breast cancer screening.

- Education: We help our members prevent disease and illness or minimize their impact by promoting lifestyle modification through education. For example, our nationally recognized smoking cessation program in Maine has helped to reduce the number of our members in Maine who smoke by 49% over four years.

- Technology: We also utilize technology to evaluate the medical care provided to our customers. For example, our Anthem Prescription Management decision support system helps to identify potentially harmful drug interactions and helps prevent members from receiving potentially dangerous combinations of drugs.

Product Value

We aim to create products that offer value to our customers. By offering a wide spectrum of products supported by broad provider networks, we seek to meet the differing needs of our various customers. The breadth and flexibility of our benefit plan options, coupled with quality care initiatives, are designed to appeal to a broad base of employer groups and individuals with differing product and service preferences. We use innovative product design, such as a three-tiered prescription program that provides customer selection among generic, brand and formulary drugs at various out-of-pocket costs. Innovative product design helps us to contain costs, which allows our products to be competitively priced in the market.

Formulary drugs are prescription drugs that have been reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and cost effectiveness. Use of medications from the formulary, which includes hundreds of brand name and generic medications, is encouraged through pharmacy benefit design. A three-tier pharmacy benefit and the use of formulary drugs allow members access to highly useful prescription medications, while also helping to control the cost of pharmacy benefits to employers. Members have the same access to medications but share a greater

portion of the cost for brand name drugs through the co-payment structure. Under a three-tier program, the customer pays the lowest price for generic drugs, a higher price for formulary brand name drugs and the highest price for brand name drugs not included in the formulary.

Operational Excellence

To provide cost-effective products, we continuously strive to improve operational efficiency. We actively benchmark our performance against other leading health benefits companies to identify opportunities to drive continuous

performance improvement. Important performance measures we use include operating margin, administrative expense ratio, administrative expense PMPM and return on equity. Current initiatives to drive operational efficiency include:

- consolidating and eliminating information systems;
- standardizing operations and processes;
- implementing e-business strategies; and
- integrating acquired businesses.

Technology

We continuously review opportunities to improve our interactions with customers, brokers and providers. By utilizing technologies, we seek to make the interactions as simple, efficient and productive as possible. We monitor ourselves using industry standard customer service metrics, which measure, among other things, call center efficiency, claims paying accuracy and speed of enrollment. We ease the administrative burden of enrolling new accounts, processing claims and updating records for our brokers and providers by automating many of these processes. We also collect information that enables us to further improve customer service, product design and underwriting decisions.

Growth

We believe that profitable growth, both organic and through acquisitions, is an important part of our business. Increased scale allows us to increase customer convenience and improve operating margins, while keeping our products competitively priced. Expansion into new geographic markets enables us to reduce exposure to economic cycles and regulatory changes and provides options for business expansion. We plan to generate earnings growth first by increasing revenues through new enrollment, while maintaining pricing discipline. In addition, we plan to increase the penetration of specialty products to existing health members through cross selling and expansion into non-Anthem markets. These specialty products include prescription management, vision, dental, group life and disability insurance. While enjoying a leading market share in seven of our eight markets, we have a market share ranging from 16% to 40% and believe there is remaining opportunity to grow profitably in each market. We also intend to make strategic acquisitions to augment our internal growth.

Our History

We were formed in 1944 under the name of Mutual Hospital Insurance, Inc., commonly known as Blue Cross of Indiana. In 1946, Mutual Medical Insurance Inc., also known as Blue Shield of Indiana, was incorporated as an Indiana mutual insurance company. In 1985, these two companies merged under the name Associated Insurance Companies, Inc. In 1993, Southeastern Mutual Insurance Company, a Kentucky-domiciled mutual insurance company doing business as Blue Cross and Blue Shield of Kentucky, was merged into us. In 1995, Community Mutual Insurance Company, an Ohio-domiciled mutual insurance company doing business as Community Mutual Blue Cross and Blue Shield, was merged into us. We changed our name to Anthem Insurance Companies, Inc. in

1996. In 1997, Blue Cross & Blue Shield of Connecticut, Inc., a Connecticut-domiciled mutual insurance company, was merged into Anthem Insurance. We completed our purchases of New Hampshire-Vermont Health Service, which did business as Blue Cross and Blue Shield of New Hampshire, and Rocky Mountain Hospital and Medical Service, which did business as Blue Cross and Blue Shield

of Colorado and Nevada, during 1999. In 2000, we completed our purchase of Associated Hospital Service of Maine, which did business as Blue Cross and Blue Shield of Maine.

Mergers and Acquisitions

Much of our recent growth in membership has resulted from strategic mergers and acquisitions, primarily with other Blue Cross and Blue Shield licensees. These combinations, coupled with growth in existing markets, have enabled us to establish multi-regional centers of focus with a significant share of each region's health benefits market. The following table sets forth our membership by state as of the dates indicated:

MEMBERSHIP

	At June 30,	At December 31,				
	2001	2000	1999	1998	1997	1996
	(In Thousands)					
Midwest						
Ohio	2,198	2,118	1,987	2,096	1,990	1,868
Indiana	1,532	1,410	1,358	1,175	1,226	1,151
Kentucky	1,096	1,054	1,037	928	1,129	1,059
Subtotal	4,826	4,582	4,382	4,199	4,345	4,078
East						
Connecticut	1,194	1,127	1,031	968	916	--
New Hampshire	526	479	366	--	--	--
Maine	496	487	--	--	--	--
Subtotal	2,216	2,093	1,397	968	916	--
West						
Colorado	581	463	395	--	--	--
Nevada	156	132	91	--	--	--
Subtotal	737	595	486	--	--	--
Total	7,779	7,270	6,265	5,167	5,261	4,078
Percentage increase (decrease) from previous year end	7%	16%	21%	(2)%	29%	--

During the last three years, we have completed the following acquisitions:

- On June 5, 2000, we purchased substantially all of the assets and liabilities of BCBS-ME. The cash purchase price was $95.4 million (including direct costs of acquisition).

- On November 16, 1999, we purchased the stock of BCBS-CO/NV. The cash purchase price was $160.7 million (including direct costs of acquisition).

- On October 27, 1999, we purchased the assets and liabilities of BCBS-NH. The cash purchase price was $125.4 million (including direct costs of acquisition).

In addition, we have signed a definitive agreement pursuant to which we have agreed to acquire BCBS-KS. See "Recent Developments--Pending Acquisition of Blue Cross and Blue Shield of Kansas."

When integrating new operations, we focus on improving customer service, underwriting, medical management and administrative operations. We improve operations by centralizing certain management and support functions, sharing best practices and consolidating information systems. We also improve underwriting practices by establishing discipline in our data analysis and product design.

The following table illustrates the success we have had in improving the operating performance of BCBS-CT, BCBS-NH and BCBS-CO/NV. The table includes operating gain (loss) of the year prior to the merger or acquisition, the year of the merger or acquisition and the year or years following the merger or acquisition:

		Operating Gain(1)				
	Date of Acquisition	2000	1999	1998	1997	1996
			(In Millions)			
BCBS-CT	August 1997	$86.6	$ 41.3(2)	$ (5.6)	$(15.6)	$(1.7)
BCBS-NH	October 1999	$11.6	$ 1.3	$(21.6)	--	--
BCBS-CO/NV	November 1999	$ 6.5	$(30.2)	$(62.2)	--	--

---

(1) Operating gain consists of operating revenue minus benefit expense and administrative expense. Results are shown on a stand alone basis including the year prior to affiliating with Anthem.

(2) Excludes one time $41.9 million expense related to settlement of claims pertaining to pre-merger operations. See "Legal and Regulatory Matters--Other Contingencies."

Core Health Benefits Products and Services

We offer a diversified mix of managed care products, including HMO, PPO and POS plans, as well as traditional indemnity products. Our managed care products incorporate a broad range of options and financial incentives for both members and participating providers, including co-payments and provider risk pools. We also offer a broad range of administrative and managed care services and partially insured products for employer self-funded plans. These services and products include underwriting, stop loss insurance, actuarial services, network access, medical cost management, claims processing and other administrative services. We charge a premium for insured plans and typically assume all or a majority of the health care risk. For self-funded or partially-insured products, we charge a fee for services while the employer assumes all or a majority of the risks. The fee is based upon the customer's selection from our portfolio of services. We also provide specialty products including group life, disability, prescription management, dental and vision care. Our principal health products, offered both on an insured and employer-funded basis, are described below. Some managed care and medical cost containment features may be included in each of these products, such as inpatient pre-certification, benefits for preventive services and reimbursement at reasonable and customary charges with no additional billing to members.

Preferred Provider Organization, or PPO. PPO products offer the member an option to select any health care provider, with benefits paid at a higher level when care is received from a participating network provider. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing limited by out-of-pocket maximums.

Traditional Indemnity. Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing limited by out-of-pocket maximums.

Health Maintenance Organization, or HMO. HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers.

A member in one of our HMOs must typically select a primary care physician, or PCP, from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care. Preventive care services are emphasized in these plans. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service, or POS. POS products blend the characteristics of HMO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expense (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

BlueCard Plan. BCBS plans across the United States share their local provider networks in a unique arrangement, where one plan's enrolled members travel or live in another plan's service area. The local or "host" plan is paid an administrative fee by the "home" or selling plan in exchange for providing claims and member services to home plan customers in the host plan's service area. All claims are reimbursed by the home plan, which may have an insured or self-funded relationship with the member's employer under any of the product designs discussed above. BlueCard membership is calculated based on the amount of BlueCard administrative fees we receive from the BlueCard members' home plans. Generally, the administrative fees we receive are based on the number and type of claims processed and a portion of the network discount on those claims. The administrative fees are then divided by an assumed PMPM factor in order to calculate the number of members. The assumed PMPM factor is based on an estimate of Anthem's experience and BCBSA guidelines.

The following table sets forth our health benefits membership data by product:

	At June 30,	At December 31,		
	2001	2000	1999	1998
		(In Thousands)		
PPO	3,072	2,835	2,540	2,322
Traditional Indemnity	1,137	1,155	1,048	1,075

HMO	1,203	1,147	980	697
POS	757	813	723	543
Directly Contracted Membership	6,169	5,950	5,291	4,637
BlueCard (Anthem Host)	1,610	1,320	974	530
Total	7,779	7,270	6,265	5,167

Specialty Products and Services

Prescription Management Services. We provide pharmacy network management, pharmacy benefits and mail order prescription services through our subsidiary, Anthem Prescription Management, or APM, our pharmacy benefit manager. APM administers its programs primarily to customers who are also Anthem health plan members. Anthem Rx, our retail pharmacy network, provides members access to more than 53,000 chain and independent pharmacies across the United States, and Anthem Rx Direct, our mail service pharmacy, provides long-term therapy medications through convenient home delivery.

Group Life and Disability. We offer an array of competitive group life insurance and disability benefit products to both large and small group customers. We have over $27.7 billion of life insurance in force, insuring over 31,000 groups with more than 800,000 employees. Our traditional group insurance products include term life, accidental death and dismemberment, short-term disability income and long-term disability income. In addition, we offer voluntary group life and disability products through employers which payroll-deduct premiums from their participating employees.

Vision and Dental Care Programs. These programs are primarily for customers enrolled in our Blue Cross and Blue Shield health plans. Vision and dental products available include both fully insured and self-insured products. In addition, we provide dental third-party administration services through Health Management Systems, Inc., our wholly owned subsidiary.

Other Products and Services

In addition to the above-described products and services, we provide services as a fiscal intermediary for the Medicare Part A and Part B program in certain states.

Marketing

We market our managed care and specialty products through three regional business units. Our health plans are generally marketed under the Blue Cross and Blue Shield brand, except for certain government programs. We organize our marketing efforts by customer segment and by region in order to maximize our ability to meet the specific needs of our customers. Marketing programs are developed by a cross-functional team including the actuarial, underwriting, sales, operations and finance departments to evaluate risk and pricing and to ensure adherence to established underwriting guidelines. We believe our reputation, financial stability, high quality customer service and exclusive BCBS license provide us with competitive advantages and allow us to gain share in our markets. We strive to develop solutions for our customers. Our keys to success include developing long-term relationships and providing stable pricing of our products. Most contracts are for one year, although we occasionally enter into multi-year arrangements.

We maintain the quality of our sales staff and independent brokers through regularly held training seminars and advisory groups, which familiarize them with evolving consumer preferences, as well as our products and current marketing strategies. In addition, we structure sales commissions to provide incentives to our sales staff and brokers to promote the full value of our products.

Each region is responsible for enrolling, underwriting and servicing its respective businesses. We pursue product standardization where practical to gain efficiencies resulting from the simplification of the marketing and sales process.

Customers

In each region, we balance the need to customize products with the efficiencies of product standardization. Overall, we seek to establish pricing and product designs to achieve an appropriate level of profitability for each of our customer categories. Our customers include several distinguishable categories:

- Large groups, defined as contracts with 51 or more eligible employees (but excluding "National business", described below), accounted for 38.9% of our operating revenue and 35.8% of our members as of and for the six months ended June 30, 2001. These groups are generally sold through brokers or consultants working with industry specialists from our in-house sales force. Large group cases are usually experience rated or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability and our ability to effectively service large complex accounts.

- Small groups, defined as contracts with one to 50 employees, accounted for 17.4% of our operating revenue and 10.4% of our members as of and for the six months ended June 30, 2001. These groups are sold exclusively through independent agents and brokers. Small group cases are sold on a fully insured basis. Underwriting and pricing is done on a community rated basis, with individual state insurance departments approving the rates. See "Legal and Regulatory Matters--Small Group Reform." Small group customers are generally

more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Account turnover is generally higher with small groups.

- Individual policies (under age 65) accounted for 4.9% of our operating revenue and 3.6% of our members as of and for the six months ended June 30, 2001. These policies are generally sold through independent agents and brokers. In some cases an in-house telemarketing unit is used to generate leads. This business is usually medically underwritten at the point of initial issuance. Rates are filed with and approved by state insurance departments. In several of our markets, there is much less competition for individual business than group contracts.

- Medicare Supplement business accounted for 6.8% of our operating revenue and 5.1% of our members as of and for the six months ended June 30, 2001. These standardized policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. New policyholders come from independent agents or brokers or through the

conversion of existing member groups or individual policies when they retire and reach age 65.

- The Federal Employee Program accounted for 10.1% of our operating revenue and 5.5% of our members as of and for the six months ended June 30, 2001. As a BCBSA licensee, we participate in a nationwide contract with the Federal government whereby we cover Federal employees and their dependents in our eight-state service area. Under a complex formula, we are reimbursed for our costs plus a fee. We also participate in the overall medical risk on a pooled basis with the other participating BCBS plans.

- Medicare + Choice accounted for 6.0% of our operating revenue and 1.3% of our members as of and for the six months ended June 30, 2001. This program is the managed care alternative to the federally funded Medicare program. Most of the premium is paid directly by the Federal government on behalf of the participant who may also be charged a small premium. Medicare+Choice is marketed in the same manner as Medicare Supplement products.

- National business (including BlueCard) accounted for 5.1% of our operating revenue, but 37.0% of our members as of and for the six months ended June 30, 2001, because much of our National business is self-insured. These groups are generally sold through brokers or consultants working with our in-house sales force. We have a significant competitive advantage when competing for very large National accounts due to our ability to access the national network of BCBS plans and take advantage of their provider discounts in their local markets.

The following chart shows our membership by customer segment:

MEMBERSHIP

	At June 30,	At December 31,		
Customer Segment	2001	2000	1999	1998
	(In Thousands)			
Large group	2,786	2,634	2,249	1,852
Small group	807	775	637	559
Individual (under age 65)	281	260	215	159
Medicare Supplement (age 65 and over)	393	390	371	319
Federal Employee Program	426	407	362	268
Medicare + Choice	101	106	96	81
National	2,877	2,468	2,106	1,696
Other (TRICARE and Medicaid)	108	230	229	233
Total	7,779	7,270	6,265	5,167

The Blue Cross Blue Shield License

We have the exclusive right to use the Blue Cross and Blue Shield names and marks for all of our health benefits products in Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. We believe that the

BCBS names and marks are valuable identifiers of our products and services in the marketplace. The license agreements, which have a perpetual term, contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks. Upon termination of the license agreements, we would cease to have the right to use the BCBS names and marks in one or more of Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada, and the BCBSA could thereafter issue a license to use the BCBS names and marks in these states to another entity. Events that could cause the termination of a license agreement with the BCBSA include:

- failure to comply with minimum capital requirements imposed by the BCBSA;
- impending financial insolvency;
- the appointment of a trustee or receiver;
- a change of control or violation of the BCBSA ownership limitations on our capital stock; and
- the commencement of any action against Anthem Insurance seeking its dissolution.

Pursuant to the rules and license standards of the BCBSA, we have certified to the BCBSA that we guarantee the contractual and financial obligations to respective customers of our subsidiaries that hold controlled affiliate licenses from the BCBSA. Those subsidiaries are Anthem Health Plans of Kentucky, Inc., Anthem Life Insurance Company, Anthem Health Plans, Inc., Community Insurance Company, Anthem Health Plans of New Hampshire, Inc., Rocky Mountain Hospital and Medical Service, Inc., Anthem Health Plans of Maine, Inc., HMO Colorado, Inc., Matthew Thornton Health Plan, Inc., Maine Partners Health Plan, Inc. and Health Management Systems, Inc.

In addition, pursuant to the rules and license standards of the BCBSA, we have agreed to indemnify BCBSA against any claims asserted against it resulting from the contractual and financial obligations of AdminaStar Federal, our subsidiary which serves as a fiscal intermediary providing administrative services for Medicare Part A and B.

Each license requires an annual fee to be paid to the Blue Cross Blue Shield Association. The fee is based upon enrollment and premium. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the Blue Cross and Blue Shield names and marks, as well as provide certain coordination among the member plans. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the Blue Cross and Blue Shield names and marks outside of our eight core states.

The BCBSA license agreements and membership standards specifically permit a licensee to operate as a for-profit, publicly traded stock company. We have obtained the consent of the BCBSA in order to continue our licenses following our conversion to a publicly traded stock company.

BCBS-KS is a licensee of the BCBSA. We will need to obtain the consent of the BCBSA to continue that license following our acquisition of BCBS-KS.

Information Systems

Information systems have played and will continue to play a key role in our ongoing efforts to continuously improve quality, lower costs and increase benefit flexibility for our customers. Our analytical technologies are designed

to support increasingly sophisticated methods of managing

costs and monitoring quality of care, and we believe that our information systems are sufficient to meet current needs and future expansion plans.

We use a combination of custom developed and licensed systems throughout our regions. An overall systems architecture is maintained to promote consistency of data and reduce duplicative platforms. This architecture assumes single separate core systems supporting each of our operating regions with centralized systems for key company-wide functions such as financial services, human resources and servicing National accounts. Focus is placed on identifying and eliminating redundant or obsolete applications with an emphasis on increasing our capability to operate in an Internet-enabled environment. Regional administration systems serving unique products and markets feed data to a combination of regional and corporate decision support systems. These systems provide sources of information for all of our data reporting and analysis needs.

Our architecture calls for significant standardization of software, hardware and networking products. Enhancements are undertaken based on a defined information systems plan. This plan, which is developed collaboratively by our technical and operating leadership, is revalidated regularly and maps out business-driven technology requirements for the upcoming three-to-five year period.

We recognize consumer demand will cause an increasing need for more of our business to be conducted electronically. Toward that end we have developed several Internet-enabled initiatives focused on improving interactions with our customers, members, providers, brokers and associates. We also are improving communication and data collection through compliance with the provisions of the Federal Health Insurance Portability and Accountability Act or HIPAA. See "Legal and Regulatory Matters--Regulation of Insurance Company and HMO Business Activities."

We are also engaged in a series of pilot programs that will result in web-enabled services such as on-line membership enrollment and on-line price quoting for brokers. Brokers will also receive on-line quoting capabilities for life, dental and vision related products. For our members, we will have on-line access to health information using carefully chosen content providers for consumer health information. All of our members currently have on-line access to physician and hospital network directories for their specific health plan.

Collaborations

In addition to internal efforts to leverage technology, we are actively involved as investors and leaders in several collaborative technology initiatives. As an example, we are one of seven major national health benefits companies that are initial investors in MedUnite, Inc., an e-business company. MedUnite is designing Internet-based technology that will permit real-time transactions between providers and insurance companies. MedUnite's solutions will address claims filing, eligibility determination and specialist referrals. These programs will make these transactions more convenient for members while improving efficiencies among doctors, hospitals and health insurers. Additionally, we are a founding member of the Coalition for Affordable Healthcare. This group, formed by 24 of the nation's largest health benefits companies and associations, develops programs to improve access to quality health care coverage and to simplify plan administration.

Pricing and Underwriting

We price our products based on our assessment of underwriting risk and competitive factors. We continually review our underwriting and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our marketing strategies and profitability goals.

We have focused our efforts to maintain consistent, competitive and strict underwriting standards. Our individual and group underwriting targets have been based on our proprietary accumulated actuarial data. Subject to applicable legal constraints, we have traditionally employed case specific underwriting procedures for small group products and traditional group underwriting procedures with respect to large group products. Also, we employ credit underwriting procedures with respect to our self-funded products.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process. A fixed premium rate is determined at the beginning of the policy period. Unanticipated increases in medical costs may not be able to be recovered in that current policy year. However, prior experience, in the aggregate, is considered in determining premium rates for future periods.

For larger groups (over 300 lives) with PPO, POS or traditional benefit designs, we often employ retrospective rating reviews. In retrospective rating, a premium rate is determined at the beginning of the policy period. Once the policy period has ended, the actual experience is reviewed. If the experience is positive (i.e., actual claim costs and other expenses are less than those expected), then a refund may be credited to the policy. If the experience is negative, then the resulting deficit may either be recovered through contractual provisions or the deficit may be considered in setting future premium levels for the group. If a customer elects to terminate coverage, deficits generally are not recovered.

We have contracts with CMS to provide HMO Medicare+Choice coverage to Medicare beneficiaries who choose health care coverage through one of our HMO programs. Under these annual contracts, CMS pays us a set rate based on membership that is adjusted for demographic factors. These rates are subject to annual unilateral revision by CMS. In addition to premiums received from CMS, most of the Medicare products offered by us require a supplemental premium to be paid by the member.

See "Legal and Regulatory Matters--Small Group Reform" for a discussion of certain regulatory restrictions on our underwriting and pricing.

Reserves

We establish and report liabilities or reserves on our balance sheet for unpaid health care costs by estimating the ultimate cost of incurred claims that have not yet been reported to us by members or providers and reported claims that we have not yet paid. Since these reserves represent our estimates, the process requires a degree of judgment. Reserves are established according to Actuarial Standards of Practice and generally accepted actuarial principles and are based on a number of factors. These factors include experience derived from historical claims payments and actuarial assumptions to arrive at loss development factors. Such assumptions and other factors include healthcare cost trends, the incidence of incurred claims, the extent to which all claims have been reported and internal claims processing charges. Due to the variability inherent in these estimates, reserves are sensitive to changes in medical claims payment patterns and changes in medical cost trends. A worsening (or improvement) of the medical cost trend or changes in claims payment patterns

from the trends and patterns assumed in estimating reserves would trigger a change. See Note 8 to our audited consolidated financial statements for quantitative information on our reserves, including a progression of reserve balances for each of the last three years.

Medical Management

Our medical management programs include a broad array of activities that are intended to improve the quality and cost-effectiveness of care provided to our members. One of the goals of these benefit features is to assure that the care delivered to our members is supported by appropriate medical and scientific evidence.

Precertification. A traditional medical management program that we use involves assessment of the appropriateness of certain hospitalizations and other medical services. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition.

Concurrent review. Another traditional medical management strategy we use is concurrent review, which is based on nationally recognized criteria developed for the industry. With concurrent review, the requirements and intensity of services during a patient's hospital stay are reviewed, often by an onsite skilled nurse professional in coordination with the hospital's medical and nursing staff.

Disease management. More and more, health plans, including ours, are moving away from traditional medical management approaches to more sophisticated models built around disease management and advanced care management. These programs focus on those members who require the greatest amount of medical services. We provide important information to our providers and members to help them optimally manage the care of their specific conditions. For example, certain therapies and interventions for patients with diabetes help prevent some of the serious, long-term medical consequences of diabetes and reduce the risks of kidney, eye and heart disease. Our information systems can provide feedback to our physicians to enable them to improve the quality of care. For other prevalent medical conditions such as heart disease or asthma, our ability to correlate pharmacy data and medical management data allows us to provide important information to our members and providers which enables them to more effectively manage these conditions.

Formulary management. APM develops a formulary, a selection of drugs based on clinical quality and effectiveness, which is used across all of our regions. A pharmacy and therapeutics committee consisting of 20 physicians, 16 of whom are academic and community physicians practicing in our markets, make pharmacy medical decisions about the clinical quality and efficacy of drugs. In the last two years, pharmacy costs have increased by 15% to 18% nationally. We have, through our focused activities in this area, been able to perform better than the national trend by 3% to 5%. Our three-tiered co-pay strategy enables members to have access to all drugs that are not covered on formulary for an additional co-pay. This has been our primary tool to contain pharmacy costs.

Medical policy. A medical policy group comprised of physician leaders from all Anthem regions, working in close cooperation with national organizations such as the Centers for Disease Control, the American Cancer Society and community physician leaders, determines Anthem's national policy for best approaches to the application of new technologies.

Patient outcomes. A significant amount of health care expenditures are used

by a small percent of our members who suffer from complex or chronic illnesses. We have developed a series of programs aimed at helping our providers better manage and improve the health of these members. Often, these programs provide benefits for home care services and other support to reduce the need for repeated, expensive hospitalizations. Increasingly, we are providing information to our hospital networks to enable them to improve medical and surgical care and outcomes to our members. We endorse, encourage and incentivize hospitals to support national initiatives to improve patient outcomes and reduce medication errors. We have been recognized as a national leader in developing hospital quality programs.

External Review Procedures (Patients' Bill of Rights). In light of increasing public concerns about health plans denying coverage of medical services, we work with outside experts through a process of external review to help provide our members with timely medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes to be settled by independent expert physicians.

Service management. In HMO and POS networks, primary care physicians serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have greater access to network physicians without a primary care physician serving as the coordinator of care.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements and outcomes of care. A key to our success has been our ability to work with our network providers to improve the quality and outcomes of the health care services provided to our members. Our ability to provide high quality service has been recognized by the National Committee on Quality Assurance, or NCQA, the largest and most respected national accreditation program for managed care health plans. All of our HMO plans in the East region hold the highest NCQA rating. Our HMO plan for Colorado has received a three-year accreditation. In our Midwest region, health plans in Ohio and Kentucky held NCQA accreditation into 1999. We decided not to seek re-accreditation in 1999 for our Midwest plans, but rather focused on consolidating provider networks, products and systems. We will again seek NCQA accreditation for our Midwest HMO and POS health plans in 2001.

A range of quality health care measures have been adopted by the Health Plan Employer Data and Information Set, or HEDIS, which has been incorporated into the oversight certification by NCQA. These HEDIS measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for heart patients. While our results on specific measures have varied over time, we are seeing continuous improvement overall in our HEDIS measurements, and a number of our state plans are among the best performers in the nation with respect to certain HEDIS standards.

In addition, we have initiated a broad array of quality programs, including those built around smoking cessation and transplant management, and an array of other programs specifically tailored to local markets. Many of these programs have been developed in conjunction with organizations such as the Arthritis Foundation and regional diabetes associations.

Provider Arrangements

Our relationships with health care providers, physicians, hospitals and those professionals that provide ancillary health care services are guided by regional and national standards for network development, reimbursement and contract methodologies.

In contrast to some health benefits companies, it is generally our philosophy not to delegate full financial responsibility to our providers in the form of capitation-based reimbursement. While capitation can be a useful method to lower costs and reduce underwriting risk, we have observed that, in general, providers do not positively accept the burden of maintaining the necessary financial reserves to meet the risks related to capitation contracts.

We attempt to provide fair, market-based hospital reimbursement along industry standards. We also seek to ensure physicians in our network are paid in a timely manner at appropriate rates. We use multi-year contracting strategies, including case or fixed rates, to limit trend exposure and increase cost predictability. In all regions, we seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members.

Depending on the consolidation and integration of physician groups and hospitals, reimbursement strategies vary substantially across markets. Fee for service is our predominant reimbursement methodology for physicians. We generally use a resource-based relative value system fee schedule to determine fee for service reimbursement. This structure was developed and

is maintained by CMS and is used by the Medicare system and other major payers. This system is independent of submitted fees and therefore is not as vulnerable to inflation. In addition, physician incentive contracting is used to reward physician quality and performance.

Like our physician contracts, our hospital contracts provide for a variety of reimbursement arrangements depending on the network. Our hospital contracts recognize the size of the facility and the volume of care performed for our members. Many hospitals are reimbursed on a fixed allowance per day for covered services (per diem) or a case rate basis similar to Medicare (Diagnosis Related Groups). Other hospitals are reimbursed on a discount from approved charge basis for covered services. Hospital outpatient services are reimbursed based on fixed case rates, fee schedules or percent of charges. To improve predictability of expected cost, we frequently use a multi-year contracting approach which provides stability in our competitive position versus other health benefit plans in the market.

We believe our market share enables us to negotiate favorable provider reimbursement rates. In some markets, we have a "modified favored rate" provision in our hospital and ancillary contracts that guarantees contracted rates at least as favorable as those given to our competitors with an equal or smaller volume of business.

Behavioral Health and Other Provider Arrangements

We have a series of contracts with third party behavioral health networks and care managers who organize and provide for a continuum of behavioral health services focusing on access to appropriate providers and settings for behavioral health care. These contracts are generally multi-year capitation based arrangements. Substance abuse and alcohol dependency treatment programs are an integral part of these behavioral health programs.

In addition, a number of other ancillary service providers, including

laboratory service providers, home health agency providers and intermediate and long term care providers, are contracted on a region-by-region basis to provide access to a wide range of services. These providers are normally paid on either a fee schedule, fixed-per-day or per case basis.

Competition

The managed care industry is highly competitive, both nationally and in our regional markets. Competition has intensified in recent years due to more aggressive marketing and pricing, a proliferation of new products and increased quality awareness and price sensitivity among customers. Significant consolidation within the industry has also added to competition. In addition, with the 1999 enactment of the Gramm-Leach-Bliley Act, banks and other financial institutions have the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health benefits fields.

Industry participants compete for customers mainly on the following factors:

- price;
- quality of service;
- access to provider networks;
- flexibility of benefit designs;
- reputation (including NCQA accreditation status);
- brand recognition; and
- financial stability.

We believe our exclusive right to market products under the Blue Cross Blue Shield brand in our markets provides us with an advantage over our competition. In addition, our strong market share and existing provider networks in both our Midwest and East regions enable us to achieve cost-efficiencies and service levels that allow us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. In our West region, the marketplace is highly fragmented with no single player having a dominant market share. There, as in all regions, we strive to distinguish our products through excellent service, product value and brand recognition.

Competitors in our markets include local and regional managed care plans, and national health benefits companies. In our Midwest region, our largest competitors include UnitedHealthcare, Humana Inc., Aetna U.S. Healthcare and Medical Mutual of Ohio. In our East region, our main competitors are Aetna U.S. Healthcare, Health Net, Inc., CIGNA HealthCare, ConnectiCare, Inc. and Harvard Pilgrim Health Care. In our West region, our principal competitors include Sierra Health Services, Inc., PacifiCare Health Systems, Inc., UnitedHealthcare, Kaiser Permanente, Aetna U.S. Healthcare and Hometown Health Plan, Inc. To build our provider networks, we also compete with other health benefits plans for contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the "non-hassle" factor or reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan. At the distribution level, we compete for qualified agents and brokers to distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to

secure new business and maintain existing accounts. The basis of competition for the services of such agents and brokers are:

- commission structure;
- support services;
- reputation and prior relationships; and
- quality of the products.

We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to our competitors in all of our regions.

Employees

As of June 30, 2001, we had approximately 14,800 full-time equivalent employees primarily located in Cincinnati and Columbus, Ohio; Indianapolis, Indiana; Louisville, Kentucky; North Haven, Connecticut; Denver, Colorado; Portland, Maine; and Manchester, New Hampshire. Employees were also located in various other cities within our regions, as well as in Illinois, Nevada and New York. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationships with our employees are good. No employees are subject to collective bargaining agreements.

Properties

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this property, our principal operating facilities are located in Denver, Colorado; North Haven, Connecticut; Indianapolis, Indiana; Cincinnati, Ohio; Columbus, Ohio; Manchester, New Hampshire; and Portland, Maine. In total, we own approximately 15 facilities and lease approximately 65 facilities, totaling 4.6 million square feet in 19 states. Many of the facilities are connected to our government businesses, which extend well beyond our eight core states. We believe that our properties are adequate and suitable for our business as presently conducted.

Regulation

We are subject to extensive regulation and supervision by authorities of each state in which we operate. We are also subject to regulation by federal and local agencies. The extent of state regulation varies, but most jurisdictions have laws and regulations requiring the licensing of insurers and HMOs and their agents and standards of solvency and business conduct for insurance companies and HMOs. State laws may also regulate withdrawal from certain markets. In addition, statutes and regulations usually require the approval of policy forms and, for certain products, the approval of premium rates. The statutes and regulations also prescribe types and concentration of investments. We are required to file detailed annual financial statements with supervisory agencies in each of the jurisdictions in which we do business. Our operations and accounts are also subject to examination by those agencies at regular intervals. We are also subject to federal and state laws and regulations affecting the conduct of our business. In addition, assessments are levied against us as a result of our mandatory participation in funds that guarantee the viability of insurance companies which assume risk in each of our states. For more information, see "Legal and Regulatory Matters--Regulation of Insurance Company and HMO Business Activities."

INVESTMENTS

Our investment objective is to preserve our asset base and to achieve rates of return which are consistent with our defined risk parameters, mix of products, liabilities and surplus. Our portfolio is structured to provide sufficient liquidity to meet general operating needs, special needs arising from changes in our financial position and changes in the financial market. In accordance with these objectives, our investment policy authorizes investments in U.S. dollar-denominated fixed income securities and publicly traded equity securities, both domestic and international, or mutual funds whose focus is investing in such securities.

As of June 30, 2001 and December 31, 2000, our cash and investment portfolio was comprised of the following (at fair value):

	June 30, 2001	Percent of Total	December 31, 2000	Percent of Total
	($ in Millions)			
Cash and cash equivalents	$ 238.9	5.9%	$ 203.3	5.5%
Fixed maturity securities:				
United States Government securities	729.7	18.1	746.5	20.1
Obligations of states and political subdivisions	3.8	0.1	0.8	--
Corporate securities	1,140.6	28.3	1,040.7	28.0
Mortgaged-backed securities	1,477.2	36.7	1,258.4	33.9
Preferred stocks	--	--	1.8	--
Total fixed maturity securities	3,351.3	83.2	3,048.2	82.0
Equity securities	439.4	10.9	463.1	12.5
Total cash and investments	$4,029.6	100.0%	$3,714.6	100.0%

Our fixed maturity and equity securities are subject to the risk of potential losses from adverse market conditions. To manage the potential for economic losses, we regularly evaluate certain risks, as well as the appropriateness of the investments, to be certain the portfolio is managed within its risk guidelines. The result is a portfolio that is well diversified, both across and within asset classes. Our primary risk exposures are (1) changes in market interest rates, (2) credit quality and (3) changes in equity prices.

Interest Rate Risk

Interest rate risk is defined as the potential for economic losses on fixed-rate securities, due to an adverse change in market interest rates. Our fixed maturity portfolio consists exclusively of U.S. dollar-denominated assets, invested primarily in U.S. government securities, corporate bonds, asset-backed bonds and mortgage-related securities, all of which represent an exposure to changes in the level of market interest rates. We manage interest rate risk by maintaining a duration commensurate with our insurance liabilities and policyholders' surplus. Further, we do not engage in the use of derivatives to manage interest rate risk, as they are prohibited in our investment policy. We

believe that a hypothetical increase in interest rates of 100 basis points would result in an estimated decrease in the fair value of the fixed income portfolio of $166.8 million.

Credit Quality Risk

Credit quality risk is defined as the risk of a credit downgrade to an individual fixed income security and the potential loss attributable to that downgrade. We manage this risk through our investment policy, which establishes credit quality limitations on the overall portfolio as well as dollar limits for individual issuers. The result is a well-diversified portfolio of fixed income securities, with an average credit rating of approximately double-A.

Equity Price Risk

Equity price risk for stocks is defined as the potential for economic losses due to an adverse change in equity prices. Equity risk exposure is managed through our investment in indexed mutual funds. Specifically, we are invested in S&P 500 and S&P 400 index mutual funds, resulting in a well- diversified and liquid portfolio that replicates the risk and performance of the broad U.S. stock market. We estimate our equity price risk from a hypothetical 10% decline in the S&P 500 and 400 indices and the relative effect of that decline in the value of our portfolio to be a decrease in fair value of $43.9 million.

Fixed Maturity Securities

Our fixed income strategy is to employ external money managers who will construct and manage a high quality, diversified portfolio of securities. External money managers are selected based on consistent performance and experience in insurance asset management. Additionally, our investment policy establishes minimum quality and diversification requirements resulting in an average credit rating of approximately double-A. The duration of our portfolio is 4.6 years as of December 31, 2000, and is managed to within +/- 20% of the Lehman Aggregate Bond Index.

Fixed Maturity Securities Quality Distribution

The following chart shows the quality distribution of our fixed maturity securities portfolio as of June 30, 2001 and December 31, 2000 (at fair value):

Credit quality(1)	June 30, 2001	Percent of Total	December 31, 2000	Percent of Total
	($ in Millions)			
Aaa	$2,399.3	71.6%	$2,267.9	74.4%
Aa	86.5	2.6	72.4	2.4
A	481.5	14.4	391.6	12.8
Baa	338.6	10.1	245.9	8.1
Ba	45.4	1.4	70.4	2.3
Total fixed maturity securities	$3,351.3	100.0%	$3,048.2	100.0%

(1) Ratings are primarily assigned by Standard & Poor's Corporation and Moody's

Investor Service.

Corporate fixed maturity securities consist primarily of investment grade bonds (securities rated triple-B or higher). Further, our investment policy prohibits investing in below double-B rated credit securities. Our corporate securities portfolio is diversified by industry and issuer, with no significant exposure to any single corporation. At June 30, 2001, our 10 largest investments in corporate securities totaled $166.9 million, or 5.0% of total fixed maturity securities.

Corporate Fixed Maturity Securities Sector Distribution

The following chart shows the sector distribution of our corporate fixed maturity securities portfolio as of June 30, 2001 and December 31, 2000 (at fair value):

	June 30, 2001	Percent of Total	December 31, 2000	Percent of Total
	($ in Millions)			
Industrial	$ 726.0	63.7%	$ 375.9	36.1%
Finance	198.0	17.4	350.8	33.7
Utility	33.1	2.9	78.5	7.6
Asset-backed securities	160.1	14.0	218.4	21.0
Other	23.4	2.1	17.1	1.6
Total fixed maturity corporate securities	$1,140.6	100.0%	$1,040.7	100.0%

Mortgage-backed securities represent 44.1% of the fixed maturity securities portfolio. A majority of this amount is agency-issued pass-through certificates and collateralized mortgage obligation securities, issued by the Federal National Mortgage Association, Federal Home Loan Mortgage Corporation and Government National Mortgage Association.

Fixed mortgage-backed securities, as of June 30, 2001 and December 31, 2000, was comprised of the following (at fair value):

	June 30, 2001	Percent of Total	December 31, 2000	Percent of Total
	($ in Millions)			
Mortgage pass through certificates	$1,092.1	73.9%	$ 911.1	72.4%
Collateralized mortgage obligations	284.8	19.3	260.9	20.7
Commercial mortgage-backed securities	100.3	6.8	86.4	6.9
Total mortgage-related securities	$1,477.2	100.0%	$1,258.4	100.0%

Equity Securities

On June 30, 2001, our equity portfolio contained readily marketable domestic investment securities that were indexed to the S&P 500 and S&P 400 by an external money manager. Specifically, $342.3 million, or 77.9% of the total equity allocation was invested to mirror the S&P 500 Index, and $97.1 million, or 22.1%, to mirror the S&P 400 Index, excluding in each case tobacco stocks. On August 10, 2001, we reduced our total equity exposure, resulting in the sale of $235.1 million of equity securities. The proceeds of that transaction were invested in fixed maturity securities.

Additionally, subsequent to that transaction, we sold the remaining equity securities in the portfolio and purchased S&P 500 and S&P 400 index mutual funds, thus eliminating direct ownership of common stocks.

Overall Investment Return

The table below shows the overall return of the fixed maturity and equity security portfolios for the six months ended June 30, 2001 and years ended December 31, 2000, 1999 and 1998. The overall return includes gross investment income earned, net realized gains or losses incurred, and the change in unrealized gains or losses on these securities.

	Fixed Maturity Securities	Equity Securities	Total
	($ in Millions)		
June 30, 2001			
Gross investment income	$ 104.7	$ 3.3	$ 108.0
Net realized gains/(losses)	11.4	(22.3)	(10.9)
Change in unrealized gains/(losses)	1.3	(0.3)	(1.0)
Total	$ 117.4	$(19.3)	$ 98.1
December 31, 2000			
Gross investment income	$ 178.8	$ 6.1	$ 184.9
Net realized gains/(losses)	(17.5)	43.4	25.9
Change in unrealized gains/(losses)	128.4	(71.2)	57.2
Total	$ 289.7	$(21.7)	$ 268.0
December 31, 1999			
Gross investment income	$ 137.0	$ 6.3	$ 143.3
Net realized gains/(losses)	(13.8)	51.3	37.5
Change in unrealized gains/(losses)	(145.0)	8.3	(136.7)
Total	$ (21.8)	$ 65.9	$ 44.1
December 31, 1998			
Gross investment income	$ 121.1	$ 7.4	$ 128.5
Net realized gains	33.9	122.0	155.9
Change in unrealized gains	10.9	18.8	29.7
Total	$ 165.9	$148.2	$ 314.1

FINANCIAL STRENGTH RATINGS

Financial strength ratings are the opinions of the rating agencies regarding the financial ability of an insurance company to meet its obligations to its policyholders. Ratings provide both industry participants and insurance consumers with meaningful information on specific insurance companies and have become an increasingly important factor in establishing the competitive position of insurance companies. Rating agencies continually review the financial performance and condition of insurers and higher ratings generally indicate financial stability and a strong ability to pay claims. The current financial strength ratings of Anthem Insurance and its consolidated subsidiaries are as follows:

Rating Agency	Financial Strength Rating	Rating Description
AM Best Company, Inc. ("Best")	A- ("Excellent")	Second highest of nine ratings categories and second highest within the category based on modifiers (i.e., A and A- are "Excellent")
Standard & Poor's Rating Services ("S&P")	A ("Strong")	Third highest of nine ratings categories and mid-range within the category based on modifiers (i.e., A+, A and A- are "Strong")
Moody's Investor Service, Inc. ("Moody's")	A3 ("Good")	Third highest of nine ratings categories and lowest within the category based on modifiers (i.e., A1, A2 and A3 are "Good")
Fitch, Inc. ("Fitch")	A+ ("Strong")	Third highest of eight ratings categories and highest within the category based on modifiers (i.e., A+, A and A- are "Strong")

These financial strength ratings reflect each rating agency's opinion as to our financial strength, operating performance and ability to meet our claim obligations to our policyholders, not shareholders. In January 2001, S&P reaffirmed our A rating and revised its outlook to positive. In April 2001, Fitch reaffirmed our A+ rating, and revised its outlook to positive. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. We believe our strong ratings are an important factor in marketing our products to our customers, since ratings information is broadly disseminated and generally used throughout the industry. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders, and are not evaluations directed toward the protection of investors in our common stock, the units or the debentures and should not be relied upon when making a decision to purchase shares of the

common stock offered hereby or the units being offered concurrently herewith.

LEGAL AND REGULATORY MATTERS

General

Our operations are subject to comprehensive and detailed state and federal regulation throughout the United States in the jurisdictions in which we do business. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of our products and services;
- monitor our solvency and reserve adequacy; and
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activities

The federal government as well as the governments of the states in which we conduct our operations have adopted laws and regulations that govern our business activities in various ways. These laws and regulations may restrict how we conduct our businesses and may result in additional burdens and costs to us. Areas of governmental regulation include:

- licensure;
- premium rates;
- benefits;
- service areas;
- market conduct;
- utilization review activities;
- prompt payment of claims;
- member rights and responsibilities;
- sales and marketing activities;
- quality assurance procedures;
- plan design and disclosures;
- disclosure of medical information;
- eligibility requirements;
- provider rates of payment;

- surcharges on provider payments;
- provider contract forms;
- underwriting and pricing;
- financial arrangements;
- financial condition (including reserves); and
- corporate governance.

These laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any state where we do not presently operate, we generally would have to obtain such a certificate. The time necessary to obtain such a certificate varies from state to state. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal.

There has been a recent trend of increased health care regulation at the federal and state levels. Legislation, regulation and initiatives relating to this trend include, among other things, the following:

- eliminating or reducing the scope of ERISA pre-emption of state medical and bad faith claims under state law, thereby exposing health benefits companies to expanded liability for punitive and other extra-contractual damages;
- extending malpractice and other liability for medical and other decisions from providers to health plans;
- imposing liability for negligent denials or delays in coverage;
- requiring
  - coverage of experimental procedures and drugs,
  - direct access to specialists for patients with chronic conditions,
  - direct access to specialists (including OB/GYNs) and chiropractors,
  - expanded consumer disclosures and notices and expanded coverage for emergency services,
  - liberalized definitions of medical necessity,
  - liberalized internal and external grievance and appeal procedures (including expedited decision making),
  - maternity and other lengths of hospital inpatient stay, and
  - point-of-service benefits for HMO plans;
- prohibiting

  - so-called "gag" and similar clauses in physician agreements,
  - incentives based on utilization, and
  - limitation of arrangements designed to manage medical costs such as capitated arrangements with providers or provider financial incentives;
- regulating and restricting the use of utilization management and review;
- regulating and monitoring the composition of provider networks, such as "any willing provider" and pharmacy laws (which generally provide that providers and pharmacies cannot be denied participation in a managed care plan where the providers and pharmacies are willing to abide by the terms and conditions of that plan);
- imposing
  - payment levels for out-of-network care, and
  - requirements to apply lifetime limits to mental health benefits with parity;
- exempting physicians from the antitrust laws that prohibit price fixing, group boycotts and other horizontal restraints on competition;
- restricting the use of health plan claims information;

- regulating procedures that protect the confidentiality of health and financial information;
- imposing third-party review of denials of benefits (including denials based on a lack of medical necessity); and
- restricting or eliminating the use of formularies for prescription drugs.

On August 8, 2001, the House of Representatives passed a version of the Patients' Bill of Rights legislation (an amended version of the Ganske-Dingell bill) which would permit health plans to be sued in state court for coverage determinations. The current administration has indicated a willingness to pass some form of patient protection legislation which could adversely affect the health benefits business, and, in fact, the bill adopted by the House was the result of a compromise reached by President Bush and Representative Charles Norwood (R-GA). Under the bill a claim would be permitted for a wrongful coverage denial which is the proximate cause of personal injury to, or the death of, a patient. Medically reviewable claims against health insurers would be tried in state court but under federal law. Patients would be required to exhaust external review before filing suit. Patients who lose an external review decision would have to overcome a rebuttable presumption that the insurer made the correct decision. The bill caps non-economic damages at $1.5 million. Punitive damages would be available only if insurers do not follow an external review decision and would be capped at an additional $1.5 million. The bill also limits class action lawsuits (both future suits and pending suits where a class has not yet been certified) against health insurers under both ERISA and the Racketeer Influenced and Corrupt Organizations Act to group health plans established by a single plan sponsor.

The Senate version of the Patients' Bill of Rights legislation (the McCain-Edwards bill) was passed on June 29, 2001 and contains broader liability provisions than the House bill. The Senate bill would permit patients to sue health plans in state court over medical judgments or in federal court over contractual issues, and it would not cap damages in state courts. In federal court, punitive damages would be allowed, up to $5 million, and there would be no limit on economic and non-economic damages. President Bush has stated that he will veto any Patients' Bill of Rights legislation that contains liability provisions similar to the Senate bill. The House and Senate versions of the bill are expected to be reconciled in the Conference Committee. We cannot predict the provisions of the Patients' Bill of Rights legislation that may emerge from the Conference Committee, if any, and whether any Patients' Bill of Rights legislation would be enacted into law. We also cannot predict what impact any Patients' Bill of Rights legislation would have on our business, financial condition and results of operations.

The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation or regulation.

Small Group Reform

All of the principal states in which Anthem does business have enacted statutes that limit the flexibility of Anthem and other health insurers relative to their small group underwriting and rating practices. Commonly referred to as "small group reform" statutes, these laws are generally consistent with model laws originally adopted by the NAIC.

In 1991, the NAIC adopted the Small Group Health Insurance Availability Model Act. This model law limits the differentials in rates carriers could charge between new business and health insurance renewal business, and with respect to small groups with similar demographic characteristics (commonly referred to as a "rating law"). It also requires that insurers disclose to customers the basis on which the insurer establishes new business and renewal rates, restricts the applicability of pre-existing condition exclusions and prohibits an insurer from terminating coverage of an employer

group because of the adverse claims experience of that group. The model law requires that all small group insurers accept for coverage any employer group applying for a basic and standard plan of benefits (commonly known as a "guarantee issue law"), and provides for a voluntary reinsurance mechanism to spread the risk of high risk employees among all small group carriers participating in the reinsurance mechanism. Representatives of Anthem actively participated in the committees of the NAIC, which drafted and proposed this model law. NAIC model laws are not applicable to the industry until adopted by individual states, and there is significant variation in the degree to which states adopt and/or alter NAIC model laws. Some, if not all, of these rating and underwriting limitations are present in small group reform statutes currently adopted in all of the principal states in which Anthem does business.

Underwriting Limitations

In the past, insurance companies were free to select and reject risks based on a number of factors, including the medical condition of the person seeking to become insured. Small group health insurers were free to accept some employees and reject other employees for coverage within one employer group. An insurance company was also free to exclude from coverage medical conditions

existing within a group which the insurance company believed represented an unacceptable risk level. Also, for the most part, insurance companies were free to cancel coverage of a group due to the medical conditions which were present in that group. Additionally, a new employee seeking medical coverage under an existing group plan could be either accepted or rejected for coverage, or could have coverage excluded or delayed for existing medical conditions.

The small group health insurance reform laws limit or abolish a number of these commonly utilized practices to address a societal need to extend availability of insurance coverage more broadly to those who were previously not eligible for coverage. Reform laws have been adopted which at a minimum generally require that a group either be accepted or rejected for coverage as one unit. The law in all of the states in which Anthem does business now prohibits the practice of terminating the coverage of an employer group based on the medical conditions existing within that group. (Insurers may still cancel business for a limited number of reasons.) These states also generally require "portability" of coverage, which means that an insurer cannot exclude coverage for a pre-existing condition of a new employee of an existing employer group if that person had previously satisfied a pre-existing condition limitation period with the prior insurer, and if that person maintained continuous coverage. Most state small group reform statutes also prohibit insurers from denying coverage to employer groups based upon industry classification.

All states in which Anthem does business require the "guarantee issue" of small group policies, either through specific state law or the states' requirement to enforce HIPAA. These laws require an insurer to issue coverage to any group that applies for coverage under any of the small group policies marketed by the insurer in that state, regardless of the medical risks presented by that group.

Rating Limitations

Prior to the adoption of state rate reform laws, there was very limited regulation of the rating practices utilized in the small group health insurance market. There was virtually no regulation of the amount by which one group's rate could vary from that of a demographically similar group with different claims experience, and there was no statutorily placed limit on the extent and frequency of rate increases that could be applied to any one employer group.

Over the last nine years, all of the principal states in which Anthem does business have enacted rating laws. These laws are designed to reduce the variation in rates charged to insured groups who have favorable and unfavorable claims experience. They also limit the extent and frequency of rate

increases. They do not, however, establish an appropriate base or "manual" rate level for an insurer. The most stringent rate reform regulation would be a pure community rating requirement, pursuant to which all persons in a geographic region would receive the same rate for the same coverage as any other person, without consideration of demographic factors such as age, gender, geographic location, medical risk or occupation. Most existing rating laws also impose a limit on the extent and frequency of a group's rate increases.

Small Group Statutory Reinsurance Mechanisms

At this time, the Connecticut, New Hampshire and Nevada (HMO only) Anthem plans are subject to involuntary assessments from state small group reinsurance mechanisms. These mechanisms are designed to provide risk-spreading mechanisms for insurers doing business in jurisdictions that mandate that health insurance

be issued on a guarantee issue basis. Guarantee issue requirements increase underwriting risk for insurers by forcing them to accept higher-risk business than they would normally accept. This reinsurance mechanism allows the insurer to cede this high-risk business to the reinsurance facility, thus sharing the underwriting experience with all insurers in the state. Each of Connecticut and New Hampshire subject insurance companies doing business in that jurisdiction to assessments to fund losses from the reinsurance mechanisms. Each of Indiana, Ohio and Nevada provide voluntary reinsurance mechanisms in which the assessment is against only those carriers electing to participate in the reinsurance mechanism. Anthem has elected not to participate in these voluntary reinsurance mechanisms. Neither Kentucky nor Maine has a small group reinsurance mechanism.

Recent Medicare Changes

In 1997, the federal government passed legislation related to Medicare that changed the method for determining premiums that the government pays to HMOs for Medicare members. In general, the new method has reduced the premiums payable to us compared to the old method, although the level and extent of the reductions varies by geographic market and depends on other factors. The legislation also requires us to pay a "user fee." The changes began to be phased in on January 1, 1998 and will continue over five years. The federal government also announced in 1999 that it planned to begin to phase in risk adjustments to its premium payments over a five-year period commencing January 1, 2000. While we cannot predict exactly what effect these Medicare reforms will have on our results of operations, we anticipate that the net impact of the risk adjustments will be to reduce the premiums payable to us.

HIPAA and Gramm-Leach-Bliley Act

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, and its regulations impose obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed health care coverage for small employers having 50 or fewer employees and for individuals who meet certain eligibility requirements. It also requires guaranteed renewability of health care coverage for most employers and individuals. The law limits exclusions based on preexisting conditions for individuals covered under group policies to the extent the individuals had prior creditable coverage, and the gap between the prior coverage and the new coverage cannot exceed certain time frames.

In addition, HIPAA authorized the Secretary of the United States Department of Health and Human Services, known as HHS, to issue standards for administrative simplification, as well as privacy and security of medical records and other individually identifiable patient data. HIPAA requirements apply to plan sponsors, health plans, health care providers and health care clearinghouses that transmit health information electronically. Regulations adopted to implement HIPAA also require that business associates acting for or on behalf of these HIPAA-covered entities be contractually obligated to meet HIPAA standards.

Although HIPAA was intended ultimately to reduce administrative expenses and burdens faced within the health care industry, we believe the law will initially bring about significant and, in some cases, costly changes. HHS has released two rules to date mandating the use of new standards with respect to certain health care transactions, including health information. The first rule requires the use of uniform standards for common health care transactions, including health care claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and

disenrollment, payment and remittance advice, plan premium payments and coordination of benefits, and it establishes standards for the use of electronic signatures. The new transaction standards became effective in October 2000, and we will be required to comply with them by October 16, 2002.

Second, HHS has developed new standards relating to the privacy of individually identifiable health information. In general, these regulations restrict the use and disclosure of medical records and other individually identifiable health information held or disclosed by health plans and other affected entities in any form, whether communicated electronically, on paper or orally, subject only to limited exceptions. In addition, the regulations provide patients with significant new rights to understand and control how their health information is used. These regulations do not preempt more stringent state laws and regulations that may apply to us. The privacy standards became effective on April 14, 2001. We must comply with these privacy standards by April 14, 2003. One more regulation integral to administration and privacy under HIPAA has yet to be published. It will address security requirements to be met regarding accessibility of personal health information. We have not quantified the cost of complying with these new standards; however, the cost of such compliance could be material.

Other recent federal legislation includes the Gramm-Leach-Bliley Act, which generally requires insurers to provide affected customers with notice regarding how their personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares non-public personal information with a non-affiliated third party. These requirements are to be implemented on a state-by-state basis by July 1, 2001. The Gramm-Leach-Bliley Act also gives banks and other financial institutions the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health benefits fields.

Investment and Retirement Products and Services

We are subject to regulation by various government agencies where we conduct business, including the insurance departments of Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada. Among other matters, these agencies may regulate premium rates, trade practices, agent licensing, policy forms, underwriting and claims practices, the maximum interest rates that can be charged on life insurance policy loans, and the minimum rates that must be provided for accumulation of surrender value.

ERISA

The provision of services to certain employee health benefit plans is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor ("DOL"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, some states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee benefit plans that are covered by ERISA.

In December 1993, in a case involving an employee benefit plan and an insurance company, the United States Supreme Court ruled that assets in the insurance company's general account that were attributable to a portion of a group pension contract issued to the plan that was not a "guaranteed benefit policy" were "plan assets" for purposes of ERISA and that the insurance

company had fiduciary responsibility with respect to those assets. In reaching its decision, the Supreme Court declined to follow a 1975 DOL interpretive bulletin that had suggested that insurance company general account assets were not plan assets.

The Small Business Job Protection Act (the "Act") was signed into law in 1996. The Act created a framework for resolving potential issues raised by the Supreme Court decision. The Act provides that, absent criminal conduct, insurers generally will not have liability with respect to general account assets held under contracts that are not guaranteed benefit policies based on claims that those assets are plan assets. The relief afforded extends to conduct that occurs before the date that is 18 months after the DOL issues final regulations required by the Act, except as provided in the anti-avoidance portion of the regulations. The regulations, which were issued on January 5, 2000, address ERISA's application to the general account assets of insurers attributable to contracts issued on or before December 31, 1998 that are not guaranteed benefit policies. The conference report relating to the Act states that policies issued after December 31, 1998 that are not guaranteed benefit policies will be subject to ERISA's fiduciary obligations. We are not currently able to predict how these matters may ultimately affect our businesses.

HMO and Insurance Holding Company Laws

After the demutualization, we will be regulated as an insurance holding company and will be subject to the insurance holding company acts of the states in which our subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates.

Additionally, the holding company acts for the states of domicile of Anthem and its subsidiaries restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such

state (with a minimum amount payable even if no premium is received). Substantially all of our premiums are currently derived from insurance underwritten in Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Maine, Colorado and Nevada.

Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance, such as Anthem, are made retrospectively and are based (up to prescribed limits) upon the ratio of (i) the insurance company's premiums received in the applicable state over the previous three calendar years on accident and sickness insurance to (ii) the aggregate amount of premiums received by all assessed member insurance companies over such three calendar years on accident and sickness insurance. The guaranty fund assessments made under these acts are administered by the state's Guaranty Association, which has its own board of directors selected by member insurers with the approval of the State Insurance Department. In general, an assessment may be abated or deferred by the Guaranty Association if, in the opinion of the board, payment would endanger the ability of the member to fulfill its contractual obligations. The other member insurers, however, may be assessed for the amount of such abatement or deferral. Any such assessment paid by a member insurance company may be offset against its premium tax liability to the state in question over a multiple year period (generally five to 10 years) following the year in which the assessment was paid. The amount and timing of any future assessments, however, cannot be reasonably estimated and are beyond our control. The life/health guaranty association assessments, prior to available premium tax offsets, paid by us totaled $5.0 million in 2000, $1.4 million in 1999, and there were none in 1998.

While the amount of any assessments applicable to life and health guaranty funds cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources.

Risk-Based Capital Requirements

The states of domicile of our subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers, taking into account the risk characteristics of an insurer's investments and products. The RBC Model Act sets forth the formula for calculating the RBC requirements which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under these laws, an insurance company must submit a report of its RBC level to the Insurance Department or Insurance Commissioner, as appropriate, of its state of domicile as of the end of the previous calendar year.

The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of a company's total adjusted capital (defined as the total of its statutory capital, surplus and asset valuation reserve) to its risk-based capital. The "Company Action Level" is triggered if a company's total adjusted capital is less than 200 percent but greater than or equal to 150 percent of its risk-based capital. At the "Company Action Level", a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250 percent and 200 percent of its risk-based capital is subject to a trend test. The trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company's

adjusted capital exceeds its risk-based capital) between the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190 percent, then "Company Action Level" regulatory action would be triggered. The "Regulatory Action Level" is triggered if a company's total adjusted capital is less than 150 percent but greater than or equal to 100 percent of its risk-based capital. At the "Regulatory Action Level", the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The "Authorized Control Level" is triggered if a company's total adjusted capital is less than 100 percent but greater than or equal to 70 percent of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including

placing the company under regulatory control. The "Mandatory Control Level" is triggered if a company's total adjusted capital is less than 70 percent of its risk-based capital, at which level the regulatory authority is mandated to place the company under its control.

The law requires increasing degrees of regulatory oversight and intervention as an insurance company's RBC declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary Insurance Commissioner of a comprehensive financial plan for increasing its RBC to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control in a rehabilitation or liquidation proceeding. As of December 31, 2000, the RBC levels of Anthem and our insurance subsidiaries exceeded all RBC thresholds.

NAIC IRIS Ratios

In the 1970's, the NAIC developed a set of financial relationships or "tests" called the Insurance Regulatory Information System, or IRIS, that were designed for early identification of companies that may require special attention by insurance regulatory authorities. Insurance companies submit statutory financial data on an annual basis to the NAIC, which in turn analyzes the data using ratios covering eleven categories of data with defined "usual ranges" for each category. An insurance company may fall out of the usual range for one or more ratios because of specific transactions or events that are, in and of themselves, immaterial. Generally, an insurance company will become subject to regulatory scrutiny if its IRIS results fall outside of the usual ranges on four or more of the ratios. If a company is outside the ranges on four or more of the ratios, a written explanation is prepared and sent to regulators. Neither Anthem nor its subsidiaries is currently subject to regulatory scrutiny based on IRIS ratios.

Litigation

A number of managed care organizations have recently been sued in class action lawsuits asserting various causes of action under federal and state law. These lawsuits typically allege that the defendant managed care organizations employ policies and procedures for providing health care benefits that are inconsistent with the terms of the coverage documents and other information provided to their members, and because of these misrepresentations and practices, a class of members has been injured in that they received benefits of lesser value than the benefits represented to and paid for by such members. Two such proceedings which allege various violations of the Employee Retirement Income Security Act of 1974 ("ERISA") have been filed in Connecticut against Anthem or our Connecticut affiliate. One proceeding, The State of Connecticut

v. Anthem Blue Cross and Blue Shield of Connecticut, Anthem Health Plans, Inc., et al., No. 3:00 CV 1716 (AWT), filed on September 7, 2000 in the United States District Court, District of Connecticut, was brought by the Connecticut Attorney General on behalf of a purported class of HMO and Point of Service members in Connecticut. No monetary damages are sought, although the suit does seek injunctive relief from the court to preclude us from allegedly utilizing arbitrary coverage guidelines, making late payments to providers or members, denying coverage for medically necessary prescription drugs and misrepresenting or failing to disclose essential information to enrollees. The complaint contends that these alleged policies and practices are a violation of ERISA. A second proceeding, William Strand v. Anthem Blue Cross and Blue Shield of Connecticut, Anthem Health Plans, Inc., et al., No. 3:00 CV 2037 (SRU), filed on October 20, 2000 in the United States District Court, District of Connecticut, was brought on behalf of a purported class of HMO and Point of Service members in Connecticut and elsewhere, and seeks injunctive relief to preclude us from allegedly making coverage decisions relating to medical necessity without complying with the express terms of the policy documents, and unspecified monetary damages (both compensatory and punitive).

In addition, our Connecticut affiliate is a defendant in three class action lawsuits brought on behalf of professional providers in Connecticut. Edward Collins, M.D., et al. v. Anthem Health Plans, Inc., No. CV-99 0156198 S, was filed on December 14, 1999, in the Superior Court Judicial District of Waterbury, Connecticut. Stephen R. Levinson, M.D., Karen Laugel, M.D. and J. Kevin Lynch, M.D. v. Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut, No. 3:01 CV 426 (JBA), was filed on February 14, 2001 in the Superior Court Judicial District of New Haven, Connecticut. Connecticut State Medical Society v. Anthem Health Plans, Inc., No. 3:01 CV 428 (JBA) was filed on February 14, 2001 in the Superior Court Judicial District of New Haven, Connecticut. The suits allege that the Connecticut affiliate has breached its contracts by, among other things, allegedly failing to pay for services in accordance with the terms of the contracts. The suits also allege violations of the Connecticut Unfair Trade Practices Act, breach of the implied duty of good faith and fair dealing, negligent misrepresentation and unjust enrichment. The Collins and Levinson suits seek injunctive relief. Collins seeks an accounting under the terms of the provider agreements and injunctive relief prohibiting us from continuing the unfair actions alleged in the complaint and violating its agreements. Levinson seeks permanent injunctive relief prohibiting us from, among other things, utilizing methods to reduce reimbursement of claims, paying claims in an untimely fashion and providing inadequate communication with regards to denials and appeals. Both of the suits seek unspecified monetary damages (both compensatory and punitive). The third suit, brought by the Connecticut State Medical Society, seeks the same injunctive relief as the Levinson case, but no monetary damages.

On July 19, 2001, the court in the Collins suit certified a class as to three of the plaintiff's fifteen allegations. The class is defined as those physicians who practice in Connecticut or group practices which are located in Connecticut that were parties to either a Participating Physician Agreement or a Participating Physicians Group Agreement with Anthem and/or its Connecticut affiliate during the period from 1993 to the present, excluding risk-sharing arrangements and certain other contracts. The claims which were certified as class claims are: Anthem's alleged failure to provide plaintiffs and other similarly situated physicians with consistent medical utilization/quality management and administration of covered services by paying financial incentive and performance bonuses to providers and Anthem staff members involved in making utilization management decisions; an alleged failure to maintain accurate books and records whereby improper payments to the plaintiffs were

made based on claim codes submitted; and an alleged failure to provide senior personnel to work with plaintiffs and other similarly situated physicians.

We intend to vigorously defend these proceedings. Anthem denies all the allegations set forth in the complaints and has asserted defenses, including improper standing to sue, failure to state a claim and failure to exhaust administrative remedies. All of the proceedings are in the early stages of litigation, and their ultimate outcomes cannot presently be determined.

On October 10, 2001, the Connecticut State Dental Association along with five dental providers filed suit against our Connecticut affiliate. Connecticut State Dental Association, Dr. Martin Rutt, Dr. Michael Egan, Dr. Sheldon Natkin, Dr. Suzanna Nemeth, and Dr. Bruce Tandy v. Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut was filed in the Superior Court Judicial District of Hartford, Connecticut. The suit alleges that our Connecticut affiliate violated the Connecticut Unfair Trade Practices Act by allegedly unilaterally altering fee schedules without notice or a basis to do so, instituting unfair and deceptive cost containment measures and refusing to enroll new providers unless they agreed to participate in all available networks. The plaintiffs seek declaratory relief that the practices alleged in the complaint constitute deceptive and unfair trade practices. A permanent injunction is also sought prohibiting us from, among other things, failing and refusing to inform network providers of the methodology supporting our fee schedules and substituting our medical judgment for that of dental providers. The suit requests costs and attorney fees, but no other specified monetary damages. Anthem denies the allegations set forth in this complaint and intends to vigorously defend this suit.

Following our purchase of BCBS-ME, the Attorney General of Maine and Consumers for Affordable Health Care filed administrative appeals challenging the Superintendent of Insurance's (the "Superintendent") decision approving the conversion of BCBS-ME to a stock insurer, which was a required step before the acquisition. Both the Attorney General and the consumers group filed a petition for administrative review seeking, among other things, a determination that the decision of the Superintendent in regard to the application of BCBS-ME to convert to a stock insurer was in violation of statute or unsupported by substantial evidence on the record. Consumers for Affordable Health Care, et al. v. Superintendent of Insurance, et al, Nos. AP-00-37, AP-00-42 (Consolidated). In addition, the Attorney General filed an independent claim for relief, requesting the court to modify the Superintendent's decision by requiring BCBS-ME to submit an update to the statutorily mandated appraisal of its fair market value and to deposit into the charitable foundation the difference between the net proceeds that have been transferred to the foundation and the final value of BCBS-ME, if greater. On May 18, 2001, the court dismissed the Attorney General's independent claim, ruling that the claim was an impermissible collateral challenge to the Superintendent's determination. The effect of this ruling is that the Attorney General does not have a cause of action separate from the administrative review that he has already requested. Following the court's May 18, 2001 order, the Attorney General filed a motion to clarify the court's ruling, asserting that the court did not intend to dismiss his independent claim with prejudice. The court denied the Attorney General's motion. Anthem intends to vigorously defend these proceedings. Anthem denies all the allegations set forth in the petitions for review and has asserted defenses, including waiver, estoppel and mootness. While the appeals are still pending, we do not believe that the appeals will have a material adverse effect on our consolidated financial position or results of operations.

On March 11, 1998, Anthem and its Ohio subsidiary, Community Insurance Company ("CIC") were named as defendants in a lawsuit, Robert Lee Dardinger, Executor of the Estate of Esther Louise Dardinger v. Anthem Blue Cross and Blue Shield, et al., filed in the Licking County Court of Common Pleas in Newark, Ohio. The plaintiff sought compensatory damages and unspecified punitive damages in connection with claims alleging wrongful death, bad faith and negligence arising out of our denial of certain claims for medical treatment for Ms. Dardinger. On September 24, 1999, the jury returned a verdict for the plaintiff, awarding $1,350 for compensatory damages, $2.5 million for bad faith in claims handling and appeals processing, $49.0 million for punitive damages and unspecified attorneys' fees in an amount to be determined by the court. The court later granted attorneys' fees of $0.8 million. Both companies filed an appeal of the verdict on November 19, 1999, and as part of the appeal, a bond in the amount of $60.0 million was posted to secure the judgment and interest and attorneys' fees. On May 22, 2001, the Ohio Court of Appeals (Fifth District) affirmed the jury award of $1,350 for breach of contract against CIC, affirmed the award of $2.5 million compensatory damages for bad faith in claims handling and appeals processing against CIC, but dismissed the claims and judgments against Anthem. The court also reversed the award of $49.0 million in punitive damages against both Anthem and CIC, and remanded the question of punitive damages against CIC to the trial court for a new trial. Anthem and CIC, as well as the plaintiff, appealed certain aspects of the decision of the Ohio Court of Appeals. On October 10, 2001, the Supreme Court of Ohio agreed to hear the plaintiff's appeal, including the question of punitive damages, and denied the cross-appeals of Anthem and CIC. The ultimate outcome of this matter cannot be determined at this time.

In addition to the lawsuits described above, we are involved in other pending and threatened litigation of the character incidental to our business or arising out of our insurance and investment operations, and are from time to time involved as a party in various governmental and administrative proceedings. We believe that any liability that may result from any one of these actions is unlikely to have a material adverse effect on our financial position or results of operations.

Other Contingencies

Anthem, like a number of other Blue Cross and Blue Shield companies, serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. The fiscal intermediaries

for these programs receive reimbursement for certain costs and expenditures, which are subject to adjustment upon audit by CMS. The laws and regulations governing fiscal intermediaries for the Medicare program are complex, subject to interpretation and can expose an intermediary to penalties for non-compliance. Fiscal intermediaries may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. In the last five years, at least eight Medicare fiscal intermediaries have made payments to settle issues raised by such audits and reviews. These payments have ranged from $0.7 million to $51.6 million, plus a payment by one company of $144.0 million. While we believe we are currently in compliance in all material respects with the regulations governing fiscal intermediaries, there are ongoing reviews by the federal government of Anthem's activities under certain of its Medicare fiscal intermediary contracts.

On December 8, 1999, Anthem Health Plans, Inc., or AHP, one of our subsidiaries, reached a settlement agreement with the Office of Inspector General, or OIG, Health and Human Services, in the amount of $41.9 million, to resolve an investigation into misconduct in the Medicare fiscal intermediary

operations of BCBS-CT, AHP's predecessor. The period investigated was before Anthem's merger with BCBS-CT. The resolution of this case involved no criminal penalties against Anthem as successor-in-interest nor any suspension or exclusion from federal programs. This expense was included in administrative expense in our statement of consolidated income for the year ended December 31, 1999.

AdminaStar Federal, Inc., one of our affiliates, has received several subpoenas from the OIG and the U.S. Department of Justice, seeking documents and information concerning its responsibilities as a Medicare Part B contractor in its Kentucky office, and requesting certain financial records from AdminaStar Federal, Inc. and from us related to our Medicare fiscal intermediary Part A and Part B operations. We have made certain disclosures to the government relating to our Medicare Part B work in Kentucky. The government, however, has not notified us of any non-compliance. We are not in a position to predict either the ultimate outcome of this review or the extent of any potential exposure should claims be made against us. However, we believe any fines or penalties that may arise from this review would not have a material adverse effect on our consolidated financial condition.

As a BCBSA licensee, we participate in a nationwide contract with the federal Office of Personnel Management to provide coverage to federal employees and their dependents in our core eight-state area. The program is called the Federal Employee Program, or FEP. On July 11, 2001, we received a subpoena from the OIG, Office of Personnel Management, seeking certain financial documents and information, including information concerning intercompany transactions, related to our operations in Ohio, Indiana and Kentucky under the FEP contract. We are currently cooperating with the OIG and the U.S. Department of Justice on this matter. We are not in a position to predict either the ultimate outcome of this review or the extent of any potential exposure should claims be made against us. Accordingly, we cannot assure you that the ultimate outcome of this review will not have a material adverse effect on our consolidated results of operations or financial condition.

We guaranteed certain financial contingencies of our subsidiary, Anthem Alliance Health Insurance Company, under a contract between Anthem Alliance and the United States Department of Defense. Under that contract, Anthem Alliance managed and administered the TRICARE Managed Care Support Program for military families from May 1, 1998 through May 31, 2001. The contract required Anthem Alliance, as the prime contractor, to assume certain risks in the event, and to the extent, the actual cost of delivering health care services exceeded the health care cost proposal submitted by Anthem Alliance (the "Health Care Risk"). The contract has a five-year term, but was transferred to a third party, effective May 31, 2001. We guaranteed Anthem Alliance's assumption of the Health Care Risk, which is capped by the contract at $20.0 million annually and $75.0 million cumulatively over the contract period. Through December 31, 2000, Anthem Alliance had subcontracts with two other BCBS companies not affiliated with us by which the subcontractors

agreed to provide certain services under the contract and to assume approximately 50% of the Health Care Risk. Effective January 1, 2001, one of those subcontracts terminated by mutual agreement of the parties, which increased Anthem Alliance's portion of the Health Care Risk to 90%. Effective May 1, 2001, the other subcontract was amended to eliminate the Health Care Risk sharing provision, which resulted in Anthem Alliance assuming 100% of the Health Care Risk for the period from May 1, 2001 to May 31, 2001. There was no call on the guarantee for the period from May 1, 1998 to April 30, 1999 (which period is now "closed"), and we do not anticipate a call on the guarantee for the periods beginning May 1, 1999 through May 31, 2001 (which periods remain

"open" for possible review by the Department of Defense).

MANAGEMENT

Directors and Executive Officers

The following table shows information as of September 30, 2001 concerning our directors and executive officers.

Name	Age	Position
L. Ben Lytle	55	Chairman of the Board of Directors
Larry C. Glasscock	53	President and Chief Executive Officer and Director
Susan B. Bayh	41	Director
William B. Hart	58	Director
Allan B. Hubbard	54	Director
Victor S. Liss	64	Director
William G. Mays	55	Director
James W. McDowell, Jr.	60	Director
B. LaRae Orullian	68	Director
Senator Donald W. Riegle, Jr.	63	Director
William J. Ryan	57	Director
George A. Schaefer, Jr.	56	Director
Dennis J. Sullivan, Jr.	69	Director
David R. Frick	57	Executive Vice President and Chief Legal and Administrative Officer
Samuel R. Nussbaum, M.D.	53	Executive Vice President and Chief Medical Officer
Michael L. Smith	53	Executive Vice President and Chief Financial and Accounting Officer
Marjorie W. Dorr	39	President, Anthem East
Keith R. Faller	54	President, Anthem Midwest
Michael D. Houk	57	Vice President and General Manager, National Accounts
Caroline S. Matthews	42	Chief Operating Officer, Anthem Blue Cross and Blue Shield in Colorado and Nevada
John M. Murphy	49	President, Specialty Business Division of Anthem
Jane E. Niederberger	41	Chief Information Officer

The following is biographical information for our directors and executive officers:

L. Ben Lytle has been a director of Anthem Insurance since 1987 and Chairman of the Board of Anthem Insurance since 1997. Mr. Lytle served as President and Chief Executive Officer from March 1989 to October 1999, when he retired. He is an Executive-in-Residence at the University of Arizona School of Business, Adjunct Fellow at the American Enterprise Institute and Senior Fellow at the Hudson Institute. He is a director of CID Equity Partners (venture capital firm); Duke Realty Corporation (real estate investment firm); and Healthx.com (privately held company providing internet services to small insurance companies).

Larry C. Glasscock has served as President and Chief Executive Officer and as a director of Anthem Insurance since October 1999. He joined Anthem Insurance in April 1998 as Senior Executive Vice President and Chief Operating Officer. He was named President and Chief Operating Officer in April 1999 and succeeded L. Ben Lytle as Chief Executive Officer upon Mr. Lytle's retirement

in October 1999. Mr. Glasscock was President and Chief Executive Officer of Blue Cross Blue Shield of the National Capital Area from 1993 to 1998 and oversaw its affiliation with Blue Cross Blue Shield of Maryland. Prior to moving to the health insurance industry, he served as President and Chief Operating Officer and a director of First American Bank, N.A. (Washington, DC) from 1991 until 1993 when the bank was sold. During 1991, Mr. Glasscock was President and Chief Executive

Officer of Essex Holdings, Inc. (an Ohio-based capital investment firm). He also held various executive positions during his twenty-year tenure with Ameritrust Corporation, a Cleveland, Ohio bank holding company. Mr. Glasscock is a director of Zimmer Holdings, Inc. (orthopaedic industry).

Susan B. Bayh has been a director of Anthem Insurance since 1998. Mrs. Bayh has been a Distinguished Visiting Professor in the College of Business Administration at Butler University since 1994. She was a member of the International Joint Commission between the United States and Canada from 1994 to 2001. Mrs. Bayh is a director of Corvas International, Inc. (biotechnology), Cubist Pharmaceuticals, Inc. (biotechnology), Curis, Inc. (biomedical) and Emmis Communications Corporation (telecommunications). She is also a member of the Board of Trustees of Butler University.

William B. Hart has been a director of Anthem Insurance since 2000. He was President of The Dunfey Group (capital consulting firm) from 1986 to 1998. Since 1999, he has been Chairman of the National Trust for Historic Preservation. He served as Chairman of the Board of the former Blue Cross Blue Shield of New Hampshire.

Allan B. Hubbard has been a director of Anthem Insurance since 1999. He has been President of E & A Industries (holding company for various industrial companies) since 1993. From 1991 to 1992, Mr. Hubbard served as Deputy Chief of Staff to the Vice President of the United States, and from 1998 to 2000 he was a director of the U.S. Chamber of Commerce. Mr. Hubbard is a director of The Hudson Institute, Maxon Corporation (manufacturer) and Medical Savings Insurance Company.

Victor S. Liss has been a director of Anthem Insurance since 1997. He has been President, Vice Chairman and Chief Executive Officer of Trans-Lux Corporation (electronics) since 1993. He is a trustee of Norwalk Hospital in Norwalk, Connecticut.

William G. Mays has been a director of Anthem Insurance since 1993. He has been President and Chief Executive Officer of Mays Chemical Company, Inc. (chemical distribution) since 1980. Mr. Mays is a director of Vectren Corporation (gas and electric utility), the Indiana University Foundation and the National Urban League.

James W. McDowell, Jr. has been a director of Anthem Insurance since 1993. He founded McDowell Associates (business management consulting) in 1992 after serving as Chief Executive Officer of Dairymen, Inc. from 1980 to 1992. He is a director of Fifth Third Bank, Kentucky. Mr. McDowell was Chairman of the Board of the former Blue Cross Blue Shield of Kentucky.

B. LaRae Orullian has been a director of Anthem Insurance since 2000. She has been Vice Chair of Guaranty Bank and a Director of the Guaranty Corporation in Denver, Colorado since 1997. From 1977 to 1997, Ms. Orullian held various executive positions with the Women's Bank of Denver. Ms. Orullian also serves as Chair of the Board of Frontier Airlines, Inc. She served as Chair of the Board of the former Blue Cross Blue Shield of Colorado and Nevada.

Senator Donald W. Riegle, Jr., has been a director of Anthem Insurance since 1999. In March 2001, he joined APCO Worldwide as Chairman of APCO Government Affairs. From 1995 to 2001, he was Deputy Chairman of Shandwick International. He served in the U.S. Senate from 1976 through 1994 and in the U.S. House of Representatives from 1967 through 1975. He is a director of Rx Optical, Cyberian Outpost (Internet fulfillment company), E. Team (Internet emergency management company) and Tri-Union Development Corp. (oil and gas development company).

William J. Ryan has been a director of Anthem Insurance since 2000. He has served as Chairman, President and Chief Executive Officer of Banknorth Financial Group since 1990. He is a director of the University of New England. Mr. Ryan is also a trustee of Colby College and the Portland Museum of Art. He served as Chairman of the Board of the former Blue Cross Blue Shield of Maine.

George A. Schaefer, Jr. has been a director of Anthem Insurance since 1995. He has been President and Chief Executive Officer of Fifth Third Bancorp since 1990. Mr. Schaefer is Vice Chairman of the Board of the University of Cincinnati. He is a trustee of the Children's Hospital in Cincinnati, Ohio.

Dennis J. Sullivan, Jr., has been a director of Anthem Insurance since 1995. He is an Executive Counselor for Dan Pinger Public Relations, a position he also held from April 1993 to September 2000. Mr. Sullivan served as interim President and Chief Executive Officer of Gaylord Entertainment Company from September 2000 to May 2001. He is a director of Fifth Third Bancorp.

David R. Frick joined Anthem Insurance in 1995 as Executive Vice President and Chief Legal and Administrative Officer. Prior to joining Anthem Insurance, he served as a member of its board of directors. Mr. Frick was a partner at the law firm of Baker & Daniels from 1982 to 1995, and he was managing partner from 1987 to 1992. He was Deputy Mayor of the City of Indianapolis from 1977 to 1982. He is a director of Artistic Media Partners, Inc. (radio stations) and The National Bank of Indianapolis Corporation (bank holding company).

Samuel R. Nussbaum, M.D. joined Anthem Insurance in January 2001 as Executive Vice President and Chief Medical Officer. From 1996 to 2000, Dr. Nussbaum served both as Executive Vice President for Medical Affairs and System Integration at BJC Health System of St. Louis and as Chairman and Chief Executive Officer of Health Partners of the Midwest. Prior to that, Dr. Nussbaum was President and Chief Executive Officer of Physician Partners of New England, Senior Vice President for Health Care Delivery at Blue Cross Blue Shield of Massachusetts and a professor at Harvard Medical School.

Michael L. Smith has been Executive Vice President and Chief Financial Officer of Anthem Insurance since 1999. From 1996 to 1998, Mr. Smith served as Chief Operating Officer and Chief Financial Officer of American Health Network, Inc., a former Anthem subsidiary. He was Chairman, President and Chief Executive Officer of Mayflower Group, Inc. (transport company) from 1989 to 1995. He is a director of First Indiana Corporation (bank holding company) and Finishmaster, Inc. (auto paint distribution).

Marjorie W. Dorr became President of Anthem East in July 2000. She has held numerous executive positions since joining Anthem Insurance in 1991, including Vice President of Corporate Finance; Chief Financial Officer of Anthem Casualty Insurance Group; President of Anthem Prescription Management, LLC; and Chief Operating Officer of Anthem Health Plans, Inc. in Connecticut.

Keith R. Faller has been President of Anthem Midwest since 1997. He has held

numerous executive positions since joining Anthem Insurance in 1970, including Senior Vice President for Customer Administration; President of Acordia of the South; Executive Vice President, Health Operations; Chief Executive Officer, Anthem Life Insurance Companies, Inc.; and President and Chief Executive Officer, Acordia Small Business Benefits, Inc.

Michael D. Houk has been Vice President and General Manager of National Accounts for Anthem Insurance since 1999. He has held various executive positions since joining Anthem Insurance in 1979, including Vice President of Sales and President and Chief Executive Officer of Acordia of Central Indiana.

Caroline S. Matthews became Chief Operating Officer of Anthem Blue Cross and Blue Shield in Colorado and Nevada in 2000. She has held various executive positions since joining Anthem Insurance in 1988, including Vice President of Corporate Finance; Vice President of Planning and Administration for Information Technology; and Chief Operating Officer and Chief Financial Officer of Acordia of the South.

John M. Murphy became President, Specialty Business Division of Anthem in 2000. He has held various executive positions since joining Anthem Insurance in 1988, including Vice President of Operations of Anthem Insurance; President and Chief Executive Officer of Anthem Life Insurance Company; and President and Chief Executive Officer of Acordia Senior Benefits, Inc.

Jane E. Niederberger joined Anthem Insurance in 1997 and has been Chief Information Officer since 1999. From 1983 to 1996, she held various executive positions with Harvard Pilgrim Health Care.

None of these executive officers and directors has family relationships with any other executive officer or director. The directors and executive officers of each of Anthem, Inc. and Anthem Insurance are initially the same.

Information about the Board of Directors of Anthem, Inc.

Composition of the Board of Directors

The business of Anthem, Inc. is managed under the direction of the board of directors. The board of directors consists of 13 directors, all of whom are non-employee directors, except Mr. Glasscock.

The directors are divided into three classes, each serving three-year terms with the terms staggered so that only one class will be elected each year: Class I, consisting of Mrs. Bayh, Mr. Hubbard, Mr. Mays, Senator Riegle, and Mr. Ryan, whose term will expire at the 2002 annual meeting; Class II, consisting of Mr. Glasscock, Mr. Hart, Mr. Lytle and Ms. Orullian, whose term will expire at the 2003 annual meeting; and Class III, consisting of Mr. Liss, Mr. McDowell, Mr. Schaefer, and Mr. Sullivan, whose term will expire at the 2004 annual meeting.

Committees of the Board of Directors

There are five standing committees of our board of directors. From time to time, the board of directors, in its discretion, may form other committees. Set forth below are the primary responsibilities and membership of each of the committees.

The Executive Committee

Between meetings of the board of directors, the Executive Committee has and

may exercise the powers and authority of the board.

Members of the Executive Committee are: L. Ben Lytle (Chairman), Larry C. Glasscock (Vice Chairman), Victor S. Liss, William G. Mays, and James W. McDowell, Jr.

The Audit Committee

The Audit Committee, composed entirely of non-employee directors, advises the board of directors in the selection of independent auditors, reviews with internal and independent auditors the scope and results of their audits, reviews financial statements and other financial disclosures, monitors developments in accounting principles and practices used in presenting financial results, and monitors our ethics and corporate compliance program.

Members of the Audit Committee are: Victor S. Liss (Chairman), George A. Schaefer, Jr. (Vice Chairman), Allan B. Hubbard, James W. McDowell, Jr., B. LaRae Orullian, and Senator Donald W. Riegle, Jr.

The Compensation Committee

The Compensation Committee, composed entirely of non-employee directors, reviews and recommends to the board of directors our overall compensation policy, reviews and approves the compensation of executive officers and administers our stock plans.

Members of the Compensation Committee are: William G. Mays (Chairman), William J. Ryan (Vice Chairman), Victor S. Liss, B. LaRae Orullian, and Dennis J. Sullivan, Jr.

The Planning Committee

The Planning Committee reviews and monitors the annual operating plan, recommends strategies to achieve the strategic plan, and reviews integration plans for mergers, acquisitions and other corporate transactions.

Members of the Planning Committee are: James W. McDowell, Jr. (Chairman), Senator Donald W. Riegle, Jr. (Vice Chairman), Susan B. Bayh, William B. Hart, L. Ben Lytle, and William J. Ryan.

The Board Governance and Executive Development Committee

The Board Governance and Executive Development Committee reviews the qualifications of potential board members, makes recommendations with respect to electing directors and filling vacancies on the board, reviews the operation and organization of the board, assists in the design and implementation of executive training and development programs, and provides counsel on executive succession planning.

Members of the Board Governance and Executive Development Committee are: L. Ben Lytle (Chairman), Susan B. Bayh (Vice Chairman), William B. Hart, William G. Mays, George A. Schaefer, Jr., and Dennis J. Sullivan, Jr.

Compensation of Directors

The compensation of non-employee directors of Anthem, Inc. will initially be the same as the compensation currently provided by Anthem Insurance to its non-employee directors. Each non-employee director will receive an annual retainer fee of $40,000, paid in equal quarterly installments, for board membership, a

meeting fee of $1,500 for attendance at each board meeting and a meeting fee of $1,200 for attendance at each standing or special committee meeting, with an additional $3,000 annual retainer for the chairperson. Employee directors are not paid a fee for their service as a director. Fees paid to directors may be deferred under the Board of Directors' Deferred Compensation Plan, which provides a method of deferring payment until a date selected by the director. Fees deferred accrue interest at the same rate as in effect from time to time under the Deferred Compensation Plan for employees. Under the 2001 Stock Incentive Plan, the Board of Directors may elect to pay non-employee directors all or a part of their retainer fees in Anthem, Inc. common stock, and non-employee directors may elect to receive all or a part of their other fees in Anthem, Inc. common stock. In addition, after six months following the effective date of the demutualization, the Board of Directors may grant non-qualified stock options to non-employee directors to purchase shares of Anthem, Inc. common stock at a price no less than the fair market value of a share of stock on the grant date of the stock option.

Compensation of Executive Officers

Since the formation of Anthem, Inc., none of the executive officers or other personnel has received any compensation from Anthem, Inc. All compensation has been paid by Anthem Insurance or one of its subsidiaries. We expect that after the demutualization, the executive officers of Anthem, Inc. will continue to be paid by Anthem Insurance or one of its subsidiaries.

The following table sets forth the compensation paid by Anthem Insurance or one of its subsidiaries to our Chief Executive Officer and our other four most highly compensated executive officers for the year ended December 31, 2000.

Summary Compensation Table

		Annual Compensation			Long Term Compensation	
Name and Principal Position	Year	Salary	Bonus(1)	Other Annual Compensation(2)	LTIP Payouts(3)	All Other Compensation(4)
Larry C. Glasscock..... President and Chief Executive Officer	2000	$800,000	$1,027,298	$65,675	$ 0	$51,467
David R. Frick..... Executive Vice President and Chief Legal and Administrative Officer	2000	$410,000	$ 520,369	$16,968	$297,049	$24,523
Michael L. Smith..... Executive Vice President and Chief Financial Officer	2000	$375,000	$ 368,122	$ 437	$ 44,557	$18,750
Keith R. Faller..... President, Anthem Midwest	2000	$350,000	$ 196,219	$30,202	$178,229	$12,779

Marjorie W. Dorr..... President, Anthem East(5)	2000	$306,731	$ 257,175	$25,406	$ 80,202	$13,456

---

(1) The amount in this column represents the Annual Incentive Plan award paid in 2000 for the prior performance year of 1999.

(2) Mr. Glasscock received $42,000 in cash and $20,812 in reimbursements as part of the Directed Executive Compensation Program including financial counseling fees for $8,892. None of the other named individuals received perquisites or other personal benefits in excess of the lesser of $50,000 or 10% of the total of their salary and bonus. Amounts include the above-market portion of interest paid on the deferred compensation for Mr. Glasscock ($2,863), Mr. Frick ($4,897), Mr. Smith ($437), Mr. Faller ($3,072) and Ms. Dorr ($1,421) and the above market portion of interest paid on the deferred long-term incentive payments for Mr. Frick ($12,070) and Mr. Faller ($27,130). Ms. Dorr's amount also includes $23,985 for reimbursement of relocation expenses.

(3) The amounts in this column represent Long-Term Incentive Plan awards received or deferred in 2000 for prior performance cycles.

(4) The amounts in this column represent matching contributions under our 401(k) and Deferred Compensation Plans.

(5) Ms. Dorr was appointed President of Anthem East, effective July 29, 2000.

Annual Incentive Plan

Under the Annual Incentive Plan (the "AIP"), employees are eligible to receive cash awards based upon the achievement of performance measures established by the Compensation Committee. Such cash awards are stated as a percentage of salary payable to the eligible employees, with the range of targets from 5% to 100%. Actual amounts payable are adjusted up or down for performance at or above targeted levels of performance, with a threshold award of 50% of target if minimum results are achieved and a maximum award of 200% of target if maximum results are achieved. Amounts payable under the AIP are paid during the year immediately following the performance year and are payable only upon approval of the Compensation Committee. An employee must be employed before October 1 of the plan year in order to receive a payment under the AIP in respect

of such fiscal year. Also, employees must be actively employed by Anthem on the last business day of the plan year to receive an award. In the event of a death, disability or an approved retirement of an employee, a prorated amount may be payable in accordance with administrative guidelines.

Long-Term Incentive Plan

Senior executives, as may be recommended by the Chief Executive Officer and approved by the Compensation Committee, are participants in the Long-Term Incentive Plan (the "LTIP"). The LTIP operates during successive three-year periods. Employees must be actively employed by us on the last business day of the period to receive an award. Under the LTIP, the Compensation Committee establishes performance goals for Anthem Insurance at the beginning of each three-year performance period which include specific objectives for growth in net income, operating margin and comparison of performance against peer companies. At the end of the period, the Compensation Committee judges the performance of Anthem Insurance against the established goals. For each participant, a target award is established as a percentage of base salary with the payouts for executives expected to range from 30% to 150% of the annual

base salary for each year of the three-year period. Actual amounts payable are adjusted up or down for performance above or below targeted levels of performance with an expected threshold award of 50% of target if minimum results are achieved. Awards under the LTIP in each three-year period become payable upon approval of the Compensation Committee and are paid in the year immediately following the end of the period, with the executive having the option to defer payment. In the event of a change of control of Anthem, an amount may be payable at the discretion of the Compensation Committee.

The table below provides information concerning estimated target awards during the period 2001-2003 depending upon achievement of the performance goals.

Long-Term Incentive Plan (2001-2003)

Name	Performance Period	Targeted Future Payouts under Non-Stock Price-Based Plan (1)(2) Threshold	Target
Larry C. Glasscock	2001-2003	$2,025,000	$4,050,000
David R. Frick	2001-2003	$ 738,000	$1,476,000
Michael L. Smith	2001-2003	$ 738,000	$1,476,000
Keith R. Faller	2001-2003	$ 540,000	$1,080,000
Marjorie W. Dorr	2001-2003	$ 420,000	$ 840,000

---

(1) Payout scheduled to occur in 2004.
(2) Under the Plan, there is no maximum limitation.

Stock Incentive Plan

We have a 2001 Stock Incentive Plan (the "Stock Plan"), the purposes of which are to promote the interests of Anthem, Inc. and its shareholders and to further align the interests of our employees with our shareholders. Directors, executives and employees, as selected by the Compensation Committee, will participate in the Stock Plan. The Compensation Committee will administer the Stock Plan and will have complete discretion to determine whether to grant incentive awards, the types of incentive awards to grant and any requirements and restrictions relating to incentive awards. The Stock Plan is an omnibus plan, which allows for the grant of stock options, restricted stock, stock appreciation rights, performance stock and performance awards.

The Stock Plan reserves for issuance 5,000,000 shares of our common stock for incentive awards to employees and non-employee directors, plus an additional 2,000,000 shares solely for issuance under grants of stock options that may be made to substantially all of our employees (and for issuance under similar grants that may be made to new employees). If any grant is for any reason canceled, terminated or otherwise settled without the issuance of some or all of the shares of common stock subject to the grant, such shares will be available for future grants. For a period of six months following the effective date of the demutualization, we may not make any grants under the Stock Plan to our directors or any executive who participates in the LTIP.

If not sooner terminated by the board of directors, the Stock Plan shall terminate at the close of business on July 29, 2011. The board of directors may amend the Stock Plan in such respects as it deems advisable provided that the shareholders must approve certain amendments. A termination or amendment of the Stock Plan shall not, without the participant's consent or unless made to ensure compliance with applicable law, adversely affect a participant's rights under an incentive award previously granted to the participant.

Options to purchase shares of stock granted under the Stock Plan to employees may be incentive stock options, as described in Internal Revenue Code (S)422, or nonstatutory stock options. Options to purchase shares of stock granted under the Stock Plan to non-employee directors must be nonstatutory stock options. The exercise price per share subject to either an incentive stock option or a nonstatutory stock option will not be less than 100% (or, in the case of an incentive stock option granted to a 10% shareholder, 110%) of the fair market value of stock on the date of the grant of such option. In addition, no more than $100,000 of incentive stock options, based on the exercise price, may be initially exercisable in any calendar year. An option shall not be exercisable more than ten years after the date of grant.

The Compensation Committee intends to grant stock options to purchase 100 shares of Anthem, Inc. common stock under the Stock Plan to each of our approximately 15,000 employees, other than our approximately top 50 executives, effective on the first day that Anthem, Inc. common stock trades on the New York Stock Exchange. None of our executive officers will receive stock options under these grants. Each of such options will have an exercise price per share equal to the initial public offering price set forth on the cover page of this prospectus and will have a term of ten years. The options will generally become fully exercisable two years after their effective date.

The Compensation Committee may grant similar stock options under the Stock Plan to new employees. The exercise price of any such options would not be less than 100% of the fair market value of a share of our common stock on the date of the grant of such option and any such options would have a term of ten years.

The Compensation Committee may issue restricted stock to employees. None of the shares of restricted stock may be transferred or encumbered until the restrictions on such shares lapse or are removed.

The Compensation Committee may award stock appreciation rights to employees either with or without related stock options. When the stock appreciation right is exercisable, the holder may surrender all or a portion of the unexercised stock appreciation right to Anthem and receive in exchange an amount equal to the difference between (i) the fair market value on the date of exercise of the stock covered by the surrendered portion of the stock appreciation right, and (ii) the exercise price of the stock on the date the stock appreciation right was awarded.

The Compensation Committee may grant performance awards to employees. For each plan year, the Compensation Committee will select the performance criteria to be used for that plan year in granting performance awards, which criteria may include asset growth, combined net worth, debt

to equity ratio, earnings per share, revenues, investment performance, operating income (with or without investment income or income taxes), operating cash flow, operating margins, net income before or after taxes, earnings before interest, taxes, depreciation and/or amortization, return on total capital,

equity, revenue or assets, medical loss ratio or number of policyholders or insureds. Performance awards will be paid in cash, Anthem, Inc. common stock or both, at such time or times as are provided in the award agreement between us and the employee. The award agreement may provide that the employee may make a prior election to defer the payment under the performance award as the Compensation Committee may determine.

All options granted under the Stock Plan to non-employee directors will become exercisable in full upon the occurrence of a change in control of Anthem, Inc. Except as otherwise provided by the Compensation Committee, upon the occurrence of a change in control of Anthem, Inc., all other options granted under the Stock Plan will become exercisable in full.

Federal Income Tax Consequences

The following is a brief summary of the federal income tax consequences of awards under the Stock Plan based on the federal income tax laws in effect on the date hereof. This summary is not intended to be exhaustive and does not describe state or local tax consequences.

No taxable income is realized by the grantee upon the grant or exercise of an incentive stock option. The difference between the fair market value of the option shares on the date an incentive stock option is exercised and their exercise price will constitute a tax preference for purposes of the individual alternative minimum tax. If a grantee does not sell the stock received for at least two years from the date of grant and one year from the date of exercise, when the shares are sold any gain or loss realized will be treated as long-term capital gain or loss. In such circumstances, no deduction will be allowed to Anthem for federal income tax purposes.

If incentive stock option shares are disposed of prior to the expiration of the holding periods described above, the grantee generally will recognize ordinary income at that time equal to the lesser of the excess of the fair market value of the shares at exercise over the price paid for such shares or the actual gain on the disposition. Anthem will generally be entitled to deduct any such recognized amount. Any further gain or loss realized by the grantee will be taxed as short-term or long-term capital gain or loss. Subject to certain exceptions for disability or death, if an incentive stock option is exercised more than three months following the termination of the grantee's employment, the incentive stock option will generally be taxed as a nonstatutory stock option.

No income is realized by the grantee at the time a nonstatutory stock option is granted. Generally upon exercise of a nonstatutory stock option, the grantee will realize ordinary income in an amount equal to the difference between the price paid for the shares and the fair market value of the shares on the date of exercise. Anthem will generally be entitled to a deduction for federal income tax purposes in the same amount and at the same time as the grantee recognizes ordinary income. Any appreciation or depreciation after the date of exercise will be treated as either short-term or long-term capital gain or loss, depending upon the length of time that the grantee has held the shares. No deduction will be available to Anthem by reason of such gain or loss.

Employee Stock Purchase Plan

The Employee Stock Purchase Plan (the "Stock Purchase Plan") is intended to comply with Internal Revenue Code (S)423 and to provide a means by which to encourage and assist employees in acquiring a stock ownership interest in Anthem, Inc. We anticipate implementing the Stock Purchase Plan by mid 2002. The Stock Purchase Plan is administered by the Compensation Committee, and the Compensation Committee will have complete discretion to interpret and administer the Stock Purchase Plan and the rights granted under it. Any

employee of Anthem is

eligible to participate, as long as such employee's customary employment is more than 20 hours per week, more than five months in a calendar year, and the employee does not own stock totaling 5% or more of the voting power or value of Anthem, Inc. No employee will be permitted to purchase more than $25,000 worth of stock in any calendar year. The Stock Purchase Plan reserves for issuance and purchase by employees 3,000,000 shares of stock.

Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Payroll deductions are accumulated during each quarter and applied toward the purchase of stock on the last trading day of each quarter. Once purchased, the stock is accumulated in the employee's investment account. The purchase price per share equals the lower of (i) 85% of the fair market value of a share of our common stock on the first trading day of the quarter, or (ii) 85% of the fair market value of a share of our common stock on the last trading day of the quarter.

The board of directors may amend the Stock Purchase Plan in such respects as it deems advisable provided that the shareholders must approve certain amendments. Rights under the Stock Purchase Plan are not transferable, except by will or the law of descent and distribution. In the event of a participant's retirement, termination or death, the amount in the participant's payroll deduction account shall be refunded.

Deferred Compensation

Highly compensated employees, as defined in the Internal Revenue Code, are eligible to participate in an unfunded non-qualified deferred compensation plan. There are three types of deferral options in the plan. The Restoration Option allows deferral amounts that are limited under our 401(k) Plan and restores company match that would otherwise be contributed in our 401(k) Plan. The Supplemental Option allows an additional deferral of base salary and commissions, up to 80%, above the Restoration Option and these deferrals are not matched by us. The Annual Incentive Deferral Option allows an additional deferral of annual incentive compensation above the Restoration Option and is matched at a rate of 3%.

The declared interest rate on deferred amounts is the average of the 10-year U.S. Treasury Note monthly average rates for the 12-month period ending on September 30 of the previous year, plus 150 basis points. Interest is accrued daily, posted monthly and compounded annually. The retirement rate is credited at 125% of the declared interest rate. Distributions are made at the end of the quarter of termination or retirement based on the participant's filed distribution election or as otherwise specified in the plan document. Limited in-service withdrawals are available in the event of unforeseeable financial emergencies.

Retirement Plan

We sponsor a non-contributory pension plan for certain employees that is qualified under Internal Revenue Code (S)401(a) and subject to the Employee Retirement Income Security Act (the "Qualified Plan"). We also sponsor the Anthem Supplemental Executive Retirement Plan (the "SERP") which provides additional benefits payable out of our general assets to certain participants. The benefits under the SERP are equal to the benefits those participants cannot receive under the Qualified Plan because of Internal Revenue Code limits on benefits and restrictions on participation by highly compensated employees, as defined in the Internal Revenue Code.

On January 1, 1997, we converted the Qualified Plan from a final average compensation pension plan into a cash balance pension plan. The Qualified Plan covers substantially all full-time,

part-time and temporary employees, including executive officers, and provides a set benefit at age 65, the normal retirement age under the Qualified Plan.

Under the Qualified Plan, at the end of each calendar quarter, a bookkeeping account for each participant is credited with (1) an amount based on the participant's compensation and years of service (the "Pay Credit"), and (2) interest based on the average of the monthly yields for 10-year U.S. Treasury Security Constant Maturities for the twelve month period ending on September 30 of the preceding plan year. The Pay Credit equals a percentage of the participant's compensation for the plan year and is determined according to the following schedule:

Years of Service	Pay Credit
Up to and including 4	3%
5-9	4%
10-19	5%
20+	6%

The definition of compensation in the Qualified Plan is the participant's total earned income, including base salary, commissions, overtime pay, and cash bonuses, before it is reduced by any before-tax contributions the participant makes to the 401(k) plan and flexible benefit plan. Compensation does not include imputed income, car allowances, non-qualified deferred compensation, severance payments, payment of accrued paid time off days, payments under the Directed Executive Compensation Program, or similar items.

The SERP continues the calculation of the retirement benefits on a uniform basis. Any excess benefit accrued to a participant under the SERP will be payable according to one of five payment options available under the SERP at termination or retirement.

Messrs. Glasscock, Frick, Smith and Faller and Ms. Dorr receive benefits under both the Qualified Plan and the SERP. The estimated benefits, under both the Qualified Plan and the SERP, payable in a lump sum upon retirement at normal retirement age are as follows: Mr. Glasscock ($1,787,981), Mr. Frick ($650,913), Mr. Smith ($774,339), Mr. Faller ($3,879,546), and Ms. Dorr ($2,581,168). Mr. Faller's benefit is calculated under a different formula through 2001 as a result of transition benefits in the Qualified Plan. These estimates use 2000 base pay and annual bonus for all future years and assume that the named executive officers remain actively employed until normal retirement age.

In addition, the employment agreements for Messrs. Glasscock, Frick and Smith set forth a Replacement Ratio SERP benefit, calculated as a retirement at age 62 or the date of termination, if later than age 62, in an amount equal to 50% of the executive's average annual pay during the three highest consecutive calendar years of his final five calendar years of employment. The benefit will be offset by the amount payable under the Qualified Plan and the SERP. The estimated replacement ratio SERP benefit payable upon retirement at age 65 is

as follows: Mr. Glasscock ($738,852 annually), Mr. Frick ($401,880 annually), and Mr. Smith ($295,008 annually). These estimates use 2000 base salary and annual bonus for all future years and assume that the named executive officers remain actively employed until normal retirement age.

Employment Agreements

Anthem Insurance has entered into employment agreements with certain of our executive officers, including Messrs. Glasscock, Frick, Smith, Faller and Ms. Dorr, that provide for each executive's continued employment with us. The current terms of the employment agreements are effective through December 31, 2005 for Mr. Glasscock, December 31, 2004 for Messrs. Frick and Smith and December 31, 2003 for Mr. Faller and Ms. Dorr.

Under these agreements, each eligible executive's terms and conditions of employment, including rate of base salary, incentive compensation opportunities, participation in employee benefit plans and perquisites are addressed.

The employment agreements provide that Anthem Insurance will have the right at any time to terminate an executive's employment and that any executive will have the right to terminate his or her employment at Anthem Insurance. Under the employment agreements with Messrs. Glasscock, Frick and Smith, Anthem Insurance will provide them for the remainder of the term with the following benefits in the event of termination by us other than for cause, in the event of an approved retirement or in the event of termination by the executive for good reason (as those terms are defined in the employment agreements):

- salary;
- all unvested prior long-term incentive awards;
- annual incentive and long-term incentive awards for the year of termination based upon the achievement of the performance goals for the plans for the entire year of termination prorated to reflect the full number of months the executive was employed;
- an amount equal to 80% of any target annual incentive and target long-term incentive opportunities;
- an amount equal to 20% of any target annual incentive and target long-term incentive opportunities if the executive is available for consultation up to a maximum of eight days each quarter of the year;
- medical and dental plan benefits and directed executive compensation for which the executive would otherwise have been eligible to receive; and
- the Replacement Ratio SERP Benefit described under "--Retirement Plan."

Section 280G and Section 4999 of the Code limit deductions for compensation paid to certain senior executives if the payment is contingent on a change of ownership or effective control of a corporation. This deduction is limited to the average taxable compensation of the affected executive for the five years prior to the year that the change of control occurred. If the payments to the executive equal or exceed three times such average taxable compensation, the deduction is limited pursuant to Code Section 280G and these payments are referred to as "golden parachute" payments. In addition, Code Section 4999 imposes a 20% nondeductible excise tax on the executive on all nondeductible payments.

Pursuant to their employment agreements, in the event Messrs. Glasscock, Frick or Smith is a recipient of a "golden parachute" payment, we will make an additional gross-up payment to the executive in order to put him in the same after-tax position that he would have been in had no excise tax been imposed. The gross-up will result in Anthem paying not only the excise tax payable by the executive but also the income and excise taxes on the additional payments.

Under the employment agreements for Ms. Dorr and Mr. Faller, Anthem Insurance will provide them with the following benefits in the event of termination by us other than for cause:

- salary;
- all unvested prior long-term incentive awards;
- annual incentive and long-term incentive awards for the year of termination based upon the achievement of the performance goals for the plans for the entire year of termination prorated to reflect the full number of months the executive was employed;

- an amount equal to 50% of any target annual incentive and target long-term incentive opportunities; and
- medical and dental plan benefits for which the executive would otherwise have been eligible to receive.

The employment agreements for Ms. Dorr and Mr. Faller also state that the foregoing benefits are limited to either the greater of one year or the remainder of the term.

Under these agreements, Messrs. Glasscock, Frick and Smith agree not to compete as an equity owner or employee with us or our subsidiaries for the greater of (i) two years after the executive's termination for any reason or (ii) the remainder of the term after their termination by us other than for cause, after an approved retirement or after termination by the executive for good reason. Mr. Faller and Ms. Dorr are subject to the same limitation but for the greater of one year or the remainder of the term after their termination other than for cause.

Ownership of Common Stock

No directors or executive officers own any stock in Anthem, Inc. and no directors or executive officers will receive any stock in connection with the demutualization. Under the plan of conversion, we cannot make any grants of our common stock or options to purchase our common stock to any of our directors or our approximately top 50 executives until six months after the effective date of the demutualization. In addition, under the Indiana Insurance Commissioner's order approving the plan of conversion, none of our directors or our approximately top 50 executives may acquire beneficial ownership of shares of our common stock for a period of six months following the effective date of the demutualization.

Certain Relationships and Related Transactions

In the ordinary course of business, we from time to time may engage in transactions with other corporations or financial institutions whose officers or directors are also directors of Anthem. Transactions with such corporations

and financial institutions are conducted on an arm's length basis and may not come to the attention of the directors of Anthem or of the other corporations or financial institutions involved.

Mr. Lytle, Chairman of the board of directors, retired as Chief Executive Officer in October 1999. Pursuant to his employment agreement and retirement agreement, Anthem pays Mr. Lytle $400,000 annually until December 31, 2002 for his consultation services up to a maximum of eight days per quarter. In addition, in any quarter in which Anthem has requested Mr. Lytle to provide more than eight days of consultation, he is to be paid five hundred dollars ($500) per hour, up to a maximum of five thousand dollars ($5,000) per day.

Compensation Committee Interlocks and Insider Participation

The Compensation Committee, among other things, approves compensation for Anthem's executive officers. The Compensation Committee members during 2000 were Victor S. Liss, William G. Mays, B. LaRae Orullian, William J. Ryan, Allan B. Hubbard and Dennis J. Sullivan, Jr. None of the Compensation Committee members were involved in a relationship requiring disclosure as an interlocking director, or under Item 404 of Regulation S-K, or as a former officer or employee of Anthem.

DESCRIPTION OF CAPITAL STOCK

The following description of our capital stock does not purport to be complete and is subject in all respects to applicable Indiana law and to the provisions of our articles of incorporation and by-laws, copies of which are included as exhibits to the registration statement of which this prospectus forms a part.

Our authorized capital stock consists of 900,000,000 shares of common stock, $.01 par value per share, and 100,000,000 shares of preferred stock, without par value. After giving effect to (a) the issuance of an estimated 54,861,000 shares of common stock in the demutualization and (b) the issuance of 48,000,000 shares of common stock in this offering, and assuming that the underwriters do not exercise their over-allotment option, we would have 102,861,000 shares of common stock issued and outstanding and no shares of preferred stock issued and outstanding. An additional 10,000,000 shares of common stock are reserved for issuance under our Stock Plan and under our Stock Purchase Plan. Additional shares of common stock will be issuable upon settlement of the purchase contracts included in the units.

Common Stock

Each holder of common stock is entitled to one vote per share of record on all matters to be voted upon by the shareholders. Holders do not have cumulative voting rights in the election of directors or any other matter. Subject to the preferential rights of the holders of any preferred stock that may at the time be outstanding, each share of common stock will entitle the holder of that share to an equal and ratable right to receive dividends when, if and as declared from time to time by the board of directors and paid out of legally available funds. We do not anticipate paying cash dividends. See "Dividend Policy."

In the event of our liquidation, dissolution or winding up, the holders of common stock will be entitled to share ratably in all assets remaining after payments to creditors and after satisfaction of the liquidation preference, if any, of the holders of any preferred stock that may at the time be outstanding. Holders of common stock have no preemptive or redemption rights and will not be

subject to further calls or assessments by us. All of the shares of common stock to be issued and sold in this offering will be, immediately upon consummation of this offering, validly issued, fully paid and non-assessable.

Preferred Stock

The authorized preferred stock is available for issuance from time to time at the discretion of the board of directors without shareholder approval. The board of directors has the authority to prescribe for each series of preferred stock it establishes the number of shares in that series, the number of votes, if any, to which the shares in that series are entitled, the consideration for the shares in that series, and the designations, powers, preferences and other rights, qualifications, limitations or restrictions of the shares in that series. Depending upon the rights prescribed for a series of preferred stock, the issuance of preferred stock could have an adverse effect on the voting power of the holders of common stock and could adversely affect holders of common stock by delaying or preventing a change in control of us, making removal of our present management more difficult or imposing restrictions upon the payment of dividends and other distributions to the holders of common stock.

Authorized But Unissued Shares

Indiana law does not require shareholder approval for any issuance of authorized shares. Authorized but unissued shares may be used for a variety of corporate purposes, including future public or private offerings to raise additional capital or to facilitate corporate acquisitions. One of the effects of the existence of authorized but unissued shares may be to enable the board of directors to issue shares to persons friendly to current management, which issuance could render more difficult or discourage an attempt to obtain control of us by means of a merger, tender offer, proxy contest or

otherwise, and thereby protect the continuity of current management and possibly deprive the shareholders of opportunities to sell their shares of common stock at prices higher than prevailing market prices.

Limitations on Ownership of Common Stock in Articles of Incorporation

Our license agreements with the BCBSA require as a condition to our retention of the licenses that our articles of incorporation contain certain provisions, including limitations on the ownership of our common stock. Our articles of incorporation provide that after the demutualization no person may beneficially own shares of our voting capital stock in excess of the specified BCBSA ownership limit, except with the prior approval of a majority of the continuing directors (as defined in our articles of incorporation). The BCBSA ownership limit, which may not be exceeded without the prior approval of the BCBSA, is the following:

- for any "Institutional Investor," one share less than 10% of our outstanding voting securities;
- for any "Noninstitutional Investor," one share less than 5% of our outstanding voting securities; and
- for any person, one share less than the number of shares of our common stock or other equity securities (or a combination thereof) representing a 20% or more ownership interest in our company.

"Institutional Investor" means any person if (but only if) such person is:

- a broker or dealer registered under Section 15 of the Securities Exchange Act of 1934, or Exchange Act;
- a bank as defined in Section 3(a)(6) of the Exchange Act;
- an insurance company as defined in Section 3(a)(19) of the Exchange Act;
- an investment company registered under Section 8 of the Investment Company Act of 1940;
- an investment adviser registered under Section 203 of the Investment Advisers Act of 1940;
- an employee benefit plan, or pension fund which is subject to the provisions of ERISA or an endowment fund;
- 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 the six bullet points listed above, does not exceed one percent of the securities of the subject class such as common stock; or
- a group, provided that all the members are persons specified in the seven bullet points listed above.

In addition, every filing made by such person with the SEC under Regulations 13D-G (or any successor regulations) under the Exchange Act with respect to that person's beneficial ownership must contain a certification substantially to the effect that our common stock acquired by that 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 our company and was not acquired in connection with or as a participant in any transaction having such purpose or effect.

"Noninstitutional Investor" means any person that is not an Institutional Investor.

Any transfer of stock that would result in any person beneficially owning shares of capital stock in excess of the ownership limit will result in the intended transferee acquiring no rights in such shares (with certain exceptions) and the person's shares will be deemed transferred to an escrow

agent to be held until the shares are transferred to a person whose ownership of the shares will not violate the ownership limit. These provisions prevent a third party from obtaining control of our company without obtaining the prior approval of our continuing directors or the 75% supermajority vote required to amend these provisions of our articles of incorporation and may have the effect of discouraging or even preventing a merger or business combination, a tender offer or similar extraordinary transaction involving us.

Certain Other Provisions of Articles of Incorporation and By-Laws

Certain other provisions of our articles of incorporation and by-laws may delay or make more difficult unsolicited acquisitions or changes of control of us. These provisions could have the effect of discouraging third parties from making proposals involving an unsolicited acquisition or change in control of us, although these proposals, if made, might be considered desirable by a majority of our shareholders. These provisions may also have the effect of

making it more difficult for third parties to cause the replacement of the current management without the concurrence of the board of directors. These provisions include:

- the division of the board of directors into three classes serving staggered terms of office of three years (see "Management--Directors and Executive Officers");
- provisions allowing the removal of directors only upon a 66 2/3% shareholder vote or upon the affirmative vote of both a majority of all directors and a majority of continuing directors (as defined in our articles of incorporation);
- provisions limiting the maximum number of directors to 19, and requiring that any increase in the number of directors then in effect must be approved by a majority of continuing directors;
- permitting only the board of directors, the Chairman, the Chief Executive Officer or the President to call a special meeting of shareholders;
- requirements for a 75% supermajority vote to amend certain provisions of our articles of incorporation, including those provisions discussed in this section; and
- requirements for advance notice for raising business or making nominations at shareholders' meetings.

Our by-laws establish an advance notice procedure with regard to business to be brought before an annual or special meeting of shareholders and with regard to the nomination of candidates for election as directors, other than by or at the direction of the board of directors. Although our by-laws do not give the board of directors any power to approve or disapprove shareholder nominations for the election of directors or proposals for action, they may have the effect of precluding a contest for the election of directors or the consideration of shareholder proposals if the established procedures are not followed, and of discouraging or deterring a third party from conducting a solicitation of proxies to elect its own slate of directors or to approve its proposal without regard to whether consideration of those nominees or proposals might be harmful or beneficial to us and our shareholders.

Our articles of incorporation provide that, in the case of a merger, sale or purchase of assets, issuance of securities or reclassification, each a "business combination," involving a beneficial owner of 10% or more of the voting power of our capital stock (a "related person"), or any affiliate or associate of a related person, such business combination must be approved by (i) 66 2/3% of the voting power of our outstanding voting stock and (ii) a majority of the then outstanding voting power of the voting stock held by shareholders other than the related person. However, these shareholder approval requirements do not apply if the business combination is approved in advance by at least

two-thirds of the continuing directors (as defined in our articles of incorporation) or the consideration to be received by shareholders in the business combination is at least equal to the highest price paid by the related person in acquiring its interest in our company, with specified adjustments, and some other requirements are met.

Certain Provisions of Indiana Law

Under the Indiana demutualization law, for a period of five years following the effective date of the demutualization, no person may acquire beneficial ownership of 5% or more of the outstanding shares of our common stock without the prior approval of the Indiana Insurance Commissioner and our board of directors.

This restriction does not apply to acquisitions made by us or made pursuant to an employee benefit plan or employee benefit trust sponsored by us. The Indiana Insurance Commissioner has adopted rules under which passive institutional investors could purchase 5% or more but less than 10% of any outstanding common stock with the approval of our board of directors and prior notice to the Indiana Insurance Commissioner.

The Indiana Business Corporation Law, or IBCL, applies to us as an Indiana corporation. Under specified circumstances, the following provisions of the IBCL may delay, prevent or make more difficult unsolicited acquisition or changes of control of us. These provisions also may have the effect of preventing changes in our management. It is possible that these provisions could make it more difficult to accomplish transactions which shareholders may otherwise deem to be in their best interests.

Control Share Acquisitions. Under Sections 23-1-42-1 to 23-1-42-11 of the IBCL, an acquiring person or group who makes a "control share acquisition" in an "issuing public corporation" may not exercise voting rights on any "control shares" unless these voting rights are conferred by a majority vote of the disinterested shareholders of the issuing corporation at a special meeting of those shareholders held upon the request and at the expense of the acquiring person. If control shares acquired in a control share acquisition are accorded full voting rights and the acquiring person has acquired control shares with a majority or more of all voting power, all shareholders of the issuing public corporation have dissenters' rights to receive the fair value of their shares pursuant to Section 23-1-44 of the IBCL.

Under the IBCL, "control shares" means shares acquired by a person that, when added to all other shares of the issuing public corporation owned by that person or in respect to which that person may exercise or direct the exercise of voting power, would otherwise entitle that person to exercise voting power of the issuing public corporation in the election of directors within any of the following ranges:

- one-fifth or more but less than one-third;
- one-third or more but less than a majority; or
- a majority or more.

"Control share acquisition" means, subject to specified exceptions, the acquisition, directly or indirectly, by any person of ownership of, or the power to direct the exercise of voting power with respect to, issued and outstanding control shares. Shares acquired within 90 days or under a plan to make a control share acquisition are considered to have been acquired in the same acquisition. "Issuing public corporation" means a corporation which is organized in Indiana and has (i) 100 or more shareholders, (ii) its principal place of business, its principal office or substantial assets within Indiana and (iii) either:

- more than 10% of its shareholders resident in Indiana;

- more than 10% of its shares owned by Indiana residents; or
- 10,000 shareholders resident in Indiana.

The above provisions do not apply if, before a control share acquisition is made, the corporation's articles of incorporation or by-laws, including a board adopted by-law, provide that they do not apply. Our articles of incorporation and by-laws do not currently exclude us from the restrictions imposed by the above provisions.

Certain Business Combinations. Sections 23-1-43-1 to 23-1-43-24 of the IBCL restrict the ability of a "resident domestic corporation" to engage in any combinations with an "interested shareholder" for five years after the interested shareholder's date of acquiring shares unless the combination or the purchase of shares by the interested shareholder on the interested shareholder's date of acquiring shares is approved by the board of directors of the resident domestic corporation before that date. If the combination was not previously approved, the interested shareholder may effect a combination after the five-year period only if that shareholder receives approval from a majority of the disinterested shares or the offer meets specified fair price criteria. For purposes of the above provisions, "resident domestic corporation" means an Indiana corporation that has 100 or more shareholders. "Interested shareholder" means any person, other than the resident domestic corporation or its subsidiaries, who is (1) the beneficial owner, directly or indirectly, of 10% or more of the voting power of the outstanding voting shares of the resident domestic corporation or (2) an affiliate or associate of the resident domestic corporation, which at any time within the five-year period immediately before the date in question, was the beneficial owner, directly or indirectly, of 10% or more of the voting power of the then outstanding shares of the resident domestic corporation. The above provisions do not apply to corporations that so elect in an amendment to their articles of incorporation approved by a majority of the disinterested shares. That amendment, however, cannot become effective until 18 months after its passage and would apply only to share acquisitions occurring after its effective date. Our articles of incorporation do not exclude us from the restrictions imposed by the above provisions.

Directors' Duties and Liability. Under Section 23-1-35-1 of the IBCL, directors are required to discharge their duties:

- in good faith;
- with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and
- in a manner the directors reasonably believe to be in the best interests of the corporation.

However, the IBCL also provides that a director is not liable for any action taken as a director, or any failure to act, unless the director has breached or failed to perform the duties of the director's office and the action or failure to act constitutes willful misconduct or recklessness. The exoneration from liability under the IBCL does not affect the liability of directors for violations of the federal securities laws.

Section 23-1-35-1 of the IBCL also provides that a board of directors, in discharging its duties, may consider, in its discretion, both the long-term and short-term best interests of the corporation, taking into account, and weighing as the directors deem appropriate, the effects of an action on the corporation's shareholders, employees, suppliers and customers and the communities in which offices or other facilities of the corporation are located and any other factors the directors consider pertinent. If a determination is made with the approval of a majority of the disinterested directors of the

board, that determination is conclusively presumed to be valid unless it can be demonstrated that the determination was not made in good faith after reasonable investigation. Once the board, in exercising its business judgment, has determined that a proposed action is not in the best interests

of the corporation, it has no duty to remove any barriers to the success of the action, including a shareholder rights plan. Section 23-1-35-1 specifically provides that specified judicial decisions in Delaware and other jurisdictions, which might be looked upon for guidance in interpreting Indiana law, including decisions that propose a higher or different degree of scrutiny in response to a proposed acquisition of the corporation, are inconsistent with the proper application of the business judgment rule under that section.

Transfer Agent and Registrar

The transfer agent and registrar for the common stock is EquiServe Trust Company, N.A.

COMMON STOCK ELIGIBLE FOR FUTURE SALE

All of the 48,000,000 shares of our common stock sold to investors in the public market in this offering (55,200,000 shares if the underwriters exercise their over-allotment option in full) will be eligible for immediate resale in the public market without restriction, except for any of those shares that are beneficially owned at any time by our affiliates, as defined in Rule 144 of the Securities Act, which sales will be subject to the timing, volume and manner of sale limitations of Rule 144.

Anthem Insurance's eligible statutory members who receive fewer than 30,000 shares of our common stock in exchange for their membership interests may sell their shares of our common stock in the public market without restriction, except for any shares owned by our affiliates, which must be sold in compliance with Rule 144. Anthem Insurance's eligible statutory members who receive 30,000 or more shares of our common stock in exchange for their membership interests (whom we estimate would hold an aggregate of approximately 11.5 million shares of our outstanding common stock after the offering) and continue to hold 30,000 or more shares will be restricted from selling their shares in the public market for 180 days following the effective date of the demutualization, except for sales in accordance with a large holder sale program we will establish, a transfer that occurs by operation of law or transfers with our written consent. After the expiration of this period, those eligible statutory members may sell their shares of our common stock in the public market without restriction, except for any shares owned by our affiliates, which must be sold in compliance with Rule 144. See "The Plan of Conversion--Large Holder Sale Program" for a description of the large holder sale program and its limitations. We anticipate that eligible statutory members receiving shares of our common stock in the demutualization will receive notices regarding the number of shares registered in their name approximately four to six weeks after the effective date of the demutualization.

In general, under Rule 144 as currently in effect, (a) a person, or persons whose shares are aggregated, who has beneficially owned restricted shares for at least one year or (b) an affiliate who holds non-restricted shares, will be entitled to sell, within any three-month period, a number of shares that does not exceed the greater of 1% of the then outstanding shares of our common stock, or the average weekly trading volume of our common stock during the four

calendar weeks preceding such sale. Sales under Rule 144 are also subject to certain provisions regarding the manner of sale, notice requirements and the availability of current public information about us. If two years have elapsed since the date of acquisition of restricted shares of our common stock from us or any of our affiliates and the holder is not deemed to have been an affiliate of ours for at least three months prior to a proposed transaction, such person would be entitled to sell such shares under Rule 144 without regard to the limitations described above.

There are 7,000,000 shares of common stock available for grant of options, restricted stock, stock appreciation rights, performance stock and performance awards under our Stock Plan. We intend to grant options to purchase 100 shares of common stock to each of our approximately 15,000 employees (other than our approximately top 50 executives), pursuant to our Stock Plan, effective on the first day that our common stock trades on the New York Stock Exchange. See "Management--Stock Incentive Plan." We intend to file a registration statement on Form S-8 to register the shares of common stock that are issuable upon the exercise of stock options outstanding or available for grant pursuant to our Stock Plan. Under our Stock Purchase Plan, we have reserved for issuance and purchase by employees 3,000,000 shares of common stock. See "Management--Employee Stock Purchase Plan." We intend to file a registration statement on Form S-8 to register the shares of common stock that are issuable under the Stock Purchase Plan. Following effectiveness of each Form S-8, shares covered by that Form S-8 will be eligible for sale in the public markets, subject to Rule 144 limitations applicable to affiliates as well as to the limitations on sale and vesting described above.

In addition, in accordance with the plan of conversion, we intend, for not less than a three month period commencing no earlier than the first business day after the 180th day following, and no later than the last business day before the twelfth-month anniversary of, the effective date of the demutualization, to provide for the public sale, at prevailing market prices and without brokerage commissions or similar fees to shareholders, of all shares of our common stock held by shareholders who own 99 shares or fewer of our common stock. We estimate that when we complete the demutualization we will have approximately 150,000 eligible statutory members who will in total receive in excess of five million shares that we believe would be eligible to participate in this commission-free sales program. We would also, simultaneously and in conjunction with the commission-free sales program, offer to each shareholder entitled to participate in the commission-free sales program the opportunity to purchase that number of shares of our common stock necessary to increase such shareholder's holdings to 100 shares without paying brokerage commissions or other similar expenses. The program may provide that we can repurchase shares of our common stock at prevailing market prices when, during any particular day of the program, the number of shares requested to be sold exceeds the number of shares requested to be purchased pursuant to round-up requests.

We have agreed with the Underwriters not to dispose of or hedge any of our common stock or securities convertible into or exchangeable for shares of common stock (other than the units to be offered and sold concurrently with this offering) during the period from the date of this prospectus continuing through the date 180 days after the date of this prospectus, except with the prior written consent of the representatives. This agreement does not apply to any existing employee benefit plans.

OWNERSHIP OF COMMON STOCK

The following table sets forth certain information regarding the beneficial ownership of our common stock as of the effective date of the demutualization by:

- each of our directors and Named Executive Officers; and
- all of our directors and executive officers as a group.

We believe that no person will beneficially own more than 5% of our outstanding shares of common stock as a result of the shares distributed pursuant to the plan of conversion and shares sold in this offering.

None of our directors or executive officers will receive any stock in connection with the demutualization, nor will they be permitted to acquire beneficial ownership of any shares of our common stock for a period of six months following the effective date of the demutulization.

Name	Number of Shares to Be Beneficially Owned (1)
L. Ben Lytle	0
Susan B. Bayh	0
Larry C. Glasscock	0
William B. Hart	0
Allan B. Hubbard	0
Victor S. Liss	0
William G. Mays	0
James W. McDowell, Jr.	0
B. LaRae Orullian	0
Senator Donald W. Riegle, Jr.	0
William J. Ryan	0
George A. Schaefer, Jr.	0
Dennis J. Sullivan, Jr.	0
David R. Frick	0
Michael L. Smith	0
Keith R. Faller	0
Marjorie W. Dorr	0
All directors and executive officers as a group (22 persons)	0

---

(1) Based on an estimated allocation of shares based upon statutory membership ownership records as of June 18, 2001.

DESCRIPTION OF THE EQUITY SECURITY UNITS

The Units

Concurrently with the closing of this initial public offering, we are selling 4,000,000 6.00% equity security units for a total gross offering of $200.0 million, plus up to an additional $30.0 million if the underwriters' option to purchase additional units is exercised in full. Each unit will initially consist of and represent:

- a purchase contract under which the holder agrees to purchase, for $50, shares of our common stock on November 15, 2004. The number of shares the holder will receive will be determined by the settlement rate described below, based on the average trading price of our common stock at that time; and

- a subordinated debenture with a principal amount of $50. The debenture will initially be pledged to secure the holder's obligations under the purchase contract.

The Purchase Contracts

The purchase contract underlying a unit obligates the holder to purchase, and us to sell, for $50, on November 15, 2004, a number of newly issued shares of our common stock. We will determine the number of shares the holder will receive by the settlement rate described below, based on the average closing price of the common stock during a specified period prior to the stock purchase date.

We will pay the holder quarterly contract fee payments on the purchase contracts at the annual rate of 0.05% of the stated amount of $50 per purchase contract, subject to our rights to defer these payments. We will make contract fee payments only to but excluding the earlier of November 15, 2004 or the most recent quarterly payment date on or before any early settlement of the related purchase contracts. We have the option to defer contract fee payments on the purchase contracts for up to three years. We may elect the option to defer payments on more than one occasion. In no event may we defer payments beyond November 15, 2004. Deferred contract fee payments will accrue additional contract fee payments until paid, compounded quarterly, at the annual rate of 6.00%. This annual rate is equal to the sum of the initial interest rate on the debentures and the rate of contract fee payments on the purchase contracts.

The Debentures

The debentures will be unsecured and will be subordinated in right of payment to all of Anthem, Inc.'s existing and future senior indebtedness. The debentures will mature on November 15, 2006.

Each debenture shall initially bear interest at the rate of 5.95% per year, payable quarterly in arrears on February 15, May 15, August 15 and November 15 of each year, subject to the deferral provisions described below, commencing February 15, 2002 and ending on November 15, 2006. The applicable interest rate on the debentures outstanding on and after August 15, 2004 will be reset on the third business day preceding August 15, 2004, effective for interest accrued from August 15, 2004 to November 15, 2006, as described below.

The reset rate will be the interest rate on the debentures determined by the reset agent to be sufficient to cause the then current aggregate market value of all then outstanding debentures to be equal to 100.5% of the remarketing value. For this purpose we will assume, even if not true, that all of the debentures will be remarketed. If the reset agent cannot establish a reset rate on the remarketing date that will be sufficient to cause the then current aggregate market value of all debentures to be equal to 100.5% of the remarketing value, and as a result the debentures cannot

be sold, the interest rate will not be reset but will continue to be the initial interest rate of the debentures. However, the reset agent may thereafter attempt to establish a reset rate meeting these requirements, and the remarketing agent may attempt to remarket the debentures, on one or more

subsequent remarketing dates after the initial remarketing date until November 15, 2004. The reset rate will be determined by a nationally recognized investment banking firm acting as reset agent.

We can, on one or more occasions, defer the interest payments due on the debentures for up to five years, unless an event of default under the debentures has occurred and is continuing. However, we cannot defer interest payments beyond the maturity date of the debentures, which is November 15, 2006. During any deferral period, interest on the debentures will continue to accrue quarterly at the initial annual rate of 5.95% of the principal amount of $50 per debenture through and including August 15, 2004, and at the reset rate from that date to November 15, 2006. Additional interest will accrue on the deferred interest at the applicable rate, to the extent permitted by law. Interest payments may be deferred if we do not have funds available to make the interest payments or for any other reason.

During any period in which we defer contract fee payments or interest payments on the debentures, in general we cannot:

- declare or pay any dividend or distribution on our capital stock; or
- redeem, purchase, acquire or make a liquidation payment on any of our capital stock.

In addition, during any period in which we defer interest payments on the debentures, in general we cannot:

- make any interest, principal or premium payment on, or repurchase or redeem, any of our debt securities that rank equally with or junior in right of payment to the debentures; or
- make any payment on any guarantee of the debt securities of any of our subsidiaries if the guarantee ranks equally with or junior in right of payment to the debentures.

Remarketing

Through a remarketing, the debentures held by the holders of units, other than those electing not to participate in the remarketing, will be sold and the proceeds used to purchase U.S. treasury securities, which will be pledged to secure the unitholders' obligations under the purchase contracts. Cash payments received on the pledged treasury securities will be used to satisfy the unitholders' obligations to purchase our common stock on November 15, 2004. Unless a holder elects not to participate in the remarketing by delivering treasury securities to secure its obligations under the purchase contract, or unless the remarketing agent delays the remarketing to a later date, the debentures will be sold in a remarketing on August 15, 2004.

Settlement

The settlement rate is the number of newly issued shares of our common stock that we are obligated to sell and the holders are obligated to buy upon settlement of a purchase contract on November 15, 2004. The settlement rate for each purchase contract will be as follows, subject to adjustment under specified circumstances:

- if the applicable market value of our common stock is equal to or greater than the threshold appreciation price (which is equal to 122% of the initial public offering price of our common stock (which initial public offering price we refer to herein as the reference price)), the settlement rate will be equal to $50 divided by the threshold appreciation price per purchase contract;

- if the applicable market value of our common stock is less than the threshold appreciation price but greater than the reference price, the settlement rate will be equal to $50 divided by the applicable market value of our common stock per purchase contract; and

- if the applicable market value of our common stock is less than or equal to the reference price, the settlement rate will be equal to $50 divided by the reference price per purchase contract.

The "applicable market value" means the average of the closing price per share of our common stock on each of the twenty consecutive trading days ending on the third trading day preceding November 15, 2004.

In addition to the remarketing, the holder's obligations under the purchase contract may be satisfied:

- if the holder has elected not to participate in the remarketing by delivering treasury securities to secure its obligations under the purchase contract, and in certain other circumstances, through the application of the cash payments received on the treasury securities;

- through the early delivery of cash to the purchase contract agent in the manner described in the purchase contracts; and

- if we are involved in a merger prior to the stock purchase date in which at least 30% of the consideration for our common stock consists of cash or cash equivalents, through an early settlement as described in the purchase contracts.

In addition, the purchase contracts, our related rights and obligations and those of the holders of the units, including their obligations to purchase common stock, will automatically terminate upon the occurrence of particular events of our bankruptcy, insolvency or reorganization. Upon termination, the debentures or treasury securities pledged to secure the holder's obligations under the purchase contract will be released and distributed to the holder.

Listing

The units have been approved for listing on the New York Stock Exchange, subject to official notice of issuance, under the symbol "ATV."

Accounting Treatment

The purchase contracts are forward transactions in our common stock. Upon settlement of a purchase contract, we will receive $50 on that purchase contract and will issue the requisite number of shares of Anthem, Inc. common stock. The $50 we receive will be credited to shareholders' equity and allocated between the common stock and additional paid-in-capital accounts.

Before settlement of the purchase contracts through the issuance of common stock, the units will be reflected in our diluted earnings per share calculations using the treasury stock method. Under this method, the number of shares of our common stock used in calculating earnings per share for any period will be deemed to be increased by the excess, if any, of the number of our shares that would be required to be issued upon settlement of the purchase contracts over the number of shares that could be purchased by us in the market, at the average market price during that period, using the proceeds that would be required to be paid upon settlement. Consequently, there will be no

dilutive effect on our earnings per share, except during periods when the average market price of our common stock is above $43.92 per share.

CERTAIN UNITED STATES TAX CONSEQUENCES TO NON-U.S. HOLDERS OF COMMON STOCK

This section summarizes certain United States federal income and estate tax consequences of the ownership and disposition of common stock by a non-U.S. holder. You are a non-U.S. holder if you are, for United States federal income tax purposes:

- a nonresident alien individual;
- a foreign corporation;
- a foreign partnership; or
- an estate or trust that in either case is not subject to United States federal income tax on a net income basis on income or gain from common stock.

This section does not consider the specific facts and circumstances that may be relevant to a particular non-U.S. holder and does not address the treatment of a non-U.S. holder under the laws of any state, local or foreign taxing jurisdiction. This section is based on the tax laws of the United States, including the Internal Revenue Code of 1986, as amended, existing and proposed regulations, and administrative and judicial interpretations, all as currently in effect. These laws are subject to change, possibly on a retroactive basis.

You should consult a tax advisor regarding the United States federal tax consequences of acquiring, holding and disposing of common stock in your particular circumstances, as well as any tax consequences that may arise under the laws of any state, local or foreign taxing jurisdiction.

Dividends

Except as described below, if you are a non-U.S. holder of common stock, dividends paid to you are subject to withholding of United States federal income tax at a 30% rate or at a lower rate if you are eligible for the benefits of an income tax treaty that provides for a lower rate. Even if you are eligible for a lower treaty rate, we and other payors will generally be required to withhold at a 30% rate (rather than the lower treaty rate) on dividend payments to you, unless you have furnished to us or another payor:

- a valid Internal Revenue Service Form W-8BEN or an acceptable substitute form upon which you certify, under penalties of perjury, your status as a non-United States person and your entitlement to the lower treaty rate with respect to such payments; or
- in the case of payments made outside the United States to an offshore account (generally, an account maintained by you at an office or branch of a bank or other financial institution at any location outside the United States), other documentary evidence establishing your entitlement to the lower treaty rate in accordance with U.S. Treasury regulations.

If you are eligible for a reduced rate of United States withholding tax under a tax treaty, you may obtain a refund of any amounts withheld in excess of that rate by filing a refund claim with the United States Internal Revenue

Service.

If dividends paid to you are "effectively connected" with your conduct of a trade or business within the United States, and, if required by a tax treaty, the dividends are attributable to a permanent establishment that you maintain in the United States, we and other payors generally are not required

to withhold tax from the dividends, provided that you have furnished to us or another payor a valid Internal Revenue Service Form W-8ECI or an acceptable substitute form upon which you represent, under penalties of perjury, that:

- you are a non-United States person; and
- the dividends are effectively connected with your conduct of a trade or business within the United States and are includible in your gross income.

"Effectively connected" dividends are taxed at rates applicable to United States citizens, resident aliens and domestic United States corporations.

If you are a corporate non-U.S. holder, "effectively connected" dividends that you receive may, under certain circumstances, be subject to an additional "branch profits tax" at a 30% rate or at a lower rate if you are eligible for the benefits of an income tax treaty that provides for a lower rate.

Gain on Disposition of Anthem, Inc. Common Stock

If you are a non-U.S. holder, you generally will not be subject to United States federal income tax on gain that you recognize on a disposition of common stock unless:

- the gain is "effectively connected" with your conduct of a trade or business in the United States, and the gain is attributable to a permanent establishment that you maintain in the United States, if that is required by an applicable income tax treaty as a condition for subjecting you to United States taxation on a net income basis;
- you are an individual, you hold the common stock as a capital asset, you are present in the United States for 183 or more days in the taxable year of the sale and certain other conditions exist; or
- we are or have been a United States real property holding corporation for federal income tax purposes and you held, directly or indirectly, at any time during the five-year period ending on the date of disposition, more than 5% of the common stock and you are not eligible for any treaty exemption.

If you are a corporate non-U.S. holder, "effectively connected" gains that you recognize may also, under certain circumstances, be subject to an additional "branch profits tax" at a 30% rate or at a lower rate if you are eligible for the benefits of an income tax treaty that provides for a lower rate.

We have not been, are not and do not anticipate becoming a United States real property holding corporation for United States federal income tax purposes.

Federal Estate Taxes

Common stock held by a non-U.S. holder at the time of death will be included in the holder's gross estate for United States federal estate tax purposes, unless an applicable estate tax treaty provides otherwise.

Backup Withholding and Information Reporting

If you are a non-U.S. holder, you are generally exempt from backup withholding and information reporting requirements with respect to:

- dividend payments; and
- the payment of the proceeds from the sale of common stock effected at a United States office of a broker,

as long as the income associated with such payments is otherwise exempt from United States federal income tax, and:

- the payor or broker does not have actual knowledge or reason to know that you are a United States person and you have furnished to the payor or broker:
  - a valid Internal Revenue Service Form W-8BEN or an acceptable substitute form upon which you certify, under penalties of perjury, that you are a non-United States person, or
  - other documentation upon which it may rely to treat the payments as made to a non-United States person in accordance with U.S. Treasury regulations; or
  - you otherwise establish an exemption.

Payment of the proceeds from the sale of common stock effected at a foreign office of a broker generally will not be subject to information reporting or backup withholding. However, a sale of common stock that is effected at a foreign office of a broker will be subject to information reporting and backup withholding if:

- the proceeds are transferred to an account maintained by you in the United States;
- the payment of proceeds or the confirmation of the sale is mailed to you at a United States address; or
- the sale has some other specified connection with the United States as provided in U.S. Treasury regulations,

unless the broker does not have actual knowledge or reason to know that you are a United States person and the documentation requirements described above are met or you otherwise establish an exemption.

In addition, a sale of common stock will be subject to information reporting (but not backup withholding) if it is effected at a foreign office of a broker that is:

- a United States person;
- a controlled foreign corporation for United States tax purposes;
- a foreign person 50% or more of whose gross income is effectively

connected with the conduct of a United States trade or business for a specified three-year period; or

- a foreign partnership, if at any time during its tax year:
  - one or more of its partners are "U.S. persons", as defined in U.S. Treasury regulations, who in the aggregate hold more than 50% of the income or capital interest in the partnership, or
  - such foreign partnership is engaged in the conduct of a United States trade or business,

unless the broker does not have actual knowledge or reason to know that you are a United States person and the documentation requirements described above are met or you otherwise establish an exemption. Backup withholding will apply if the sale is subject to information reporting and the broker has actual knowledge that you are a United States person.

You generally may obtain a refund of any amounts withheld under the backup withholding rules that exceed your income tax liability by filing a refund claim with the Internal Revenue Service.

UNDERWRITING

Anthem, Inc., Anthem Insurance and the underwriters named below (the "Underwriters") have entered into an underwriting agreement with respect to the shares being offered. Subject to certain conditions, each Underwriter has severally agreed to purchase the number of shares indicated in the following table. Goldman, Sachs & Co., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Morgan Stanley & Co. Incorporated, J.P. Morgan Securities Inc., Banc of America Securities LLC, Credit Suisse First Boston Corporation, Lehman Brothers Inc., UBS Warburg LLC, ABN AMRO Rothschild LLC, Dresdner Kleinwort Wasserstein Securities LLC, A.G. Edwards & Sons, Inc., McDonald Investments Inc. and Utendahl Capital Partners, L.P. are the representatives of the Underwriters.

Underwriters	Number of Shares
Goldman, Sachs & Co.	15,367,600
Merrill Lynch, Pierce, Fenner & Smith Incorporated	6,403,200
Morgan Stanley & Co. Incorporated	6,403,200
J.P. Morgan Securities Inc.	2,475,900
Banc of America Securities LLC	2,475,900
Credit Suisse First Boston Corporation	2,475,900
Lehman Brothers Inc.	2,475,900
UBS Warburg LLC	2,475,900
ABN AMRO Rothschild LLC	426,900
Dresdner Kleinwort Wasserstein Securities LLC	426,900
A.G. Edwards & Sons, Inc.	426,900
McDonald Investments Inc.	426,900
Utendahl Capital Partners, L.P.	426,900
BNY Capital Markets, Inc.	294,000
Dain Rauscher Incorporated	294,000
Epoch Securities, Inc.	294,000
First Union Securities, Inc.	294,000

Edward D. Jones & Co., L.P.	294,000
Keefe, Bruyette & Woods, Inc.	294,000
Prudential Securities Incorporated	294,000
Sandler O'Neill & Partners, L.P.	294,000
SunTrust Capital Markets, Inc.	294,000
Wells Fargo Van Kasper, LLC.	294,000
Advest, Inc.	168,000
Robert W. Baird & Co. Incorporated	168,000
William Blair & Company, L.L.C.	168,000
Blaylock & Partners, L.P.	168,000
Dowling & Partners Securities, LLC	168,000
C.L. King & Associates, Inc.	168,000
Legg Mason Wood Walker, Incorporated	168,000
Loop Capital Markets, LLC	168,000
Melvin Securities, L.L.C.	168,000
NatCity Investments, Inc.	168,000
Neuberger Berman, LLC	168,000
Ramirez & Co., Inc.	168,000
Stephens Inc.	168,000
Stifel, Nicholaus & Company, Incorporated	168,000
May Davis Group, Inc.	20,000
Total	48,000,000

The consummation of the offering of the shares is conditioned on the consummation of the demutualization.

If the Underwriters sell more shares than the total number set forth in the table above, the Underwriters have an option to buy, at the initial public offering price less the underwriting discount, up to an additional 7,200,000 shares from Anthem, Inc. to cover such sales. They may exercise that option for 30 days. If any shares are purchased pursuant to this option, the Underwriters will severally purchase shares in approximately the same proportion as set forth in the table above.

The following table shows the per share and total underwriting discounts and commissions to be paid to the Underwriters by Anthem, Inc. Such amounts are shown assuming both no exercise and full exercise of the Underwriters' option to purchase 7,200,000 additional shares.

	Paid by Anthem, Inc.		No Exercise	Full Exercise
Per Share			$ 1.656	$ 1.656
Total			$79,488,000	$91,411,200

A prospectus in electronic format may be made available on the web sites maintained by one or more Underwriters or by third parties with whom one or more Underwriters have arrangements in place to host the prospectus. The Underwriters may agree to allocate a number of shares to Underwriters for sale to their online brokerage account holders. Internet distributions will be allocated by the lead managers to Underwriters that may make Internet distributions on the same basis as other allocations.

Shares sold by the Underwriters to the public will initially be offered at the initial public offering price set forth on the cover of this prospectus. Any shares sold by the Underwriters to securities dealers may be sold at a discount of up to $1.00 per share from the initial public offering price. Any such securities dealers may resell any shares purchased from the Underwriters to certain other brokers or dealers at a discount of up to $0.10 per share from the initial public offering price. If all the shares are not sold at the initial public offering price, the representatives may change the offering price and the other selling terms.

Anthem, Inc. has agreed with the Underwriters not to dispose of or hedge any of its common stock or securities convertible into or exchangeable for shares of common stock (other than the equity security units to be offered and sold concurrently with this offering) during the period from the date of this prospectus continuing through the date 180 days after the date of this prospectus, except with the prior written consent of the representatives. This agreement does not apply to any existing employee benefit plans. See "Common Stock Eligible for Future Sale" for a discussion of certain transfer restrictions.

Prior to the demutualization and this offering, there has been no public market for the shares. The initial public offering price has been negotiated among Anthem, Inc. and the representatives. Among the factors considered in determining the initial public offering price of the shares, in addition to prevailing market conditions, were Anthem's historical performance, estimates of our business potential and earnings prospects, an assessment of our management and the consideration of the above factors in relation to market valuation of companies in related businesses.

The common stock has been approved for listing, upon official notice of issuance, on the New York Stock Exchange under the symbol "ATH". In order to meet one of the requirements for listing the common stock on the NYSE, the Underwriters have undertaken to sell lots of 100 or more shares to a minimum of 2,000 beneficial holders.

In connection with the offering, the Underwriters may purchase and sell shares of common stock in the open market. These transactions may include short sales, stabilizing transactions and

purchases to cover positions created by short sales. Shorts sales involve the sale by the Underwriters of a greater number of shares than they are required to purchase in the offering. "Covered" short sales are sales made in an amount not greater than the Underwriters' option to purchase additional shares from Anthem, Inc. in the offering. The Underwriters may close out any covered short position by either exercising their option to purchase additional shares or purchasing shares in the open market. In determining the source of shares to close out the covered short position, the underwriters will consider, among other things, the price of shares available for purchase in the open market as compared to the price at which they may purchase shares through the over-allotment option. "Naked" short sales are any sales in excess of such option. The Underwriters must close out any naked short position by purchasing shares in the open market. A naked short position is more likely to be created if the Underwriters are concerned that there may be downward pressure on the price of the common stock in the open market after pricing that could adversely affect investors who purchase in the offering. Stabilizing transactions consist of various bids for or purchases of common stock made by the Underwriters in the open market prior to the completion of the offering.

The Underwriters may also impose a penalty bid. This occurs when a

particular Underwriter repays to the Underwriters a portion of the underwriting discount received by it because the representatives have repurchased shares sold by or for the account of such underwriter in stabilizing or short covering transactions.

Purchases to cover a short position and stabilizing transactions may have the effect of preventing or retarding a decline in the market price of Anthem, Inc.'s common stock, and together with the imposition of the penalty bid, may stabilize, maintain or otherwise affect the market price of the common stock. As a result, the price of the common stock may be higher than the price that otherwise might exist in the open market. If these activities are commenced, they may be discontinued at any time. These transactions may be effected on the NYSE, in the over-the-counter market or otherwise.

The Underwriters do not expect sales to discretionary accounts to exceed five percent of the total number of shares offered.

Each Underwriter has represented and agreed that (1) it has not offered or sold and prior to the date six months after the date of issue of the shares will not offer or sell any shares to persons in the United Kingdom, except to persons whose ordinary activities involve in them in acquiring, holding, managing or disposing of investments (as principal or agent) for the purposes of their businesses or otherwise in circumstances that have not resulted and will not result in an offer to the public in the United Kingdom within the meaning of the Public Offers of Securities Regulations 1995; (2) it has complied, and will comply with, all applicable provisions of the Financial Services Act 1986 of Great Britain with respect to anything done by it in relation to the shares in, from or otherwise involving the United Kingdom; and (3) it has only issued or passed on and will only issue or pass on in the United Kingdom any document received by it in connection with the issuance of the shares to a person who is of a kind described in Article 11(3) of the Financial Services Act 1986 (Investment Advertisements) (Exemptions) Order 1996 of Great Britain or is a person to whom the document may lawfully be issued or passed on.

Each Underwriter has acknowledged and agreed that the shares have not been registered under the Securities and Exchange Law of Japan and are not being offered or sold and may not be offered or sold, directly or indirectly, in Japan or to or for the account of any resident of Japan, except (i) pursuant to an exemption from the registration requirements of the Securities and Exchange Law of Japan and (ii) in compliance with any other applicable requirements of Japanese law. As part of the offering, the Underwriters may offer shares in Japan to a list of 49 offerees in accordance with the above provisions.

The shares may not be offered, sold, transferred or delivered in or from The Netherlands, as part of their initial distribution or as part of any re-offering, and neither this prospectus nor any other document in respect of the offering may be distributed or circulated in The Netherlands, other than to individuals or legal entities which include, but are not limited to, banks, brokers, dealers, institutional investors and undertakings with a treasury department, who or which trade or invest in securities in the conduct of a business or profession.

Each of the Underwriters has agreed that it has not and will not offer or sell any shares or distribute any document or other material relating to the shares, either directly or indirectly, to the public or any member of the public in Singapore other than (i) to an institutional investor or other person specified in Section 106C of the Companies Act, Chapter 50 of Singapore (the "Singapore Companies Act") or (ii) to a sophisticated investor in accordance

with the conditions specified in Section 106D of the Singapore Companies Act or (iii) otherwise pursuant to, and in accordance with the conditions of, any other provision of the Singapore Companies Act.

Anthem, Inc. estimates that the total expenses of the offering, excluding underwriting discounts and commissions, will be approximately $10.0 million.

Anthem, Inc. and Anthem Insurance have agreed to indemnify the several Underwriters against certain liabilities, including liabilities under the Securities Act of 1933.

Certain of the Underwriters or their affiliates have provided from time to time, and expect to provide in the future, investment and commercial banking and financial advisory services to us and our affiliates in the ordinary course of business, for which they have received and may continue to receive customary fees and commissions. The lead managing underwriter, Goldman, Sachs & Co., is currently acting as financial advisor to us in connection with the demutualization and lead managing underwriter of the concurrent offering of the units.

VALIDITY OF COMMON STOCK

The validity of the shares of our common stock that are being offered by this prospectus will be passed upon for Anthem, Inc. by Baker & Daniels, Indianapolis, Indiana, and for the Underwriters by Sullivan & Cromwell, New York, New York. Sullivan & Cromwell will rely on the opinion of Baker & Daniels as to all matters of Indiana law.

EXPERTS

Ernst & Young LLP, independent auditors, have audited our consolidated financial statements at December 31, 2000 and 1999, and for each of the three years in the period ended December 31, 2000, as set forth in their report. We have included our consolidated financial statements in this prospectus and in the registration statement in reliance on the report of Ernst & Young LLP, given on their authority as experts in accounting and auditing.

Daniel J. McCarthy, FSA, MAAA, Dale S. Hagstrom, FSA, MAAA, and Robert H. Dobson, FSA, MAAA, consulting actuaries associated with Milliman USA, Inc., have rendered an opinion, dated June 18, 2001, to our board of directors that is included as Annex A to this prospectus. Such opinion is included herein in reliance upon the authority of such actuaries as experts in actuarial matters generally and in the application of actuarial concepts to insurance matters.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED FINANCIAL STATEMENTS

CONTENTS

REPORT OF INDEPENDENT AUDITORS

Board of Directors
Anthem Insurance Companies, Inc.

We have audited the accompanying consolidated balance sheets of Anthem Insurance Companies, Inc. as of December 31, 2000 and 1999, and the related consolidated statements of income, policyholders' surplus and cash flows for each of the three years in the period ended December 31, 2000. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audits 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. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Anthem Insurance Companies, Inc. at December 31, 2000 and 1999, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2000, in conformity with accounting principles generally accepted in the United States.

/s/ Ernst & Young LLP

Indianapolis, Indiana
January 29, 2001,
except for Note 17, as to which
the date is June 18, 2001

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED BALANCE SHEETS

	December 31	
	2000	1999
	(In Millions)	
Assets		
Current assets:		
Investments available-for-sale, at fair value:		
Fixed maturity securities	$3,048.2	$2,280.3
Equity securities	463.1	487.7
	3,511.3	2,768.0
Cash and cash equivalents	203.3	204.4
Premium and self funded receivables	477.5	388.1
Reinsurance receivables	105.1	179.7
Other receivables	272.4	168.1
Income tax receivables	11.0	37.6
Other current assets	32.2	59.5
Total current assets	4,612.8	3,805.4
Other noncurrent investments	18.0	15.8
Restricted cash and investments	89.6	99.6
Property and equipment	428.8	408.5
Goodwill and other intangible assets	498.9	398.5
Other noncurrent assets	60.4	88.4
Total assets	$5,708.5	$4,816.2
Liabilities and policyholders' surplus		
Liabilities		
Current liabilities:		
Policy liabilities:		
Unpaid life, accident and health claims	$1,393.0	$1,145.5
Future policy benefits	186.5	172.4
Other policyholder liabilities	118.8	113.2
Total policy liabilities	1,698.3	1,431.1
Unearned income	262.8	226.3
Accounts payable and accrued expenses	262.7	178.6
Bank overdrafts	250.5	146.7
Income taxes payable	25.7	4.7
Other current liabilities	307.5	249.6
Total current liabilities	2,807.5	2,237.0
Long term debt, less current portion	597.5	522.0
Retirement benefits	175.1	181.2
Other noncurrent liabilities	208.6	215.1
Total liabilities	3,788.7	3,155.3
Policyholders' surplus		
Surplus	1,848.6	1,622.6

Accumulated other comprehensive income	71.2	38.3
Total policyholders' surplus	1,919.8	1,660.9
Total liabilities and policyholders' surplus	$5,708.5	$4,816.2

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year ended December 31,		
	2000	1999	1998
	(In Millions)		
Revenues			
Premiums	$7,737.3	$5,418.5	$4,739.5
Administrative fees	755.6	611.1	575.6
Other revenue	50.6	51.0	74.6
Total operating revenue	8,543.5	6,080.6	5,389.7
Net investment income	201.6	152.0	136.8
Net realized gains on investments	25.9	37.5	155.9
	8,771.0	6,270.1	5,682.4
Expenses			
Benefit expense	6,551.0	4,582.7	3,934.2
Administrative expense	1,808.4	1,469.4	1,420.1
Interest expense	54.7	30.4	27.9
Amortization of goodwill and other intangible assets	27.1	12.7	12.0
Endowment of non-profit foundations	--	114.1	--
	8,441.2	6,209.3	5,394.2
Income from continuing operations before income taxes and minority interest	329.8	60.8	288.2
Income taxes	102.2	10.2	110.9
Minority interest (credit)	1.6	(0.3)	(1.1)
Income from continuing operations	226.0	50.9	178.4
Discontinued operations, net of income taxes			
Loss from discontinued operations prior to disposal	--	--	(3.9)
Loss on disposal of discontinued operations	--	(6.0)	(2.1)
Net income	$ 226.0	$ 44.9	$ 172.4

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF POLICYHOLDERS' SURPLUS

	Surplus	Accumulated Other Comprehensive Income	Total Policyholders' Surplus
		(In Millions)	
Balance at December 31, 1997	$1,405.3	$119.4	$1,524.7
Net income	172.4	--	172.4
Change in net unrealized gains on securities	--	5.4	5.4
Comprehensive income			177.8
Balance at December 31, 1998	1,577.7	124.8	1,702.5
Net income	44.9	--	44.9
Change in net unrealized gains on securities	--	(88.5)	(88.5)
Change in additional minimum pension liability	--	2.0	2.0
Comprehensive loss			(41.6)
Balance at December 31, 1999	1,622.6	38.3	1,660.9
Net income	226.0	--	226.0
Change in net unrealized gains on securities	--	36.8	36.8
Change in additional minimum pension liability	--	(3.9)	(3.9)
Comprehensive income			258.9
Balance at December 31, 2000	$1,848.6	$ 71.2	$1,919.8

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year ended December 31		
	2000	1999	1998
	(In Millions)		
Operating activities			
Net income	$ 226.0	$ 44.9	$ 172.4
Adjustments to reconcile net income to net cash provided by operating activities:			
Realized gains on investments	(25.9)	(37.5)	(155.9)
Depreciation, amortization and accretion	102.1	61.8	58.3
Deferred income taxes	36.6	23.0	32.0
Loss from discontinued operations	--	6.0	6.0
Loss on sale of assets	0.5	0.2	2.6
Changes in operating assets and liabilities, net of effect of purchases and divestitures:			
Restricted cash and investments	10.0	(2.1)	93.7
Receivables	(70.7)	6.0	(76.8)
Other assets	25.3	80.7	(31.4)
Policy liabilities	124.1	105.6	(40.3)
Unearned income	22.3	15.9	22.8
Accounts payable and accrued expenses	69.9	(7.5)	27.2
Other liabilities	119.0	(40.1)	23.3
Income taxes	47.5	(20.4)	10.1
Net cash provided by continuing operations	686.7	236.5	144.0
Net cash used in discontinued operations	(2.2)	(16.7)	(24.1)
Cash provided by operating activities	684.5	219.8	119.9
Investing activities			
Purchases of investments	(3,544.8)	(2,331.1)	(3,286.8)
Sales or maturities of investments	2,925.2	2,308.3	3,217.2
Purchases of subsidiaries, net of cash acquired	(85.1)	(246.8)	(35.2)
Sales of subsidiaries, net of cash sold	5.4	2.3	79.3
Proceeds from sale of property and equipment	11.5	7.2	5.9
Purchases of property and equipment	(73.3)	(96.7)	(89.2)
Cash used in investing activities	(761.1)	(356.8)	(108.8)
Financing activities			
Proceeds from borrowings	295.9	220.1	0.4
Payments on borrowings	(220.4)	--	(4.2)
Cash provided by (used in) financing activities	75.5	220.1	(3.8)
Change in cash and cash equivalents	(1.1)	83.1	7.3
Cash and cash equivalents at beginning of year	204.4	121.3	114.0
Cash and cash equivalents at end of year	$ 203.3	$ 204.4	$ 121.3

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2000
(Dollars in Millions)

1. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements of Anthem Insurance Companies, Inc. ("Anthem"), a mutual insurance company, and its subsidiaries (collectively, the "Company") have been prepared in conformity with generally accepted accounting principles. All significant intercompany accounts and transactions have been eliminated in consolidation. Anthem or its subsidiary insurance companies are licensed in all states and are Blue Cross Blue Shield Association licensees in Indiana, Kentucky, Ohio, Connecticut, Maine, New Hampshire, Colorado and Nevada. Products include health and group life insurance, managed health care, and government health program administration.

Minority interest represents other shareholders' interests in subsidiaries, which are majority-owned by Anthem, or its subsidiaries.

Use of Estimates: Preparation of the consolidated financial statements requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Investments: All fixed maturity and equity securities are classified as "available-for-sale" securities and investments in equity securities that have readily determinable fair values and all fixed maturity securities are reported at fair value. The Company has determined that all investments in its portfolio are available to support current operations and, accordingly, has classified such investment securities as current assets. The unrealized gains or losses on these securities are included in accumulated other comprehensive income as a separate component of policyholders' surplus unless the decline in value is deemed to be other than temporary, in which case the loss is charged to income.

Realized gains or losses, determined by specific identification of investments sold, are included in income.

Cash Equivalents: All highly liquid investments with maturities of three months or less when purchased are classified as cash equivalents.

Premium and Self Funded Receivables: Premium and self funded receivables include the uncollected amounts for insured and self funded groups, less an allowance for doubtful accounts of $35.1 and $38.7 as of December 31, 2000 and 1999, respectively.

Reinsurance Receivables: Reinsurance receivables represent amounts recoverable on claims paid or incurred, and amounts paid to the reinsurer for premiums collected but not yet earned, and are estimated in a manner consistent with the liabilities associated with the reinsured policies. These receivables have been reduced by an allowance for uncollectible amounts of $0.0 and $1.7 as of December 31, 2000 and 1999, respectively.

Other Receivables: Other receivables include amounts for interest earned on investments, government programs, pharmacy sales and other miscellaneous amounts due to the Company. These receivables have been reduced by an allowance for uncollectible amounts of $33.4 and $29.4 as of December 31, 2000 and 1999, respectively.

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

Restricted Cash and Investments: Restricted cash and investments represent fiduciary amounts held under an insurance contract and other agreements.

Property and Equipment: Property and equipment is recorded at cost. Depreciation is computed principally by the straight-line method over the estimated useful lives of the assets.

Goodwill and Other Intangible Assets: Goodwill represents the excess of cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to non-compete agreements, and licenses and agreements. Goodwill and other intangible assets are amortized using the straight-line method over periods ranging from two to 20 years.

Accumulated amortization of goodwill and other intangible assets at December 31, 2000 and 1999 was $58.4 and $27.3, respectively.

The carrying value of goodwill and other intangible assets is reviewed annually to determine if the facts and circumstances indicate that they may be impaired. The carrying value of these assets is reduced to its fair value if this review, which includes comparison of asset carrying amounts to expected cash flows, indicates that such amounts will not be recoverable.

Policy Liabilities: Liabilities for unpaid claims include estimated provisions for both reported and unreported claims incurred on an undiscounted basis. The liabilities are adjusted regularly based on historical experience and include estimates of trends in claim severity and frequency and other factors, which could vary as the claims are ultimately settled. Although it is not possible to measure the degree of variability inherent in such estimates, management believes these liabilities are adequate.

The life future policy benefit liabilities represent primarily group term benefits determined using standard industry mortality tables with interest rates ranging from 3.0% to 5.5%.

Premium deficiency losses are recognized when it is probable that expected claims expenses will exceed future premiums on existing health and other insurance contracts without consideration of investment income. For purposes of premium deficiency losses, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts.

Retirement Benefits: Retirement benefits represent outstanding obligations for retiree health, life and dental benefits and any unfunded liability related to defined benefit pension plans.

Comprehensive Income: Comprehensive income includes net income, the change in unrealized gains (losses) on investments and the change in the additional minimum pension liability.

Revenue Recognition: Gross premiums for fully insured contracts are prorated over the term of the contracts, with the unearned premium representing the unexpired term of policies. For insurance contracts with retrospective rated premiums, the estimated ultimate premium is recognized as revenue over the period of the contract. Actual experience is reviewed once the policy period is completed and adjustments are recorded when determined. Premium rates for

certain lines of business are subject to approval by the Department of Insurance of each respective state.

Administrative fees include revenue from certain groups contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion of their claims experience. The Company charges self-funded groups an administrative fee which is based on the number of

members in a group or the group's claim experience. Under the Company's self-funded arrangements, amounts due are recognized based on incurred claims paid plus administrative and other fees. In addition, administrative fees include amounts received for the administration of Medicare or certain other government programs. Administrative fees are recognized in accordance with the terms of the contractual relationship between the Company and the customer. Such fees are based on a percentage of the claim amounts processed or a combination of a fixed fee per claim plus a percentage of the claim amounts processed. All benefit payments under these programs are excluded from benefit expenses.

Other revenue principally includes amounts from the sales of prescription drugs and revenues are recognized as prescription drug orders are delivered or shipped.

Federal Income Taxes: Anthem files a consolidated return with its subsidiaries that qualify as defined by the Internal Revenue Code.

Reclassifications: Certain prior year balances have been reclassified to conform to the current year presentation.

2. Acquisitions, Divestitures and Discontinued Operations

Acquisitions:

2000

On June 5, 2000, the Company completed its purchase of substantially all of the assets and liabilities of Associated Hospital Service of Maine, formerly d/b/a Blue Cross and Blue Shield of Maine ("BCBS-ME"), in accordance with the Asset Purchase Agreement dated July 13, 1999. The purchase price was $95.4 (including direct costs of acquisition) and resulted in $92.6 of goodwill and other intangible assets which are being amortized over periods which range from ten to 20 years. The application of purchase accounting for this acquisition is subject to further refinement based on final valuation studies and post-closing adjustments in certain circumstances. This acquisition was accounted for as a purchase and the net assets and results of operations have been included in the Company's consolidated financial statements from the purchase date. The pro forma effects of the BCBS-ME acquisition would not be material to the Company's consolidated results of operations for periods preceding the purchase date.

1999

On October 27, 1999, the Company completed its purchase of the assets and liabilities of New Hampshire-Vermont Health Services, formerly d/b/a Blue Cross Blue Shield of New Hampshire ("BCBS-NH"), in accordance with the Asset Purchase Agreement entered into on February 19, 1999. The purchase price was $125.4 (including direct costs of acquisition), which resulted in $107.9 of goodwill

and other intangible assets which are being amortized over periods which range from two to 20 years.

On November 16, 1999, the Company completed its purchase of the stock of Rocky Mountain Hospital and Medical Service, formerly d/b/a Blue Cross and Blue Shield of Colorado and Blue Cross and Blue Shield of Nevada ("BCBS-CO/NV"). The purchase price was $160.7 (including direct costs of acquisition) and resulted in $152.1 of goodwill and other intangible assets which are being amortized over periods which range from five to 20 years.

These acquisitions were accounted for as purchases and the net assets and results of operations have been included in the Company's consolidated financial statements from the respective purchase dates. During 2000, purchase price allocations for these acquisitions were refined based on final valuation studies resulting in increases to goodwill and other intangible assets of $33.8.

Unaudited pro forma results of operations assuming the 1999 acquisitions occurred on January 1, 1999 would have resulted in total revenues of $7,186.4, income from continuing operations of $83.3 and net income of $5.5 for 1999, respectively.

1998

During 1998, the Company made acquisitions with purchase prices aggregating $35.2. All acquisitions were accounted for as purchases and the purchase prices were allocated to the assets and liabilities of the acquired entities based upon their estimated fair values. The total purchase price for these acquisitions exceeded the fair value of the net tangible assets acquired by approximately $28.3, which was assigned to goodwill and other intangible assets and are being amortized over periods not to exceed 20 years. The pro forma effects of these acquisitions are insignificant to the Company's consolidated results of operations.

Divestitures:

1999

During 1999, the Company divested of several small business operations, which were no longer deemed strategically aligned with the Company's core business. The Company recognized a loss of $14.2 (net of income tax benefit of $6.1) on these disposals. The pro forma effects of these divestitures are insignificant to the consolidated results of operations.

Discontinued Operations:

1999

During 1999, the Company recognized additional losses of $6.0, net of income tax benefit of $6.2, resulting from sales agreement contingency adjustments relating to the discontinued operations sold in prior years.

1998

In March 1998, the Company made the decision to exit principally all of its non-Blue Cross and Blue Shield health businesses as follows:

In May 1998 the Company principally completed its exit from its non-health insurance related businesses through the sale of its durable medical equipment business for $23.3, resulting in a gain of $12.9 (net of income tax expense of $8.4).

In June 1998, the Company completed the sale of two of its HMO businesses for $10.1 resulting in a gain of $3.3 (net of income tax expense of $1.8). Further, in July 1998, the Company completed the sale of Anthem Health and Life Insurance Company for $77.5 resulting in a gain of $1.1 (including income tax benefit of $14.1). In September 1998, the Company made a provision of $10.4

(net of income tax benefit of $3.4) for the estimated loss on the disposal of its one remaining non-Blue Cross and Blue Shield health business.

During 1998, the Company disposed of its health finance and management operations and its integrated health delivery operations resulting in a net loss of $7.9 (including income tax expense of $2.7) greater than the reserve of $43.2 (net of income tax benefit of $23.3) which was reported as discontinued operations in 1997.

Additionally, during 1998 the Company recognized a loss of $1.1, with no income tax benefit, relating to all other operations discontinued in 1997.

Operating results from discontinued operations prior to disposal in 1998 (none in 2000 or 1999), exclusive of the aforementioned provisions, were as follows: operating revenues $190.8, loss before provision for income taxes $(5.6) and loss from discontinued operations net of income taxes $(3.9).

3. Endowment of Non-Profit Foundations

During 1999, Anthem reached agreements with the states of Kentucky, Ohio and Connecticut to resolve any questions as to whether Anthem or the predecessor/successor entities were in possession of property that was impressed with a charitable trust.

In 1999, contributions of $45.0, $28.0 and $41.1, respectively, were made for the benefit of charitable foundations in Kentucky, Ohio, and Connecticut, respectively, from Anthem's subsidiaries, Anthem Health Plans of Kentucky, Inc., Community Insurance Company and Anthem Health Plans, Inc., respectively.

4. Investments

The following is a summary of available-for-sale securities:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized (Losses)	Fair Value
December 31, 2000				

Fixed maturity securities:				
United States Government securities	$ 723.4	$ 25.6	$ (2.5)	$ 746.5
Obligations of states and Political subdivisions	0.8	--	--	0.8
Corporate securities	1,041.4	19.4	(20.1)	1,040.7
Mortgage-backed securities	1,250.3	21.1	(13.0)	1,258.4
Preferred stocks	1.9	--	(0.1)	1.8
Total fixed maturity securities	3,017.8	66.1	(35.7)	3,048.2
Equity securities	376.2	162.0	(75.1)	463.1
	$3,394.0	$228.1	$(110.8)	$3,511.3

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized (Losses)	Fair Value
December 31, 1999				
Fixed maturity securities:				
United States Government securities	$ 550.1	$ 0.2	$ (29.3)	$ 521.0
Obligations of states and political subdivisions	34.2	--	(2.1)	32.1
Corporate securities	816.8	0.4	(35.6)	781.6
Mortgage-backed securities	975.3	0.9	(32.1)	944.1
Preferred stocks	1.9	--	(0.4)	1.5
Total fixed maturity securities	2,378.3	1.5	(99.5)	2,280.3
Equity securities	329.6	186.0	(27.9)	487.7
	$2,707.9	$187.5	$(127.4)	$2,768.0

The amortized cost and fair value of fixed maturity securities at December 31, 2000, by contractual maturity, are shown below. Expected maturities may be less than contractual maturities because the issuers of the securities may have the right to prepay obligations without prepayment penalties.

	Amortized Cost	Fair Value
Due in one year or less	$ 48.2	$ 48.4
Due after one year through five years	611.7	618.1
Due after five years through ten years	439.3	451.9

Due after ten years	666.4	669.6
	1,765.6	1,788.0
Mortgage-backed securities	1,250.3	1,258.4
Preferred stocks	1.9	1.8
	$3,017.8	$3,048.2

The major categories of net investment income are as follows:

	Year ended December 31		
	2000	1999	1998
Fixed maturity securities	$ 178.8	$ 137.0	$ 121.1
Equity securities	6.1	6.3	7.4
Cash, cash equivalents and other	21.5	12.8	11.9
Investment revenue	206.4	156.1	140.4
Investment expense	(4.8)	(4.1)	(3.6)
Net investment income	$ 201.6	$ 152.0	$ 136.8

Proceeds from sales of fixed maturity and equity securities during 2000, 1999 and 1998 were $2,911.8, $2,336.8 and $3,162.8, respectively. Gross gains of $71.3, $86.8 and $175.3 and gross losses of $45.4, $49.3 and $19.4 were realized in 2000, 1999 and 1998, respectively, on those sales.

5. Long Term Debt and Commitments

Debt consists of the following at December 31:

	2000	1999
Surplus notes at 9.00% due 2027	$197.2	$197.0
Surplus notes at 9.125% due 2010	295.5	--
Senior guaranteed notes at 6.75% due 2003	99.5	99.3
Bank credit agreements	--	220.0
Other	5.5	5.9
Long term debt	$597.7	$522.2
Current portion of long-term debt	(0.2)	(0.2)
Long-term debt, less current portion	$597.5	$522.0

====== ======

On January 28, 2000, Anthem issued $300.0 principal amount of 9.125% surplus notes due April 1, 2010. On February 3, 2000, a portion of the proceeds was used for repayment of the $220.0 outstanding under the revolving bank credit agreement discussed below. The remainder of the proceeds was used for general corporate purposes including the acquisition of BCBS-ME (see Note 2).

The Company has a $300.0 revolving credit agreement with a syndicate of banks which is available for general corporate purposes and to support the Company's commercial paper program. The facility matures in 2002. In 1999, the Company borrowed $220.0 to facilitate the acquisitions of BCBS-NH and BCBS-CO/NV as described in Note 2. No additional borrowings were made under this credit agreement during 2000 and 1999 borrowings were paid in February 2000. Availability under this facility is reduced by the amount of any commercial paper outstanding.

The Company has a $300.0 commercial paper program available for general corporate purposes. Commercial paper is sold through a dealer, in denominations greater than $150 thousand dollars with a maturity not to exceed 270 days from date of issuance, at then available market rates. Availability under the commercial paper program is reduced by the amount of any borrowings outstanding under the Company's revolving credit agreement. There were no commercial paper notes outstanding at December 31, 2000 or 1999.

The Company must maintain certain financial covenants including limits on minimum net worth, maximum consolidated debt, and maximum asset dispositions annually.

Any payment of interest or principal on the surplus notes may be made only with the prior approval of the Indiana Department of Insurance ("DOI"), and only out of policyholders' surplus funds that the DOI determines to be available for the payment under Indiana insurance laws. For statutory accounting purposes, the surplus notes are considered a part of policyholders' surplus.

Interest paid during 2000, 1999 and 1998 was $54.7, $28.2 and $28.0, respectively.

Future maturities of debt are as follows: 2001, $0.2; 2002, $0.3; 2003, $99.9; 2004, $1.4; 2005, $0.5 and thereafter $495.4.

6. Fair Value of Financial Instruments

Considerable judgment is required to develop estimates of fair value for financial instruments. Accordingly, the estimates shown are not necessarily indicative of the amounts that would be realized in a one time, current market exchange of all of the financial instruments.

The carrying values and estimated fair values of certain financial instruments are as follows at December 31:

	2000		1999	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Fixed maturity securities	$3,048.2	$3,048.2	$2,280.3	$2,280.3
Equity securities	463.1	463.1	487.7	487.7
Restricted investments	42.7	42.7	38.8	38.8
Debt	597.7	562.2	522.2	507.0

The carrying value of all other financial instruments approximates fair value because of the relatively short period of time between the origination of the instruments and their expected realization. Fair values for securities and restricted investments are based on quoted market prices, where available. For securities not actively traded, fair values are estimated using values obtained from independent pricing services. The fair value of debt is estimated using discounted cash flow analyses, based on the Company's current incremental borrowing rates for similar types of borrowing arrangements.

7. Property and Equipment

Property and equipment includes the following at December 31:

	2000	1999
Land and improvements	$ 21.0	$ 17.2
Building and components	251.3	222.2
Data processing equipment, furniture and other equipment	407.6	425.2
Leasehold improvements	37.2	39.2
	717.1	703.8
Less accumulated depreciation and amortization	288.3	295.3
	$428.8	$408.5

Property and equipment includes non-cancelable capital leases of $7.4 and $8.7 at December 31, 2000 and 1999, respectively. Total accumulated amortization on these leases at December 31, 2000 and 1999 was $3.7 and $4.5, respectively. The related lease amortization expense is included in depreciation and amortization expense. Depreciation and leasehold improvement amortization expense for 2000, 1999 and 1998 was $75.3, $47.1, and $43.7, respectively.

8. Unpaid Life, Accident and Health Claims

The following table provides a reconciliation of the beginning and ending

balances for unpaid life, accident and health claims:

	2000	1999	1998
Balances at January 1, net of reinsurance	$1,036.3	$ 734.6	$ 707.8
Business combinations	113.9	190.4	--
Incurred related to:			
Current year	6,611.1	4,608.9	3,960.0
Prior years	(60.1)	(30.9)	(32.8)
Total incurred	6,551.0	4,578.0	3,927.2
Paid related to:			
Current year	5,381.2	3,785.1	3,245.4
Prior years	956.0	681.6	655.0
Total paid	6,337.2	4,466.7	3,900.4
Balances at December 31, net of reinsurance	1,364.0	1,036.3	734.6
Reinsurance recoverables at December 31	29.0	109.2	92.2
Reserve gross of reinsurance recoverables on unpaid claims at December 31	$1,393.0	$1,145.5	$ 826.8

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Negative amounts reported for incurred related to prior years resulted from claims being settled for amounts less than originally estimated.

9. Reinsurance

The Company reinsures certain of its risks with other companies and assumes risk from other companies and such reinsurance is accounted for as a transfer of risk. The Company is contingently liable for amounts recoverable from the reinsurer in the event that it does not meet its contractual obligations.

The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities, or economic characteristics of the reinsurers to minimize its exposure to significant losses from reinsurer insolvencies.

The details of net premiums written and earned are as follows for the years ended December 31:

	2000		1999		1998	
	Written	Earned	Written	Earned	Written	Earned
Consolidated:						
Direct	$7,993.0	$7,961.5	$5,674.8	$5,693.7	$4,956.8	$4,945.6
Assumed	0.7	1.9	23.9	26.9	12.4	11.6
Ceded	(229.2)	(226.1)	(305.6)	(302.1)	(218.6)	(217.7)
Net Premiums	$7,764.5	$7,737.3	$5,393.1	$5,418.5	$4,750.6	$4,739.5

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

	2000		1999		1998	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Midwest	$4,240.4	$4,203.1	$3,708.6	$3,729.3	$3,554.4	$3,533.3
East	2,753.0	2,768.9	1,490.3	1,495.4	1,076.2	1,088.3
West	571.1	569.6	64.5	64.2	--	--
Specialty	123.7	123.7	96.3	96.3	90.3	90.3
Other	76.3	72.0	33.4	33.3	29.7	27.6
Total	$7,764.5	$7,737.3	$5,393.1	$5,418.5	$4,750.6	$4,739.5

The effect of reinsurance on policyholder benefits is as follows for the years ended December 31:

	2000	1999	1998
Benefits assumed--increase in policyholder benefits expense	$ 8.6	$ 27.4	$ 2.5
Benefits ceded--decrease in policyholder benefits expense	233.0	299.8	208.3

The effect of reinsurance on certain assets and liabilities is as follows at December 31:

	2000	1999
Policy liabilities assumed	$28.6	$30.6
Unearned premiums assumed	0.2	0.2
Premiums payable ceded	8.5	36.3
Premiums receivable assumed	0.3	0.7

10. Income Taxes

The components of deferred income taxes are as follows:

	December 31	
	2000	1999
Deferred tax assets:		
Pension and postretirement benefits	$ 84.7	$ 87.9
Accrued expenses	85.2	69.5
Alternative minimum tax and other credits	83.7	35.4
Insurance reserves	33.0	32.3
Net operating loss carryforwards	174.5	57.4
Bad debt reserves	35.1	30.1
Other	31.5	24.1
Total deferred tax assets	527.7	336.7
Valuation allowance	(338.7)	(148.2)
Total deferred tax assets, net of valuation allowance	189.0	188.5
Deferred tax liabilities:		
Unrealized gains on securities	41.4	21.0
Goodwill and other tax intangibles	55.1	57.7
Other	72.4	52.2
Total deferred tax liabilities	168.9	130.9
Net deferred tax asset	$ 20.1	$ 57.6

The resolution of an Internal Revenue Service examination during 2000 resulted in certain subsidiaries having an increase in alternative minimum tax credits and net operating loss carryforwards. Due to the uncertainty of the realization of these deferred tax assets, the Company increased its valuation allowance accordingly. The net change in the valuation allowance for 2000, 1999 and 1998 totaled $190.5, $(14.4) and $1.1, respectively.

Deferred tax assets and liabilities reported with other current assets and other noncurrent assets on the accompanying consolidated balance sheets are as follows:

	December 31	
	2000	1999
Deferred tax assets--current	$10.5	$29.4
Deferred tax assets--noncurrent	9.6	28.2
Net deferred tax assets	$20.1	$57.6

Significant components of the provision for income taxes consist of the following:

	Year ended December 31		
	2000	1999	1998
Current tax expense (benefit):			
Federal	$ 53.9	$(2.6)	$ 63.0
State and local	3.9	(7.0)	9.8
Total current tax expense (benefit)	57.8	(9.6)	72.8
Deferred tax expense	44.4	19.8	38.1
Total income tax expense	$102.2	$10.2	$110.9

Current federal income taxes consisted of amounts due for alternative minimum tax and tax obligations of subsidiaries not included in the consolidated return of Anthem. During 2000, 1999 and 1998 federal income taxes paid totaled $26.3, $0.0 and $23.7, respectively.

A reconciliation between actual income tax expense and the amount computed at the statutory rate is as follows:

	Year ended December 31					
	2000		1999		1998	
	Amount	%	Amount	%	Amount	%
Amount at statutory rate	$115.4	35.0	$21.3	35.0	$100.9	35.0
State and local income taxes (benefit) net of federal tax benefit	2.6	0.8	(4.8)	(7.9)	7.0	2.4
Amortization of goodwill	5.6	1.7	3.1	5.1	3.0	1.1
Dividends received deduction	(1.2)	(0.4)	(1.3)	(2.1)	(1.7)	(0.6)
Deferred tax valuation allowance change, net of net operating loss carryforwards and other tax credits	(20.0)	(6.0)	(14.4)	(23.7)	1.1	0.4
Other, net	(0.2)	(0.1)	6.3	10.4	0.6	0.2
	$102.2	31.0	$10.2	16.8	$110.9	38.5

At December 31, 2000, the Company had unused federal tax net operating loss carryforwards of approximately $498.7 to offset future taxable income. The loss carryforwards expire in the years 2001 through 2019.

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

11. Accumulated Other Comprehensive Income

The following is a reconciliation of the components of accumulated other comprehensive income at December 31:

	2000	1999
Gross unrealized gains on securities	$ 228.1	$ 187.5
Gross unrealized losses on securities	(110.8)	(127.4)
Total pretax net unrealized gains on securities	117.3	60.1
Deferred tax liability	(41.4)	(21.0)
Net unrealized gains on securities	75.9	39.1
Additional minimum pension liability	(7.2)	(1.2)
Deferred tax asset	2.5	0.4
Net additional minimum pension liability	(4.7)	(0.8)
Accumulated other comprehensive income	$ 71.2	$ 38.3

A reconciliation of the change in unrealized and realized gains (losses) on securities included in accumulated other comprehensive income follows:

	2000	1999	1998
Change in pretax net unrealized gains on securities	$ 83.1	$(99.2)	$185.6
Less change in deferred taxes	(28.4)	36.9	(64.0)
Less net realized gains on securities, net of income taxes (2000, $8.0; 1999, $11.3; 1998, $54.6), included in net income	(17.9)	(26.2)	(101.3)
Change in net unrealized gains of discontinued operations	--	--	(14.9)
Change in net unrealized gains on securities	$ 36.8	$(88.5)	$ 5.4

12. Leases

The Company leases office space and certain computer equipment using noncancelable operating leases. Related lease expense for 2000, 1999 and 1998 was $64.0, $60.9, and $42.9, respectively.

At December 31, 1999, future lease payments for operating leases with

initial or remaining noncancelable terms of one year or more consisted of the following: 2001, $48.7; 2002, $38.6; 2003, $31.7; 2004, $25.1; 2005, $22.9; and thereafter $136.7.

13. Retirement Benefits

Anthem and its subsidiaries, Anthem Health Plans of New Hampshire, Inc. (which acquired the business of BCBS-NH), Rocky Mountain Hospital and Medical Service, Inc. ("RMHMS") (formerly known as BCBS-CO/NV) and Anthem Health Plans of Maine, Inc. (which acquired the business of BCBS-ME), all sponsor defined benefit pension plans. These plans generally cover all full-time employees who have completed one year of continuous service and attained the age of twenty-one.

The Company plan, which includes all affiliates except for Anthem Health Plans of New Hampshire, Inc., RMHMS, and Anthem Health Plans of Maine, Inc., is a cash balance arrangement where participants have an individual account balance and will earn a pay credit equal to three to six

percent of compensation, depending on years of service. In addition to the pay credit, participant accounts earn interest at a rate based on the 10-year Treasury notes.

Anthem Health Plans of New Hampshire, Inc. sponsors a plan that is also a cash balance arrangement where participants have an individual account balance and will earn a pay credit equal to five percent of compensation. The participant accounts earn interest at a rate based on the lesser of the 1-year Treasury note or 7%.

RMHMS sponsors a pension equity plan where the participant earns retirement credit percentages based on their age and service when the credit was earned. A lump sum benefit is calculated for each participant based on this formula. Effective December 31, 2000, the RMHMS plan was frozen and its participants became participants of the Company's plan on January 1, 2001.

Anthem Health Plans of Maine, Inc. sponsors a final average pay defined benefit plan with contributions made at a rate intended to fund the cost of benefits earned. The plan's benefits are based on years of service and the participant's highest five year average compensation during the last ten years of employment. Effective December 31, 2000, the Anthem Health Plans of Maine, Inc. plan was merged into the Company's plan and its participants became participants of the Company's plan on January 1, 2001.

All of the plans' assets consist primarily of common and preferred stocks, bonds, notes, government securities, investment funds and short-term investments. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan members.

The effect of the above acquisitions on the consolidated benefit obligation and plan assets is reflected through the business combination lines of the tables below.

In addition to the Company's defined benefit and defined contribution plans, the Company offers most active and retired employees certain life, health, vision and dental benefits upon retirement. There are several plans that differ in amounts of coverage, deductibles, retiree contributions, years of service and retirement age. The Company funds certain benefit costs through contributions to a Voluntary Employees' Beneficiary Association ("VEBA") trust and others are accrued, with the retiree paying a portion of the costs. Postretirement plan assets held in the VEBA trust consist primarily of bonds and equity securities.

The reconciliation of the benefit obligation for the years ended December 31 is as follows:

	Pension Benefits		Other Benefits	
	2000	1999	2000	1999
Benefit obligation at beginning of year.....	$471.8	$473.3	$117.1	$ 91.8
Service cost.....	27.3	26.6	1.3	2.1
Interest cost.....	36.6	31.4	8.4	6.2
Plan amendments.....	(1.2)	--	(5.2)	(13.5)
Actuarial (gain) loss.....	35.4	(47.9)	(11.0)	9.1
Business combinations.....	50.8	73.2	9.0	28.9
Benefits paid.....	(53.1)	(84.8)	(8.0)	(7.5)
Benefit obligation at end of year.....	$567.6	$471.8	$111.6	$117.1

The changes in plan assets were as follows:

	Pension Benefits		Other Benefits	
	2000	1999	2000	1999
Fair value of plan assets at beginning of year...	$557.5	$445.4	$23.2	$21.2
Actual return on plan assets.....	75.3	80.5	3.1	8.3
Employer contributions.....	30.0	37.0	1.2	1.2
Business combinations.....	40.9	79.4	4.6	--
Benefits paid.....	(53.1)	(84.8)	(3.7)	(7.5)
Fair value of plan assets at end of year.....	$650.6	$557.5	$28.4	$23.2

The reconciliation of the funded status to the net benefit cost accrued is

as follows:

	Pension Benefits		Other Benefits	
	2000	1999	2000	1999
Funded status	$ 83.0	$ 85.7	$ (83.2)	$ (93.9)
Unrecognized net gain	(61.5)	(68.7)	(44.1)	(33.1)
Unrecognized prior service cost	(22.8)	(24.9)	(41.9)	(43.3)
Unrecognized transition asset	(1.0)	(2.8)	--	--
Additional minimum liability	(7.2)	(1.2)	--	--
Accrued benefit cost at September 30	(9.5)	(11.9)	(169.2)	(170.3)
Payments made after the measurement date	1.0	0.5	2.6	0.5
Accrued benefit cost at December 31	$ (8.5)	$(11.4)	$(166.6)	$(169.8)

The weighted average assumptions used in calculating the accrued liabilities for all plans are as follows:

	Pension Benefits			Other Benefits		
	2000	1999	1998	2000	1999	1998
Discount rate	7.50%	7.50%	6.75%	7.50%	7.50%	6.75%
Rate of compensation increase	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%
Expected rate of return on plan assets	9.00%	9.00%	9.55%	6.27%	6.50%	6.50%

The assumed health care cost trend rate used in measuring the other benefit obligations is generally 6% in 2000 and is assumed to decrease to 5% in 2001, and remain level thereafter. For 1999, the rates were generally 7% decreasing by 1% per year, to 5% in 2001.

The health care cost trend rate assumption can have a significant effect on the amounts reported. A one-percentage point change in assumed health care cost trend rates would have the following effects:

	1-Percentage Point Increase	1-Percentage Point Decrease
Effect on total of service and interest cost components	$0.4	$(0.4)
Effect on the postretirement benefit obligation	5.2	(4.3)

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)

Below are the components of net periodic benefit cost:

	Pension Benefits			Other Benefits		
	2000	1999	1998	2000	1999	1998
Service cost	$ 27.3	$ 26.6	$ 27.5	$ 1.3	$ 2.1	$ 2.5
Interest cost	36.6	31.4	32.2	8.4	6.2	6.9
Expected return on assets	(49.9)	(39.6)	(42.2)	(1.4)	(1.2)	(1.2)
Recognized actuarial (gain) loss	2.8	1.2	0.3	(1.7)	(2.4)	(2.1)
Amortization of prior service cost	(3.3)	(3.3)	(3.6)	(6.5)	(5.4)	(5.6)
Amortization of transition asset	(1.7)	(2.0)	(2.1)	--	--	--
Net periodic benefit cost before curtailments	11.8	14.3	12.1	0.1	(0.7)	0.5
Net settlement/curtailment credit	--	(7.9)	(3.3)	--	--	(5.4)
Net periodic benefit cost (credit)	$ 11.8	$ 6.4	$ 8.8	$ 0.1	$(0.7)	$(4.9)

The net settlement/curtailment credits in 1999 and 1998 result from the divestitures of several non-core businesses as previously discussed in Note 2.

The Company has several qualified defined contribution plans covering substantially all employees. Eligible employees may only participate in one plan. Voluntary employee contributions are matched at the rate of 40% to 50% depending upon the plan subject to certain limitations. Contributions made by the Company totaled $10.3, $8.7 and $10.0 during 2000, 1999 and 1998, respectively.

14. Contingencies

Litigation:

A number of managed care organizations have recently been sued in class action lawsuits asserting various causes of action under federal and state law. These lawsuits typically allege that the defendant managed care organizations employ policies and procedures for providing health care benefits that are inconsistent with the terms of the coverage documents and other information provided to their members, and because of these misrepresentations and practices, a class of members has been injured in that they received benefits of lesser value than the benefits represented to and paid for by such members. Two such proceedings which allege various violations of the Employee Retirement Income Security Act of 1974 ("ERISA") have been filed in Connecticut against the Company or its Connecticut affiliate. One proceeding, brought by the Connecticut Attorney General on behalf of a purported class of HMO and Point of Service members in Connecticut, seeks to enjoin the policies and practices that are alleged to violate ERISA. No monetary damages are sought. A second

proceeding, brought on behalf of a purported class of HMO and Point of Service members in Connecticut and elsewhere, seeks injunctive relief and monetary damages (both compensatory and punitive).

In addition, the Company's Connecticut affiliate is a defendant in three class action lawsuits brought on behalf of professional providers in Connecticut. The suits allege that the Connecticut affiliate has breached its contracts by, among other things, failing to pay for services in accordance with the terms of the contracts. The suits also allege violations of the Connecticut Unfair Trade Practices Act, breach of the implied duty of good faith and fair dealing, negligent misrepresentation and unjust enrichment. Two of the suits seek injunctive relief and monetary damages (both

compensatory and punitive). The third suit, brought by the Connecticut State Medical Society, seeks injunctive relief only.

The Company intends to vigorously defend these proceedings. All of the proceedings are in the early stages of litigation, and their ultimate outcomes cannot presently be determined. Accordingly, no provision has been made in the accompanying consolidated financial statements for liability, if any, that may result from these proceedings.

Following the purchase of BCBS-ME, appeals have been filed by two parties that intervened in the administrative proceeding before Maine's Superintendent of Insurance (the "Superintendent"), challenging the Superintendent's decision approving the conversion of BCBS-ME to a stock insurer, which was a required step before the acquisition. In one appeal, Maine's Attorney General is requesting the Court to modify the Superintendent's decision, by requiring BCBS-ME to submit an update to the statutorily mandated appraisal of its fair market value and to deposit into the charitable foundation the difference between the net proceeds that have been transferred to the foundation and the final value of BCBS-ME, if greater. In the other appeal, a consumers' group is also challenging that portion of the Superintendent's decision regarding the value of BCBS-ME. While the appeals are still pending, Anthem does not believe that the appeals will have a material adverse effect on its consolidated financial position or results of operations.

On March 11, 1998, Anthem and a subsidiary were named as defendants in a lawsuit, Robert Lee Dardinger, Executor of the Estate of Esther Louise Dardinger v. Anthem Blue Cross and Blue Shield, et al., filed in the Licking County Court of Common Pleas in Newark, Ohio. The plaintiff sought compensatory damages and unspecified punitive damages in connection with claims alleging wrongful death, bad faith and negligence arising out of the Company's denial of certain claims for medical treatment for Ms. Dardinger. On September 24, 1999, the jury returned a verdict for the plaintiff, awarding $1,350 (actual dollars) for compensatory damages, $2.5 for bad faith in claims handling and appeals processing, $49.0 for punitive damages and unspecified attorneys' fees in an amount to be determined by the court. The court later granted attorneys' fees of $0.8. An appeal of the verdict was filed by the defendants on November 19, 1999, and as part of the appeal, a bond in the amount of $60.0 was posted to secure the judgement and interest and attorneys' fees. The ultimate outcome of this appeal cannot be determined at this time. (See Note 17, fourth paragraph.)

In addition to the lawsuits described above, the Company is involved in other pending and threatened litigation of the character incidental to the

business transacted, arising out of its insurance and investment operations and is from time to time involved as a party in various governmental and administrative proceedings. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on its financial position or results of operations.

Other Contingencies:

The Company, like a number of other Blue Cross and Blue Shield companies, serves as a fiscal intermediary for Medicare Part A and B. The fiscal intermediaries for these programs receive reimbursement for certain costs and expenditures, which are subject to adjustment upon audit by the Health Care Finance Administration. The laws and regulations governing fiscal intermediaries for the Medicare program are complex, subject to interpretation and can expose an intermediary to penalties for non-compliance. Fiscal intermediaries may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. In the last five years, at least eight Medicare fiscal intermediaries have made payments to settle issues raised by such audits and reviews. These

payments have ranged from $0.7 to $51.6, plus a payment by one company of $144.0. While the Company believes it is currently in compliance in all material respects with the regulations governing fiscal intermediaries, there are ongoing reviews by the federal government of the Company's activities under certain of its Medicare fiscal intermediary contracts.

On December 8, 1999, Anthem Health Plans, Inc. ("AHP"), a subsidiary of Anthem, reached a settlement agreement with the Office of Inspector General, Department of Health and Human Services ("OIG"), in the amount of $41.9, to resolve an investigation into misconduct in the Medicare fiscal intermediary operations of Blue Cross and Blue Shield of Connecticut, Inc. ("BCBS-CT"), AHP's predecessor. The period investigated was before Anthem merged with BCBS-CT. The resolution of this case involved no criminal penalties against the Company nor any suspension or exclusion from federal programs. This expense was included in administrative expenses in the statement of consolidated income for the year ended December 31, 1999.

AdminaStar Federal, Inc., an affiliate of Anthem, has received two subpoenas from the OIG, one seeking documents and information concerning its responsibilities as a Medicare Part B contractor in its Kentucky office, and the other requesting certain financial records of AdminaStar Federal, Inc. and Anthem related to the Company's Medicare fiscal intermediary (Part A) and carrier (Part B) operations. The Company has made certain disclosures to the government of issues relating to its Medicare Part B work in Kentucky. The Company is not in a position to predict either the ultimate outcome of this review or the extent of any potential exposure should claims be made against the Company. However, the Company believes any fines or penalties that may arise from this review would not have a material adverse effect on the consolidated financial condition of the Company.

Anthem guarantees certain financial contingencies of its subsidiary, Anthem Alliance Health Insurance Company (Anthem Alliance), under a contract between Anthem Alliance and the United States Department of Defense. Under that contract, Anthem Alliance manages and administers the TRICARE Managed Care Support Program for military families. The contract requires Anthem Alliance,

as the prime contractor, to assume certain risks in the event, and to the extent, the actual cost of delivering health care services during the five-year contract period exceeds the health care cost proposal submitted by Anthem Alliance ("the Health Care Risk"). Anthem has guaranteed Anthem Alliance's assumption of the Health Care Risk, which is capped by the contract at $20.0 annually and $75.0 cumulatively over the five-year contract period. Anthem Alliance has subcontracts with two other Blue Cross and Blue Shield companies not affiliated with the Company by which the subcontractors have agreed to provide certain services under the contract and to assume approximately 50% of the Health Care Risk. Effective January 1, 2001, one of those subcontracts will terminate by mutual agreement of the parties. As a result, Anthem Alliance would then have one Blue Cross and Blue Shield subcontractor assuming 10% of the Health Care Risk.

Vulnerability from Concentrations:

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities and premiums receivable. All investment securities are managed by professional investment managers within guidelines authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premiums receivable are limited due to the large number of employer groups that constitute the Company's customer base in the geographic regions in which we conduct business. As of December 31, 2000, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

15. Segment Information

The Company's principal reportable segments are strategic business units primarily delineated by geographic areas that essentially offer similar insurance products and services. They are managed separately because each geographic region has unique market, regulatory and healthcare delivery characteristics. The geographic regions are: the Midwest region, which operates primarily in Indiana, Kentucky and Ohio; the East region, which operates primarily in Connecticut, New Hampshire and Maine; and the West region, which operates in Colorado and Nevada. BCBS-NH was added to the East region effective with its October 27, 1999 acquisition, while the West region was established following the acquisition of BCBS-CO/NV on November 16, 1999. BCBS-ME is included in the East segment since its acquisition date of June 5, 2000.

In addition to its three principal reportable geographic segments, the Company operates a Specialty segment which includes business units providing group life insurance benefits, pharmacy benefit management and third party occupational health and dental administration services. Various ancillary business units (reported with the Other segment) consist primarily of AdminaStar Federal which administers Medicare programs in Indiana, Illinois, Kentucky and Ohio and Anthem Alliance which provides health care benefits and administration in nine states for the Department of Defense's TRICARE Program for military families. The Other segment also includes intersegment revenue and expense eliminations and corporate expenses not allocated to reportable segments.

Through its participation in the Federal Employee Program ("FEP"), Medicare, Medicare at Risk, and TRICARE Program, the Company generated approximately 22%, 23%, and 22% of its total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2000, 1999, and 1998, respectively.

The Company defines operating revenues to include premium income, administrative fees and other revenues. Operating revenues are derived from premiums and fees received primarily from the sale and administration of health benefit products. Operating expenses are comprised of benefit and administrative expenses. The Company calculates operating gain or loss as operating revenue less operating expenses.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies except that pension and postretirement benefit costs for each segment are recognized on a per associate per month charge, which in aggregate approximates the consolidated expense. Any difference between the per associate per month charge and actual consolidated expense is included in corporate expenses not allocated to reportable segments. Intersegment sales and expenses are recorded at cost, and eliminated in the consolidated financial statements. The Company evaluates performance of the reportable segments based on operating gain or loss as defined above. The Company evaluates investment income, interest expense, amortization expense, income taxes, and asset and liability details on a consolidated basis as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

The following tables present operating gain (loss) by reportable segment for each of the years ended December 31, 2000, 1999 and 1998:

	Reportable Segments					
	Midwest	East	West	Specialty	Other	Total
2000						
Premiums	$4,203.1	$2,768.9	$569.6	$123.7	$ 72.0	$7,737.3
Administrative fees	254.8	144.1	52.8	31.8	272.1	755.6
Other revenues	2.6	8.9	--	176.8	(137.7)	50.6
Operating revenue(1)	4,460.5	2,921.9	622.4	332.3	206.4	8,543.5
Benefit expense	3,555.4	2,332.4	491.7	92.6	78.9	6,551.0
Administrative expense(2)	817.3	485.7	128.2	214.8	162.4	1,808.4
Operating expense	4,372.7	2,818.1	619.9	307.4	241.3	8,359.4
Operating gain (loss)	$ 87.8	$ 103.8	$ 2.5	$ 24.9	$ (34.9)	$ 184.1
(1) Includes intersegment revenues	$ 8.2	$ --	$ --	$143.5	$(151.7)	$ --
(2) Includes depreciation and						

amortization.....	16.9	17.1	8.7	2.1	30.5	75.3

	Reportable Segments					
	Midwest	East	West	Specialty	Other	Total
1999						
Premiums.....	$3,729.3	$1,495.4	$ 64.2	$ 96.3	$ 33.3	$5,418.5
Administrative fees.....	242.8	99.7	1.7	14.6	252.3	611.1
Other revenues.....	3.4	3.8	6.8	138.2	(101.2)	51.0
Operating revenue(1)....	3,975.5	1,598.9	72.7	249.1	184.4	6,080.6
Benefit expense.....	3,162.2	1,259.9	55.0	73.8	31.8	4,582.7
Administrative expense(2).....	776.9	339.9	21.2	159.1	172.3	1,469.4
Operating expense.....	3,939.1	1,599.8	76.2	232.9	204.1	6,052.1
Operating gain (loss)...	$ 36.4	$ (0.9)	$ (3.5)	$ 16.2	$ (19.7)	$ 28.5
(1) Includes intersegment revenues..	$ 7.5	$ --	$ --	$103.7	$(111.2)	$ --
(2) Includes depreciation and amortization.....	16.6	8.5	0.5	1.4	20.1	47.1

	Reportable Segments					
	Midwest	East	West	Specialty	Other	Total
1998						
Premiums.....	$3,533.3	$1,088.3	$ --	$ 90.3	$ 27.6	$4,739.5
Administrative fees.....	234.8	91.4	--	21.1	228.3	575.6
Other revenues.....	3.0	11.2	--	130.2	(69.8)	74.6
Operating revenue(1).....	3,771.1	1,190.9	--	241.6	186.1	5,389.7
Benefit expense.....	2,922.9	901.9	--	76.1	33.3	3,934.2
Administrative expense(2).....	797.7	294.6	--	142.3	185.5	1,420.1
Operating expense.....	3,720.6	1,196.5	--	218.4	218.8	5,354.3
Operating gain (loss)....	$ 50.5	$ (5.6)	$ --	$ 23.2	$ (32.7)	$ 35.4
(1) Includes intersegment revenues.....	$ 9.4	$ --	$ --	$104.3	$(113.7)	$ --
(2) Includes depreciation and amortization.....	16.2	9.3	--	1.1	17.1	43.7

Asset and equity details by reportable segment have not been disclosed, as they are not reported internally by the Company.

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the consolidated statements of income for 2000, 1999 and 1998 is as follows:

	2000	1999	1998
Reportable segments operating revenues	$8,543.5	$6,080.6	$5,389.7
Net investment income	201.6	152.0	136.8
Net realized gains on investments	25.9	37.5	155.9
Total revenues	$8,771.0	$6,270.1	$5,682.4

A reconciliation of reportable segment operating gain to income from continuing operations before income taxes and minority interest included in the consolidated statements of income for 2000, 1999 and 1998 is as follows:

	2000	1999	1998
Reportable segments operating gain	$184.1	$ 28.5	$ 35.4
Net investment income	201.6	152.0	136.8
Net realized gains on investments	25.9	37.5	155.9
Interest expense	(54.7)	(30.4)	(27.9)
Amortization of goodwill and other intangible assets	(27.1)	(12.7)	(12.0)
Endowment of non-profit foundations	--	(114.1)	--
Income from continuing operations before income taxes and minority interest	$329.8	$ 60.8	$288.2

16. Statutory Information

Statutory policyholders' surplus of Anthem amounted to $1,907.5 and $1,444.2 at December 31, 2000 and 1999, respectively. Statutory net income of Anthem was $91.7, $201.7 and $80.6 for 2000, 1999 and 1998, respectively. Surplus of insurance subsidiaries of Anthem is subject to regulatory restrictions with respect to amounts available for dividends to Anthem.

In 1998, the National Association of Insurance Commissioners adopted codified statutory accounting principles ("Codification") which will be

effective January 1, 2001. Codification will result in changes to certain accounting practices that Anthem and it's insurance subsidiaries use to prepare statutory-basis financial statements. Management believes the impact of these changes will not be significant.

17. Subsequent Events

On January 29, 2001 Anthem's board of directors appointed a special committee to work with management to develop a plan for demutualization and conversion to a publicly traded stock company (the "Plan") for the board's further review. On June 18, 2001, the Plan was approved by Anthem's board of directors and management believes that the demutualization and conversion process could be completed before the end of 2001. Anthem's members will see no increase in premiums or changes to the terms of their health care benefits as a result of the demutualization.

On April 18, 2001, Anthem and its subsidiary Anthem Alliance Health Insurance Company ("Alliance"), entered into an Agreement and Plan of Merger to sell the TRICARE operations of Alliance to a subsidiary of Humana, Inc. The transaction closed on May 31, 2001.

On May 30, 2001, Anthem and Blue Cross and Blue Shield of Kansas ("BCBS-KS") signed a definitive agreement pursuant to which BCBS-KS will become a wholly owned subsidiary of Anthem. Under the proposed transaction, BCBS-KS will demutualize and convert to a stock insurance company. The agreement calls for Anthem to pay $190.0 in exchange for all of the shares of BCBS-KS. Subject to the approval of BCBS-KS policyholders and the approval of the Kansas Department of Insurance, the transaction is expected to close in early 2002.

On May 22, 2001, the Ohio Court of Appeals (Fifth District) affirmed the jury award of $1,350 (actual dollars) for breach of contract against Community Insurance Company ("CIC"), a subsidiary of the Company, affirmed the award of $2.5 compensatory damages for bad faith in claims handling and appeals processing against CIC, but dismissed the claims and judgments against Anthem. The court also reversed the award of $49.0 in punitive damages against both the Company and CIC, and remanded the question of punitive damages against CIC to the trial court for a new trial. (See Note 14, fifth paragraph.)

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
	($ in Millions)			
2000 Data				
Total revenues	$1,962.1	$2,104.1	$2,320.0	$2,384.8
Operating gain	32.4	34.2	53.3	64.2
Net income	40.4	49.9	63.5	72.2
1999 Data				
Total revenues	$1,450.3	$1,465.3	$1,571.8	$1,782.7
Operating gain (loss)(1)	(0.4)	6.5	27.9	(5.5)
Income (loss) from continuing operations(2)	11.9	24.4	17.8	(3.2)
Discontinued operations, net of				

income taxes(3).....	--	--	--	(6.0)
Net income (loss).....	11.9	24.4	17.8	(9.2)

---

(1) The operating loss of $(5.5 million) for the quarter ended December 31, 1999 includes a non recurring charge of $41.9 million related to the settlement agreement with the OIG. See Note 14 to our audited consolidated financial statements.

(2) During 1999, we reached agreements with the states of Kentucky, Ohio and Connecticut to resolve any questions as to whether we or our predecessor/successor entities were in possession of property that was impressed with a charitable trust. Income (loss) from continuing operations for the quarters ended March 31, September 30 and December 31, 1999 includes the non-recurring after-tax endowment of non-profit foundations of $18.2 million, $26.8 million and $26.8 million, respectively. See Note 3 to our audited consolidated financial statements.

(3) Loss on discontinued operations for the quarter ended December 31, 1999 resulted when we recognized additional losses resulting from sales agreement contingency adjustments relating to discontinued operations sold in prior years. See Note 2 to our audited consolidated financial statements.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED BALANCE SHEET
(Unaudited)

	June 30, 2001
	(In Millions)
Assets	
Current assets:	
Investments available-for-sale, at fair value:	
Fixed maturity securities.....	$3,351.3
Equity securities.....	439.4
	3,790.7
Cash and cash equivalents.....	238.9
Premium and self funded receivables.....	498.5
Reinsurance receivables.....	78.9
Other receivables.....	194.5
Income tax receivables.....	7.4
Other current assets.....	33.4
Total current assets.....	4,842.3
Other noncurrent investments.....	13.1
Restricted cash and investments.....	51.1
Property and equipment.....	409.6
Goodwill and other intangible assets.....	480.4
Other noncurrent assets.....	41.5
Total assets.....	$5,838.0
Liabilities and policyholders' surplus	
Liabilities	
Current liabilities:	
Policy liabilities:	

Unpaid life, accident and health claims	$1,295.1
Future policy benefits	237.5
Other policyholder liabilities	61.2
Total policy liabilities	1,593.8
Unearned income	321.2
Accounts payable and accrued expenses	269.0
Bank overdrafts	281.6
Income taxes payable	34.6
Other current liabilities	283.7
Total current liabilities	2,783.9
Long term debt, less current portion	597.5
Retirement benefits	187.5
Other noncurrent liabilities	205.2
Total liabilities	3,774.1
Policyholders' surplus	
Surplus	1,991.6
Accumulated other comprehensive income	72.3
Total policyholders' surplus	2,063.9
Total liabilities and policyholders' surplus	$5,838.0

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF INCOME
(Unaudited)

	Six Months Ended June 30	
	2001	2000
	(In Millions)	
Revenues		
Premiums	$4,542.8	$3,589.3
Administrative fees	430.3	356.5
Other revenue	22.6	18.9
Total operating revenue	4,995.7	3,964.7
Net investment income	109.0	95.0
Net realized gains (losses) on investments	(10.9)	6.5
Gain on sale of subsidiary operations	25.0	--
	5,118.8	4,066.2
Expenses		
Benefit expense	3,870.8	3,080.6
Administrative expense	991.6	817.5
Interest expense	28.0	27.0

Amortization of goodwill and other intangible assets.....	15.7	11.4
Demutualization expenses.....	3.0	--
	4,909.1	3,936.5
Income before income taxes and minority interest.....	209.7	129.7
Income taxes.....	68.6	38.9
Minority interest (credit).....	(1.9)	0.5
Net income.....	$ 143.0	$ 90.3

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF POLICYHOLDERS' SURPLUS
(Unaudited)

	Surplus	Accumulated Other Comprehensive Income	Total Policyholders' Surplus
		(In Millions)	
Balance at December 31, 2000.....	$1,848.6	$71.2	$1,919.8
Net income.....	143.0	--	143.0
Change in net unrealized gains on securities.....	--	1.1	1.1
Comprehensive income.....			144.1
Balance at June 30, 2001.....	$1,991.6	$72.3	$2,063.9
Balance at December 31, 1999.....	$1,622.6	$38.3	$1,660.9
Net income.....	90.3	--	90.3
Change in net unrealized gains on securities.....	--	5.1	5.1
Comprehensive income.....			95.4
Balance at June 30, 2000.....	$1,712.9	$43.4	$1,756.3

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited)

	Six Months Ended June 30	
	2001	2000
	(In Millions)	
Operating activities		
Net income	$ 143.0	$ 90.3
Adjustments to reconcile net income to net cash provided by operating activities:		
Realized (gains) losses on investments	10.9	(6.5)
Gain on sale of subsidiary operations	(25.0)	--
Depreciation, amortization and accretion	61.2	47.2
Deferred income taxes	16.9	3.4
Loss on sale of assets	2.9	0.6
Changes in operating assets and liabilities, net of effect of purchases and divestitures:		
Restricted cash and investments	(3.3)	5.1
Receivables	12.2	21.9
Other assets	(3.7)	(8.9)
Policy liabilities	27.0	91.6
Unearned income	64.7	27.9
Accounts payable and accrued expenses	6.7	(18.3)
Other liabilities	(63.4)	75.7
Income taxes	12.5	36.7
Net cash provided by continuing operations	262.6	366.7
Net cash used in discontinued operations	(1.5)	(1.3)
Cash provided by operating activities	261.1	365.4
Investing activities		
Purchases of investments	(1,957.9)	(1,685.2)
Sales or maturities of investments	1,721.4	1,458.3
Purchases of subsidiaries, net of cash acquired	(2.7)	(69.2)
Sales of subsidiaries, net of cash sold	45.0	6.0
Proceeds from sale of property and equipment	0.9	4.4
Purchases of property and equipment	(32.2)	(35.2)
Cash used in investing activities	(225.5)	(320.9)
Financing activities		
Proceeds from borrowings	--	295.3
Payments on borrowings	--	(220.0)
Cash provided by financing activities	--	75.3
Change in cash and cash equivalents	35.6	119.8
Cash and cash equivalents at beginning of period	203.3	204.4
Cash and cash equivalents at end of period	$ 238.9	$ 324.2

See accompanying notes.

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

June 30, 2001
(Dollars in Millions)

1. Basis of Presentation

The accompanying unaudited consolidated financial statements of Anthem Insurance Companies, Inc. ("Anthem") and its subsidiaries (collectively, the "Company") have been prepared in accordance with accounting principles generally accepted in the United States ("GAAP") for interim financial reporting. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation have been included. The results of operations for the six month period ended June 30, 2001 are not necessarily indicative of the results that may be expected for the full year ending December 31, 2001. These unaudited consolidated interim financial statements should be read in conjunction with the Company's audited consolidated financial statements for the year ended December 31, 2000.

2. Demutualization

On January 29, 2001 Anthem's board of directors appointed a special committee to work with management to develop a plan for demutualization and conversion to a publicly traded stock company (the "Plan") for the board's further review. On June 18, 2001, the Plan was approved by Anthem's board of directors and management believes that the demutualization and conversion process could be completed before the end of 2001. Anthem's members will see no increase in premiums or change to the terms of their health care benefits as a result of the demutualization.

3. Disposition and Pending Acquisition

On April 18, 2001, Anthem and its subsidiary Anthem Alliance Health Insurance Company ("Alliance"), entered into an Agreement and Plan of Merger to sell the TRICARE operations of Alliance to a subsidiary of Humana, Inc. for $45.0. The transaction, which closed on May 31, 2001 resulted in a gain on sale of subsidiary operations of $25.0, net of selling expenses.

On May 30, 2001, Anthem and Blue Cross and Blue Shield of Kansas ("BCBS-KS") signed a definitive agreement pursuant to which BCBS-KS will become a wholly owned subsidiary of Anthem. Under the proposed transaction, BCBS-KS will demutualize and convert to a stock insurance company. The agreement calls for Anthem to pay $190.0 in exchange for all of the shares of BCBS-KS. Subject to the approval of BCBS-KS policyholders and the approval of the Kansas Department of Insurance, the transaction is expected to close in early 2002.

4. Pending Adoption of Accounting Standard

On June 29, 2001, members of the Financial Accounting Standards Board voted unanimously in favor of FAS 141, Business Combinations, and FAS 142, Goodwill and Other Intangible Assets. Both FAS 141 and FAS 142 will be issued in July 2001. FAS 141 will require business combinations completed after June 30, 2001 to be accounted for using the purchase method of accounting. Under FAS 142 goodwill will not be amortized but will be tested for impairment at least annually. The Company will be required to adopt FAS 142 on January 1, 2002 and early adoption is not permitted. The Company has not yet completed the analysis necessary to provide a precise estimate of the effect of the adoption of FAS

142, however the elimination of goodwill expense from the consolidated statements of income is expected to be material.

5. Contingencies

Litigation

A number of managed care organizations have recently been sued in class action lawsuits asserting various causes of action under federal and state law. These lawsuits typically allege that the defendant managed care organizations employ policies and procedures for providing health care benefits that are inconsistent with the terms of the coverage documents and other information provided to their members, and because of these misrepresentations and practices, a class of members has been injured in that they received benefits of lesser value than the benefits represented to and paid for by such members. Two such proceedings which allege various violations of the Employee Retirement Income Security Act of 1974 ("ERISA") have been filed in Connecticut against the Company or its Connecticut affiliate. One proceeding was brought by the Connecticut Attorney General on behalf of a purported class of HMO and Point of Service members in Connecticut. No monetary damages are sought, although the suit does seek injunctive relief from the court to preclude the Company from allegedly utilizing arbitrary coverage guidelines, making late payments to providers or members, denying coverage for medically necessary prescription drugs and misrepresenting or failing to disclose essential information to enrollees. The complaint contends that these alleged policies and practices are a violation of ERISA. A second proceeding, brought on behalf of a purported class of HMO and Point of Service members in Connecticut and elsewhere, seeks injunctive relief to preclude the Company from allegedly making coverage decisions relating to medical necessity without complying with the express terms of the policy documents, and unspecified monetary damages (both compensatory and punitive).

In addition, the Company's Connecticut affiliate is a defendant in three class action lawsuits brought on behalf of professional providers in Connecticut. The suits allege that the Connecticut affiliate has breached its contracts by, among other things, failing to pay for services in accordance with the terms of the contracts. The suits also allege violations of the Connecticut Unfair Trade Practices Act, breach of the implied duty of good faith and fair dealing, negligent misrepresentation and unjust enrichment. Two of the suits seek injunctive relief and monetary damages (both compensatory and punitive). The third suit, brought by the Connecticut State Medical Society, seeks injunctive relief only.

The Company intends to vigorously defend these proceedings. All of the proceedings are in the early stages of litigation, and their ultimate outcomes cannot presently be determined. Accordingly, no provision has been made in the accompanying unaudited consolidated financial statements for liability, if any, that may result from these proceedings.

Following the purchase of BCBS-ME, appeals have been filed by two parties that intervened in the administrative proceeding before Maine's Superintendent of Insurance (the "Superintendent"), challenging the Superintendent's decision approving the conversion of BCBS-ME to a stock insurer, which was a required

step before the acquisition. In one appeal, Maine's Attorney General is requesting the Court to modify the Superintendent's decision, by requiring BCBS-ME to submit an update to the statutorily mandated appraisal of its fair market value and to deposit into the charitable foundation the difference between the net proceeds that have been transferred to the foundation and the final value of BCBS-ME, if greater. In the other appeal, a consumers' group is also challenging that portion of the Superintendent's decision regarding the value of BCBS-ME. While the appeals are still pending, Anthem does not believe that the appeals will have a material adverse effect on its unaudited consolidated financial position or results of operations.

On March 11, 1998, Anthem and its Ohio subsidiary Community Insurance Company ("CIC") were named as defendants in a lawsuit, Robert Lee Dardinger, Executor of the Estate of Esther Louise Dardinger v. Anthem Blue Cross and Blue Shield, et al., filed in the Licking County Court of Common Pleas in Newark, Ohio. The plaintiff sought compensatory damages and unspecified punitive damages in connection with claims alleging wrongful death, bad faith and negligence arising out of the Company's denial of certain claims for medical treatment for Ms. Dardinger. On September 24, 1999, the jury returned a verdict for the plaintiff, awarding $1,350 (actual dollars) for compensatory damages, $2.5 for bad faith in claims handling and appeals processing, $49.0 for punitive damages and unspecified attorneys' fees in an amount to be determined by the court. The court later granted attorneys' fees of $0.8. An appeal of the verdict was filed by the defendants on November 19, 1999, and as part of the appeal, a bond in the amount of $60.0 was posted to secure the judgement and interest and attorneys' fees. On May 22, 2001, the Ohio Court of Appeals (Fifth District) affirmed the jury award of $1,350 (actual dollars) for breach of contract against CIC, affirmed the award of $2.5 compensatory damages for bad faith in claims handling and appeals processing against CIC, but dismissed the claims and judgments against Anthem. The court also reversed the award of $49.0 in punitive damages against CIC to the trial court for a new trial. Anthem and CIC, as well as the plaintiff, appealed certain aspects of the decision of the Ohio Court of Appeals. On October 10, 2001, the Supreme Court of Ohio agreed to hear the plaintiff's appeal, including the question of punitive damages, and denied the cross-appeals of Anthem and CIC. The ultimate outcome of this matter cannot be determined at this time.

In addition to the lawsuits described above, the Company is also involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its insurance and investment operations and is from time to time involved as a party in various governmental and administrative proceedings. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on its financial position or results of operations.

Other Contingencies

The Company, like a number of other Blue Cross and Blue Shield companies, serves as a fiscal intermediary for Medicare Part A and B. The fiscal intermediaries for these programs receive reimbursement for certain costs and expenditures, which is subject to adjustment upon audit by the Health Care Finance Administration. The laws and regulations governing fiscal intermediaries for the Medicare program are complex, subject to interpretation

and can expose an intermediary to penalties for non-compliance. Fiscal intermediaries may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. In the last five years, at least eight Medicare fiscal intermediaries have made payments to settle issues raised by such audits and reviews. These payments have ranged from $0.7 to $51.6, plus a payment by one company of $144.0. While the Company believes it is currently in compliance in all material respects with the regulations governing fiscal intermediaries, there are ongoing reviews by the federal government of the Company's activities under certain of its Medicare fiscal intermediary contracts.

AdminaStar Federal, Inc., an affiliate of Anthem, has received several subpoenas from the Office of Inspector General, Department of Health and Human Services, one seeking documents and information concerning its responsibilities as a Medicare Part B contractor in its Kentucky office, and the other requesting certain financial records of AdminaStar Federal, Inc. and Anthem related to the Company's Medicare fiscal intermediary (Part A) and carrier (Part B) operations. The Company has made certain disclosures to the government of issues relating to its Medicare Part B work in Kentucky. The Company is not in a position to predict either the ultimate outcome of this review or

the extent of any potential exposure should claims be made against the Company. However, the Company believes any fines or penalties that may arise from this review would not have a material adverse effect on the consolidated financial condition of the Company.

As a Blue Cross Blue Shield Association licensee, the Company participates in the Federal Employee Program ("FEP"), a nationwide contract with the federal Office of Personnel Management, to provide coverage to federal employees and their dependents. On July 11, 2001 the Company received a subpoena from the Office of Inspector General, Office of Personnel Management, seeking certain financial documents and information, including information concerning intercompany transactions, related to operations in Ohio, Indiana and Kentucky under the FEP contract. The Company is currently evaluating the subpoena and intends to cooperate with the government's review. The Company is not in a position to predict either the ultimate outcome of this review or the extent of any potential exposure should claims be made against the Company. There can be no assurance that the ultimate outcome of this review will not have a material adverse effect on the Company's consolidated results of operations or financial condition.

Anthem guaranteed certain financial contingencies of its subsidiary, Anthem Alliance Health Insurance Company ("Alliance") under a contract between Alliance and the United States Department of Defense. Under that contract, Alliance managed and administered the TRICARE Managed Care Support Program for military families from May 1, 1998 through May 31, 2001. The contract required Alliance, as the prime contractor, to assume certain risks in the event, and to the extent, the actual cost of delivering health care services exceeded the health care cost proposal submitted by Alliance ("the Health Care Risk"). The contract has a five-year term, but was transferred to a third party, effective May 31, 2001. Anthem guaranteed Alliance's assumption of the Health Care Risk, which is capped by the contract at $20.0 annually and $75.0 cumulatively over the contract period. Through December 31, 2000, Alliance had subcontracts with two other Blue Cross and Blue Shield companies not affiliated with the Company

by which the subcontractors agreed to provide certain services under the contract and to assume approximately 50% of the Health Care Risk. Effective January 1, 2001, one of those subcontracts terminated by mutual agreement of the parties, which increased Alliance's portion of the Health Care Risk to 90%. Effective May 1, 2001, the other subcontract was amended to eliminate the Health Care Risk sharing provision, which resulted in Alliance assuming 100% of the Health Care Risk for the period from May 1, 2001 to May 31, 2001. There was no call on the guarantee for the period from May 1, 1998 to April 30, 1999 (which period is now "closed"), and we do not anticipate a call on the guarantee for the periods beginning May 1, 1999 through May 31, 2001 (which periods remain "open" for possible review by the Department of Defense).

6. Segment Information

The following tables show financial data by segment for the six months ended June 30, 2001 and 2000:

	Reportable Segments					
	Midwest	East	West	Specialty	Other	Total
Six Months Ended June 30, 2001						
Premiums	$2,313.0	$1,658.3	$327.3	$47.4	$196.8	$4,542.8
Administrative fees	152.8	99.6	29.6	18.0	130.3	430.3
Other revenue	0.9	0.8	--	120.1	(99.2)	22.6
Operating revenue(1)	2,466.7	1,758.7	356.9	185.5	227.9	4,995.7
Benefit expense	1,952.8	1,418.1	275.3	31.8	192.8	3,870.8
Administrative expense(2)	428.9	292.2	78.5	137.8	54.2	991.6
Operating expense	2,381.7	1,710.3	353.8	169.6	247.0	4,862.4
Operating gain (loss)	$ 85.0	$ 48.4	$ 3.1	$15.9	$(19.1)	$ 133.3
(1) Includes intersegment revenues	$ --	$ --	$ --	$97.5	$(97.5)	$ --
(2) Includes depreciation and amortization	0.5	1.2	1.3	1.4	40.4	44.8

	Reportable Segments					
	Midwest	East	West	Specialty	Other	Total
Six Months Ended June 30, 2000						
Premiums	$2,046.4	$1,175.6	$278.1	$64.3	$ 24.9	$3,589.3
Administrative fees	123.7	57.9	24.9	14.8	135.2	356.5

Other revenues.....	1.3	2.5	0.1	82.3	(67.3)	18.9
Operating revenue(1)....	2,171.4	1,236.0	303.1	161.4	92.8	3,964.7
Benefit expense.....	1,748.7	1,012.2	240.2	51.2	28.3	3,080.6
Administrative expense(2).....	386.5	189.7	61.6	100.4	79.3	817.5
Operating expense.....	2,135.2	1,201.9	301.8	151.6	107.6	3,898.1
Operating gain (loss).....	$ 36.2	$ 34.1	$ 1.3	$ 9.8	$(14.8)	$ 66.6
(1) Includes intersegment revenues.....	$ 3.9	$ --	$ --	$68.6	$(72.5)	$ --
(2) Includes depreciation and amortization.....	8.9	7.2	4.4	1.0	14.5	36.0

ANTHEM INSURANCE COMPANIES, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS--(Continued)
(Unaudited)

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the unaudited consolidated statements of income for the six months ended June 30, 2001 and 2000 is as follows:

	Six Months Ended June 30	
	2001	2000
Reportable segments operating revenue.....	$4,995.7	$3,964.7
Net investment income.....	109.0	95.0
Net realized gains (losses) on investments.....	(10.9)	6.5
Gain on sale of subsidiary operations.....	25.0	--
Total revenues.....	$5,118.8	$4,066.2

A reconciliation of reportable segment operating gain to income before income taxes and minority interest included in the unaudited consolidated statements of income for the six months ended June 30, 2001 and 2000 is as follows:

	Six Months Ended June 30	
	2001	2000
Reportable segments operating gain.....	$ 133.3	$ 66.6

Net investment income...	109.0	95.0
Net realized gains (losses) on investments.....	(10.9)	6.5
Gain on sale of subsidiary operations..	25.0	--
Interest expense.....	(28.0)	(27.0)
Amortization of goodwill and other intangible assets.....	(15.7)	(11.4)
Demutualization expenses.....	(3.0)	--
Income before income taxes and minority interest.....	$ 209.7	$ 129.7

ANNEX A

ACTUARIAL OPINIONS

[LOGO OF MILLIMAN]

One Pennsylvania Plaza, 38th Floor
New York, NY 10119
Tel +1 212 279.7166
Fax +1 212 629.5657
www.milliman.com

June 18, 2001

Board of Directors
Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

Re: Plan of Conversion of Anthem Insurance Companies, Inc.

STATEMENT OF ACTUARIAL OPINIONS

Subject of this Opinion Letter

This opinion letter relates to the actuarial aspects of the proposed reorganization of Anthem Insurance Companies, Inc. ("Anthem Insurance") pursuant to its Plan of Conversion (the "Plan") as presented to the Board of Directors of Anthem Insurance for its consideration and approval on June 18, 2001. The specific opinions set forth herein relate to the proposed allocation of consideration among the Eligible Statutory Members of Anthem Insurance and the decision not to include a Closed Block dividend preservation mechanism, each of which is described in the Plan.

Capitalized terms have the same meaning in this opinion as they have in the Plan.

Qualifications and Usage

We, Robert H. Dobson, Dale S. Hagstrom, and Daniel J. McCarthy, are associated with the firm of Milliman USA ("Milliman") and are Members of the American Academy of Actuaries, qualified under the Academy's Qualification Standards to render the opinions set forth herein. We, and other Milliman staff acting under our direction, have advised Anthem Insurance during the course of its development of the Plan and the Actuarial Contribution Memorandum, which is Exhibit F thereto. The Plan is based on authority in Title 27 Article 15 of the Indiana Code ("the Indiana Demutualization Law"). The opinions set forth herein are not legal opinions concerning the Plan, the Articles of Incorporation of Anthem Insurance, or Indiana law, but rather are opinions concerning the application of actuarial concepts and standards of practice to the provisions of the Plan.

Chapter 3 Section 2 (11) of the Indiana Demutualization Law requires "an actuarial opinion as to the following: (A) The reasonableness and appropriateness of the methodology or formulas used to allocate consideration among eligible members, and (B) The reasonableness of the plan of operation . . . of . . . the closed block if a closed block is used for . . . policies that provide for the distribution of policy dividends." We are aware that, per Chapter 3 Section 4 (4) of the Indiana Demutualization Law, our opinion will be furnished to the Insurance Commissioner of the State of Indiana in fulfillment of this requirement and for her use in determining the fairness of the Plan, and to the Statutory Members of Anthem Insurance as part of the Member Information Statement that will be delivered to them, and we consent to the use of this opinion letter for those purposes.

Reliance

In forming the opinions set forth in this opinion letter, we have received from Anthem Insurance extensive information concerning the past and present practices and financial results of Anthem Insurance and its predecessors. We also received from Anthem Insurance relevant corporate documents and Membership information. We, and other Milliman staff acting under our direction, met with personnel of Anthem Insurance and defined the information we required. In all cases, we were provided with the information we requested to the extent that it was available or to the extent it was practicable to develop the information from the records of Anthem Insurance. We have made no independent verification of this information, although we have reviewed it where practicable for general reasonableness and internal consistency. We have relied on this information, which was provided under the general direction of Cynthia S. Miller, Vice President and Chief Actuary of Anthem Insurance. Our opinions depend on the substantial accuracy of this information.

Process

In all cases, we and other Milliman staff acting under our direction either derived the results on which our opinions rest or reviewed derivations carried out by Anthem Insurance employees.

Opinion #1

Under the Plan, consideration (shares of Common Stock or their equivalent value in cash) is to be distributed to each Eligible Statutory Member in exchange for such Member's Membership Interest. In our opinion, the principles, assumptions, methodologies, and formulas used to allocate consideration among the Eligible Statutory Members of Anthem Insurance as set forth in Article VII of the Plan (including the Actuarial Contribution Memorandum, which is Exhibit F thereto) are reasonable and appropriate and consistent with the requirements

of the Indiana Demutualization Law, and the resulting allocation of consideration is fair and equitable to the Eligible Statutory Members.

Discussion

Statutory requirements. Chapter 9 Section 1 of the Indiana Demutualization Law requires that "The method or formula for allocating consideration among the eligible members shall provide for each eligible member to receive (1) a fixed value, amount or proportion of consideration; (2) a variable value, amount or proportion of consideration; or (3) a combination of fixed and variable values, amounts, or proportions of consideration." Section 2 of Chapter 9 further requires that "Any method used or formula developed for the fair and equitable allocation of stock among eligible members under this article must utilize generally accepted actuarial principles."

General description of the method of allocation of consideration among Eligible Statutory Members. In general, Statutory Members with coverage in force on both the Board Adoption Date and the Effective Date are eligible to receive consideration, which will consist of both a variable component and a fixed component of consideration. The amount of such consideration, whether actually distributed in the form of cash or shares of Common Stock, is expressed in terms of shares of Common Stock. (For a further discussion of this subject, see "The effect of different forms of consideration", below.)

Prior mergers. Statutory Members of Anthem Insurance include Statutory Members whose initial eligibility arose from three companies--Southeastern Mutual Insurance Company, Community Mutual Insurance Company, and Blue Cross & Blue Shield of Connecticut, Inc.-- that were merged into Anthem Insurance in 1993, 1995 and 1997, respectively. The Articles of Incorporation of Anthem Insurance contain provisions arising from these three mergers, and these provisions in the Articles of Incorporation are important to our understanding of the Plan and our view of the fairness and equity of the allocation. The allocation of the Aggregate Variable Component and the Aggregate Fixed Component, discussed below, reflects these provisions.

The Aggregate Variable Component and its allocation. The Aggregate Variable Component is the majority of the consideration to be distributed to Eligible Statutory Members (approximately 80%

of the total). Its allocation among the Eligible Statutory Members is based on an "actuarial contribution method", which takes into account Actuarial Contributions of policies held by Eligible Statutory Members. The "actuarial contribution" method used with respect to Anthem Insurance takes into account, at each past merger point and at the Actuarial Contribution Date, both historical contributions to surplus and then-anticipated future contributions to surplus. The concept of an actuarial contribution method is recognized in the actuarial literature, most notably in Actuarial Standard of Practice number 37, "Allocation of Policyholder Consideration in Mutual Life Insurance Company Demutualizations" ("ASOP 37") as an appropriate allocation method. While ASOP 37 does not strictly apply to a nonlife insurer such as Anthem Insurance, there is no other Actuarial Standard of Practice regarding allocation of consideration in a demutualization that does apply. Further, much of the health insurance underwritten by Anthem Insurance could be underwritten by a life insurer, to which ASOP 37 would apply. In our view, the conformance of the Plan with ASOP 37 means that the distribution methodology proposed in the Plan is consistent with generally accepted actuarial principles. We therefore find that the use of the "actuarial contribution" method as the principal basis underlying the allocation of consideration is reasonable and appropriate. We further find that the actuarial contribution method has been implemented in a

reasonable manner, consistent with the Articles of Incorporation, as well as with the past and present business practices of Anthem Insurance. We disclose, as a deviation from the guidance of ASOP 37, the fact that Actuarial Contributions of group insurance policies issued by Anthem Insurance and by the three previously-mentioned companies that were merged into Anthem Insurance were calculated by treating the experience of such policies on a pooled basis, notwithstanding that some of them have historically been rated on a policy-by-policy basis. This deviation is justified principally because of data limitations; with respect to most of the time period over which historical contributions to surplus were analyzed, Anthem Insurance does not have sufficiently complete or reliable data to support a policy-by-policy analysis of such contributions.

The Aggregate Fixed Component and its allocation. The distribution also takes into account, through the Aggregate Fixed Component, the fact that Statutory Members have membership rights that are independent of their actuarial contributions. Each Eligible Statutory Member is, under the Plan, allocated a fixed number of shares of Common Stock without regard to the Actuarial Contribution of Policies of which that Statutory Member is the Holder. This element of the allocation assures that each Eligible Statutory Member will receive some distribution, and is consistent with overall concepts of equity. Under the Plan, the percentage of the total consideration that is allocated in this manner (approximately 20% of the total) is small relative to that allocated in proportion to positive actuarial contributions, which is appropriate. We find that including a fixed share in the allocation to each Eligible Statutory Member to reflect intangible membership rights is reasonable and appropriate.

The effect of different forms of consideration and of conditions under which shares of Common Stock may be sold.

a. Section 6.1 of the Plan provides that, subject to the limitations set forth therein, Eligible Statutory Members who do not affirmatively elect to receive their consideration in the form of shares of Common Stock may, at the option of Anthem Insurance and Anthem, Inc., receive consideration in cash. Section 6.3 of the Plan provides that, if the average of the closing prices ("average price") of the Common Stock for the twenty consecutive days commencing with the Effective Date exceeds 110% of the IPO Price, each recipient of cash will receive an amount equal to the number of shares of Common Stock determined as set forth above multiplied by a price per share equal to the sum of the IPO Price and either (A) the excess of the average price over 110% of the IPO Price or (B) 10% of the IPO Price, whichever is less; otherwise, each recipient of cash will receive an amount equal to the number of shares of Common Stock determined as set forth above multiplied by a price per share equal to the IPO price.

b. Section 6.2 of the Plan provides that Common Stock distributed to an Eligible Statutory Member who receives 30,000 or more shares of such Common Stock (a "large holder")

may be sold or otherwise transferred, during the 180 days following the Effective Date, only under "Large holder sale program procedures and restrictions" set forth in Exhibit E to the Plan.

We find that for recipients of cash, the adjustment to the allocation of consideration described in (a) above is fair and equitable because it reasonably reflects the different risks assumed by recipients of cash in contrast to those of recipients of Common Stock. We find that for large

holders, the conditions and restrictions referred to in (b) above are fair and equitable because in their absence, such holders might have the unfair advantage of being able to dispose of their Common Stock on favorable terms to the detriment of other holders of Common Stock, and that those conditions and restrictions are not likely to impose an economic disadvantage on them.

Opinion #2

Pursuant to Article VIII of the Plan, no special provisions, such as a closed block, are being created to preserve the dividend expectations of policyholders and members. In our opinion, this is fair and reasonable.

Discussion

Our opinion is based on the following considerations:

1. Anthem Insurance has not paid policyholder dividends regularly enough to create any expectations; in fact, Anthem Insurance and its predecessors have paid no policyholder dividends for more than twenty-five years. In addition, almost all policies are silent as to dividends or even as to participating status vs. nonparticipating status.

2. Because there are no reasonable dividend expectations to preserve, no special provisions are needed in the Plan.

3. Anthem Insurance has no individual life insurance policies or annuity contracts in force, nor has it ever issued any such contracts. Thus, under the Indiana Demutualization Law, a closed block is not required.

Sincerely yours,

/s/ Robert H. Dobson
Robert H. Dobson
Consulting Actuary

/s/ Dale S. Hagstrom
Dale S. Hagstrom
Consulting Actuary

/s/ Daniel J. McCarthy
Daniel J. McCarthy
Consulting Actuary

No dealer, salesperson or other person is authorized to give any information or to represent anything not contained in this prospectus. You must not rely on any unauthorized information or representations. This prospectus is an offer to sell only the shares offered hereby, but only under circumstances and in jurisdictions where it is lawful to do so. The information contained in this prospectus is current only as of its date.

TABLE OF CONTENTS

Through and including November 23, 2001 (the 25th day after the date of this prospectus), all dealers effecting transactions in these securities, whether or not participating in this offering, may be required to deliver a prospectus. This is in addition to a dealer's obligation to deliver a prospectus when acting as an underwriter and with respect to an unsold allotment or subscription.

48,000,000 Shares

Anthem, Inc.

Common Stock

[LOGO]

Goldman, Sachs & Co.
Merrill Lynch & Co.
Morgan Stanley

JPMorgan
Banc of America Securities LLC
Credit Suisse First Boston
Lehman Brothers
UBS Warburg
ABN AMRO Rothschild LLC
Dresdner Kleinwort Wasserstein
A.G. Edwards & Sons, Inc.
McDonald Investments Inc.
Utendahl Capital Partners, L.P.

Representatives of the Underwriters
