Audited Financial Report

FINANCIAL STATEMENTS – STATUTORY BASIS AND SUPPLEMENTAL FINANCIAL INFORMATION

The Health Plan of the Upper Ohio Valley, Inc.
Years Ended December 31, 2011 and 2010
With Report of Independent Auditors

The Health Plan of the Upper Ohio Valley, Inc.

Financial Statements – Statutory Basis
and Supplemental Financial Information

Years Ended December 31, 2011 and 2010

Contents

Audited Financial Report

Report of Independent Auditors

The Board of Directors of
The Health Plan of the Upper Ohio Valley, Inc.
St. Clairsville, Ohio

We have audited the accompanying statutory-basis balance sheets of The Health Plan of the Upper Ohio Valley, Inc. (the Company) as of December 31, 2011 and 2010, and the related statutory-basis statements of revenues, expenses, and changes in surplus, and statements of cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 2 to the financial statements, the Company presents its financial statements in conformity with accounting practices prescribed or permitted by the State of West Virginia Insurance Commission, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles and the effects on the accompanying financial statements are described in Note 2.

Also, in our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company at December 31, 2011 and 2010, and the results of its operations and its cash flows for the years then ended, in conformity with accounting practices prescribed or permitted by the State of West Virginia Insurance Commission.

Audited Financial Report

Our audits were conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual* and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in our audits of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the statutory-basis financial statements as a whole.

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May 30, 2012

The Health Plan of the Upper Ohio Valley, Inc.		
Balance Sheets – Statutory Basis		
	December 31	
	2011	**2010**
Admitted assets		
Cash and invested assets:		
Bonds and mortgage-backed securities	**$ 93,228,334**	$ 93,520,271
Stocks:		
Preferred stock	**99,495**	84,553
Common stock, including mutual funds	**95,400,630**	65,676,757
Investments in subsidiaries	**21,054,147**	16,884,975
Investment in real estate	**5,915,061**	6,199,661
Cash, cash equivalents, and short-term investments	**11,935,577**	35,065,989
Total cash and invested assets	**227,633,244**	217,432,206
Accrued interest receivable	**909,986**	896,603
Premiums receivable	**5,508,820**	5,879,163
Reinsurance receivable	**–**	329,361
Other admitted assets	**1,594,377**	2,303,683

Audited Financial Report

Total admitted assets	**$ 235,646,427**	$ 226,841,016
	December 31	
	2011	**2010**
Liabilities and surplus		
Liabilities:		
Medical costs payable	**$ 41,648,691**	$ 39,807,868
Unpaid claims adjustment expense	**1,313,043**	1,328,540
Premium deficiency reserve	**1,263,061**	949,855
Unearned premium revenue	**3,108,358**	3,570,444
Accounts payable and accrued expenses	**4,853,346**	4,423,419
Amounts retained for others	**202,907**	250,604
Payable to Medicare	**–**	90,536
Amounts held under self-funded plans	**3,534,852**	731,422
Total liabilities	**55,924,258**	51,152,688
Surplus:		
Unrealized gains on equity investments,		
including investment in subsidiaries	**4,739,995**	15,438,401
Contingency reserves	**550,000**	550,000
Unassigned surplus	**174,432,174**	159,699,927
Total surplus	**179,722,169**	175,688,328
Total liabilities and surplus	**$ 235,646,427**	$ 226,841,016
See accompanying notes.		

The Health Plan of the Upper Ohio Valley, Inc.

Statements of Revenues, Expenses, and Changes in Surplus – Statutory Basis

	Year Ended December 31	
	2011	**2010**
Net premium revenue	**$ 383,288,141**	$ 380,517,968
Hospital and medical benefits	**350,382,439**	338,087,560
Net reinsurance recoveries	**(325,436)**	(374,156)
Administrative expenses	**26,023,252**	24,775,990
Total underwriting deductions	**376,080,255**	362,489,394
Net underwriting gain	**7,207,886**	18,028,574
Net investment income earned	**5,740,942**	5,052,891
Net realized capital gains	**3,925,329**	11,251,699
Net investment gains	**9,666,271**	16,304,590
Other income	**5,569,957**	81,957
Net income	**22,444,114**	34,415,121
Other changes in surplus:		
Change in nonadmitted assets, net	**(2,935,655)**	(465,356)

Audited Financial Report

Unrealized loss on investments, net	**(15,474,618)**	(6,363,290)
Total change in surplus	**4,033,841**	27,586,475
Surplus at beginning of year	**175,688,328**	148,101,853
Surplus at end of year	**$ 179,722,169**	$ 175,688,328
See accompanying notes.		

The Health Plan of the Upper Ohio Valley, Inc.

Statements of Cash Flows – Statutory Basis

	Year Ended December 31	
	2011	**2010**
Operating activities		
Premiums and third-party administrative		
income received, net of reinsurance paid	**$ 383,542,211**	$ 381,078,033
Net investment income received	**5,777,863**	4,345,613
Insurance benefits paid, net of		
reinsurance recoveries received	**(347,886,819)**	(338,148,330)
General administrative expenses paid	**(16,472,717)**	(26,110,795)
Net cash provided by operating activities	**24,960,538**	21,164,521
Investment activities		
Proceeds from sales, maturities, or		
repayments of investments:		
Bonds	**356,114,763**	321,824,942
Stocks and limited partnerships	**4,482,524**	60,441,835
Miscellaneous proceeds	**–**	829,709
Total investment proceeds	**360,597,287**	383,096,486
Cost of investments acquired:		
Bonds	**352,261,398**	351,012,551
Stocks and limited partnerships,		
including controlled subsidiaries	**52,754,984**	54,074,404
Real estate	**15,832**	76,218
Miscellaneous applications	**462,585**	600,798
Total investments acquired	**405,494,799**	405,763,971
Net cash used in investment activities	**(44,897,512)**	(22,667,485)
Financing activities		
Other cash (used in) provided by, net	**(3,193,438)**	240,557
Net cash (used in) provided by financing activities	**(3,193,438)**	240,557
Net decrease in cash, cash equivalents,		
and short-term investments	**(23,130,412)**	1,262,407)
Cash, cash equivalents, and short-term investments:		
Beginning of year	**35,065,989**	36,328,396
End of year	**$ 11,935,577**	$ 35,065,989

Audited Financial Report

See accompanying notes.		

1. Organization and Operations

The financial statements include the accounts of The Health Plan of the Upper Ohio Valley, Inc. (The Health Plan). The Health Plan is a nonstock, nonprofit organization organized under Section 501(c)(4) of the Internal Revenue Code and, as such, is exempt from federal and state income taxes and related income.

The Health Plan has been designated by the Department of Health and Human Services (DHHS), the State of West Virginia Insurance Commission, and the Ohio Insurance Department as a state–certified, federally qualified Health Maintenance Organization (HMO), which provides comprehensive health care services on a prepaid basis. HMO operations cover four service areas, which include counties in eastern/northeastern Ohio and north/north-central West Virginia with approximately 81,000 HMO members as of December 31, 2011.

The Health Plan also provides third-party administration of self-insured employer health benefit plans. These services are provided to employers throughout the HMO service area and also in the Commonwealth of Kentucky.

2. Significant Accounting Policies

Basis of Presentation

The Health Plan prepares its statutory-basis financial statements in conformity with accounting practices prescribed or permitted by the State of West Virginia Insurance Commission. The state of West Virginia requires that insurance companies domiciled in the state of West Virginia prepare their statutory-basis financial statements in accordance with the National Association of Insurance Commissioners' (NAIC) *Accounting Practices and Procedures Manual* subject to any deviations prescribed or permitted by the State of West Virginia Insurance Commission.

As of December 31, 2011 and 2010, the more significant variances between statutory accounting practices prescribed or permitted by the State of West Virginia Insurance Commission and accounting principles generally accepted in the United States (GAAP) are as follows:

Cash, cash equivalents, and short-term investments in the statements of cash flows represent cash balances and investments with initial maturities of one year or less. In accordance with GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less.

Audited Financial Report

2. Significant Accounting Policies (continued)

- Investments in bonds are reported at amortized cost or fair value based on their NAIC rating. Equity investments and bonds rated by the NAIC higher than Level 2 are reported at fair value based on values determined by the Securities Valuation Office (SVO) of the NAIC. Unrealized losses on equity investments and bonds with fair values less than cost to the extent determined to be for other than interest reasons are evaluated for other-than-temporary impairment. For GAAP, unrealized holding gains and losses are reported in operations for those investments designated as trading and as a separate component of net assets for those designated as nontrading unless unrealized losses are determined to be other-than-temporarily impaired. Fair value for GAAP is determined in accordance with the Financial Accounting Standards Board Accounting Standards Codification 820.

- All single-class and multiclass mortgage-backed/asset-backed securities (e.g., CMOs) are adjusted for the effects of changes in prepayment assumptions on the related accretion of discount or amortization of premium of such securities using either the retrospective or prospective methods. If it is determined that a decline in fair value is other than temporary, the cost basis of the security is written down to the undiscounted estimated future cash flows. For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets (e.g., CMO, CBO, CDO, CLO, MBS, and ABS securities), other than high-credit-quality securities, are adjusted using the prospective method when there is a change in estimated future cash flows. If it is determined that a decline in fair value is other than temporary, the cost basis of the security is written down to the discounted fair value. If high-credit-quality securities are adjusted, the retrospective method is used.

Certain types of assets classified as “nonadmitted” are excluded from the accompanying balance sheets and are charged directly to unassigned surplus. Nonadmitted assets include office furniture and fixtures and related accumulated depreciation, computer software and related amortization, accounts receivable greater than 90 days, prepaid expenses, assets capitalized under capital leases, non-income-producing investments, pharmacy rebates that do not meet specific criteria, and other assets not specifically identified as an admitted asset within the NAIC’s *Accounting Practices and Procedures Manual.* In accordance with GAAP, such assets are included in the balance sheets to the extent those assets are not impaired.

Audited Financial Report

2. Significant Accounting Policies (continued)

- All leases are considered operating leases under statutory accounting principles, whereas, in accordance with GAAP, leases may be accounted for as either operating or capital depending on the terms of the lease.

- The Health Plan's wholly owned subsidiaries, Hometown Health Plan; Hometown HHP Services, Inc. (HHP Services); HP Agency, Inc.; and THP Insurance Company, are accounted for on the equity basis with equity earnings recorded as a component of unrealized gains (losses) in surplus. In accordance with GAAP, the accounts and operations of these subsidiaries would be consolidated with The Health Plan.

- The accrual for other postretirement benefits excludes the benefit related to nonvested employees. In accordance with GAAP, the accrual for other postretirement benefits includes the benefit for vested and nonvested employees.

Other significant accounting policies are as follows.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Cash, Cash Equivalents, and Short-Term Investments

Cash, cash equivalents, and short-term investments include demand deposits with financial institutions and highly liquid investments with maturities of one year or less. The Health Plan is required to maintain a $3,000,000 compensating balance under a banking agreement.

Investments

Debt investments, which are classified as bonds and consist of government securities and corporate bonds, are recorded at amortized cost or fair value based on their NAIC rating. Premiums and discounts on debt investments are amortized on the effective yield method over the term of the investment.

Common and preferred stock, which includes mutual funds, are recorded at fair value, as determined by the SVO.

Audited Financial Report

2. Significant Accounting Policies (continued)

All mortgage-backed/asset-backed securities are adjusted for the effects of changes in prepayment assumptions on the related accretion of discount or amortization of premium of such securities using either the prospective method. If it is determined that a decline in fair value is other than temporary, the cost basis of the security is written down to the undiscounted estimated future cash flows.

Realized capital gains and losses for all investments are determined on the first-in, first-out cost method. Changes in admitted asset carrying amounts of bonds and common and preferred stocks are credited or charged directly to surplus unless a decline in fair value is determined to be other than temporary. If a decline of fair value is determined to be other than temporary, the cost basis of the security is written down to the fair value and the amount is recorded as a component of net income.

The Health Plan's insurance subsidiary is reported in the accompanying balance sheets at its underlying statutory equity. The Health Plan's investments in noninsurance subsidiaries (Hometown; HHP Services, Inc.; and HP Agency, Inc.), which have no significant ongoing operations and nonaudited insurance subsidiaries, are treated as nonadmitted assets. The net change in the subsidiaries' equity is included in the change in net unrealized gains or losses on investments in the statements of revenues, expenses, and changes in surplus.

Investment in Real Estate

Land and real estate that represents property occupied by The Health Plan and its subsidiaries is reported at depreciated cost. Depreciation is calculated on the straight-line method over the estimated useful lives of the properties ranging from 7 to 45 years.

Investment in real estate consists of the following at December 31:

	2011	2010
Land	**$ 800,000**	$ 800,000
Building and improvements	**7,543,620**	7,582,694
Less accumulated depreciation	**2,428,559**	2,183,033
Net investment in real estate	**$ 5,915,061**	$ 6,199,661

Audited Financial Report

2. Significant Accounting Policies (continued)

Revenue Recognition

Member premiums are recognized as income in the period in which enrollees are entitled to receive health care services. Premiums billed and collected prior to the period of coverage are classified as unearned premiums.

The Health Plan also participates in the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage and Medicare Advantage Part D programs. The Health Plan offers medical or medical and prescription drug benefits under its Medicare Advantage contract to both individuals and employer groups. CMS pays The Health Plan a capitated payment based on beneficiary characteristics as defined by CMS. In addition to the payment from CMS, the member and/or employer also pays a monthly premium. The Health Plan is at risk for the medical expenses for these members.

Certain elements of the payments The Health Plan receives related to the Medicare Advantage Part D program represent payments for The Health Plan's insurance risk coverage under Part D, and are recognized as premium revenues. Other elements of the payments The Health Plan receives, including the catastrophic reinsurance subsidy and low-income member cost-sharing subsidies (collectively, subsidies) represent cost reimbursements for which The Health Plan is fully reimbursed. As such, amounts received for these subsidies are not reflected in premium revenues, but rather are accounted for as deposits. In addition, the payments received from CMS are subject to risk corridor adjustments, whereby variances that exceed certain thresholds from a target amount result in CMS making additional payments to The Health Plan, or require The Health Plan to refund to CMS a portion of the premium received. Each CMS contract and benefit plan is calculated individually, rather than netting the payables and receivables together. As of December 31, 2011 and 2010, The Health Plan has recorded a receivable of $436,000 and $1,055,000 (included in other admitted assets), respectively, for amounts relating to CMS cost-sharing subsidies. In addition, The Health Plan has recorded a receivable of $936,000 and $0 (included in amounts held under self-funded plans), respectively.

In addition to the capitated amount that The Health Plan receives from CMS for the Medicare Advantage program, there may be additional amounts due to The Health Plan based on characteristics of the member such as age, working status, or specific health issues. CMS has implemented a risk adjustment formula, which apportions premiums paid to all Medicare Advantage health plans according to the health status of each beneficiary enrolled. The CMS risk adjustment formula pays more for members with predictably higher costs. Diagnosis data from

Audited Financial Report

2. Significant Accounting Policies (continued)

inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premium payment received by The Health Plan. The Health Plan collects, captures, and submits the necessary diagnosis data to CMS within prescribed deadlines. Management estimates risk adjustment revenues based upon this diagnosis data submitted to and ultimately accepted by CMS. Premiums receivable includes approximately $1,607,000 and $1,847,000 at December 31, 2011 and 2010, respectively, related to the Medicare Advantage risk adjustment. Premium revenues were increased in 2011 by approximately $660,000 for a change in estimate related to the Medicare Advantage risk adjustment for a prior period. The Health Plan's Medicare contract with CMS had a term of one year, which expired December 31, 2011, and was renewed through December 31, 2012.

Medicare and Medicaid premiums represent 42% and 14%, respectively, of member premiums for the year ended December 31, 2011, and 44% and 14%, respectively, for the year ended December 31, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs will change by a material amount in the near term. The Health Plan believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. Compliance with such laws and regulations can be subject to government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

Premium Deficiency Reserves

Premium deficiency reserves are established for the amount of anticipated losses, loss adjustment expenses, commissions and other acquisition costs, and maintenance costs that have not previously been expensed in excess of the recorded unearned premium reserve and future installment premiums on existing policies. The Health Plan does not consider anticipated investment income when calculating its premium deficiency.

Audited Financial Report

2. Significant Accounting Policies (continued)

Medical Costs

The Health Plan provides medical care to its members under contracts with various health care providers on a modified fee-for-service and capitation basis. Medical costs payable includes estimates for claims reported and estimated claims costs for claims incurred but unreported. Such estimates also include the cost of services, which will continue to be rendered after the balance sheet date when The Health Plan is obligated to render such services in accordance with contract provisions or regulatory requirements. Adjustments to prior-period estimates of medical costs are reflected in the current period.

Medical costs payable represent management's best estimate. There is uncertainty as to whether the actual medical costs payable will conform to the assumptions inherent in the determination of the amount. Because of the uncertainties related to the recording of health care costs, the ultimate settlement of the health care cost estimates may vary significantly from the estimated amounts included in the accompanying financial statements.

Pharmacy Rebates

The Health Plan has pharmaceutical rebate contracts with vendors that manufacture and distribute pharmaceutical products to pharmacies and others that are purchased by The Health Plan enrollees. The Health Plan receives a purchase discount in the form of a rebate, which is based on the volume of pharmaceutical products purchased by its enrollees. The estimated rebates are recognized as a reduction in medical costs in the period in which the rebates are incurred and later adjusted, as necessary, when the actual rebates are received. The rebates totaled approximately $7,233,000 and $5,003,000 for the years ended December 31, 2011 and 2010, respectively. The Health Plan received additional rebates of $3,618,000 and $2,888,000 during 2011 and 2010, respectively, relating to a guarantee provision in the contracts. At December 31, 2011 and 2010, The Health Plan had approximately $1,718,000 and $1,592,000, respectively, of receivables related to pharmacy rebates, which have been reported as nonadmitted assets.

Audited Financial Report

2. Significant Accounting Policies (continued)

Reinsurance

The Health Plan purchases reinsurance, which provides coverage for catastrophic inpatient hospital claims. Deductibles range between $350,000 and $400,000, depending on line of business, of allowable expenses subject to a 20% coinsurance for each member for each contract year with a maximum lifetime reinsurance indemnity for each member of $2,000,000. The Health Plan and its subsidiary, THP Insurance Company, share a combined reinsurance risk with the reinsurance carrier through a layered risk arrangement in which the layers of risk are based on a per-member, per-month calculation. The Health Plan is contingently liable for reinsured losses to the extent that the reinsurance company cannot meet its obligations under the reinsurance contract.

Reinsurance expenses of approximately $631,000 and $620,000 in 2011 and 2010, respectively, are included in the statements of revenues, expenses, and changes in surplus as a reduction of member premiums. Reinsurance recoveries of approximately $325,000 and $374,000 for 2011 and 2010, respectively, are included in the statements of revenues, expenses, and changes in surplus as a reduction of hospital and medical benefits expense.

Neither The Health Plan nor any of its affiliates control, directly or indirectly, any direct reinsurers with whom The Health Plan conducts business. No policies issued by The Health Plan have been reinsured with a foreign company, which is controlled, either directly or indirectly, by a party not primarily engaged in the business of insurance. The Health Plan does not have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel the agreement.

Amounts Retained for Others and Amounts Held Under Self-Funded Plans

Amounts retained for others represent payroll taxes payable and voluntary payroll deductions payable. Amounts held under self-funded plans represent cash held for groups to which The Health Plan provides pension administration services and self-insured employer group administrative services.

Audited Financial Report

3. Fair Value Measurements

On December 5, 2009, the NAIC issued Statement of Statutory Accounting Principles No. 100 (SSAP No. 100), *Fair Value Measurements*, which established a framework for measuring fair value and required specific disclosures regarding assets and liabilities that are measured at fair value. This statement was effective December 31, 2011. The Health Plan elected to adopt SSAP No. 100 as of December 31, 2010.

Included in various investment-related line items in the financial statements are certain financial instruments carried at fair value. Other financial instruments are periodically measured at fair value, such as when impaired, or, for certain bonds when carried at the lower of cost or market.

As defined in SSAP No. 100, fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. SSAP No. 100 establishes a three-level hierarchy for valuing assets and liabilities based on how transparent (observable) the inputs are that are used to determine fair value, with the inputs considered most observable categorized as Level 1 and those that are the least observable categorized as Level 3. For some assets, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. When this is the case, the asset is categorized in the table based on the lowest level input that is significant to the fair value measurement in its entirety. The Health Plan's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment, and considers factors specific to the assets being valued.

Hierarchy levels are defined by SSAP No. 100 as follows:

- Level 1: Quoted (unadjusted) market prices in active markets for identical assets and liabilities. For The Health Plan, Level 1 inputs are generally quoted for debt or equity securities actively traded in exchange or over-the-counter markets.

Level 2: Market data obtained from sources independent of the reporting entity (observable inputs). For The Health Plan, Level 2 inputs generally include quoted prices in markets that are not active, quoted prices for similar assets/liabilities, and other observable inputs such as interest rates and yield curves that are generally available at commonly quoted intervals.

Audited Financial Report

3. Fair Value Measurements (continued)

- Level 3: The reporting entity's own assumptions about market participant assumptions developed based on the best information available in the circumstances (unobservable inputs). For The Health Plan, Level 3 inputs are used in situations where little or no Level 1 or 2 inputs are available or are inappropriate given the particular circumstances. Level 3 inputs include results from pricing models and discounted cash flow methodologies as well as adjustments to externally quoted prices that are based on management judgment or estimation.

The following tables present the financial instruments measured at fair value on a recurring basis as of December 31, 2011 and 2010.

At December 31, 2011	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets at fair value				
Preferred stock	**$ –**	**$ 99,495**	**$ –**	**$ 99,495**
Common stock	**95,400,630**	**–**	**–**	**95,400,630**
Total assets at fair value	**$ 95,400,630**	**$ 99,495**	**$ –**	**$ 95,500,125**

At December 31, 2010	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets at fair value				
Preferred stock	$ –	$ 84,553	$ –	$ 84,553
Common stock	65,676,757	–	–	65,676,757
Total assets at fair value	$ 65,676,757	$ 84,553	$ –	$ 65,761,310

Certain financial assets are measured at fair value on a nonrecurring basis, such as certain bonds valued at the lower of cost or fair value, or investments that are impaired during the reporting period and recorded at fair value on the balance sheets.

Audited Financial Report

4. Investments

The following is a summary of investments at December 31, 2011 and 2010, with amortized cost for fixed income securities and actual, historical cost for stock and mutual funds:

	Amortized Cost/Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Carrying Value
At December 31, 2011					
U.S. government and agencies	**$ 7,627,986**	**$ 378,190**	**$ 215**	**$ 7,980,649**	**$ 7,602,674**
Corporate bonds	**50,876,425**	**2,355,144**	**326,708**	**52,720,287**	**50,691,851**
Mortgage-backed securities:					
U.S. government and agencies	**5,494,235**	**461,608**	**–**	**5,955,843**	**5,494,235**
Corporate	**29,967,573**	**1,758,651**	**109,236**	**31,088,989**	**29,439,574**
Preferred and common stock, including mutual funds	**93,180,695**	**5,103,734**	**2,737,173**	**95,500,125**	**95,500,125**
Total investments	**$ 187,146,914**	**$ 10,057,327**	**$ 3,173,332**	**$ 193,245,893**	**$ 188,728,459**

	Amortized Cost/Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Carrying Value
At December 31, 2010					
U.S. government and agencies	$ 12,733,218	$ 135,075	$ 21,760	$ 12,835,884	$ 12,722,569
Corporate bonds	47,384,437	1,893,925	252,655	48,962,628	47,321,358
Mortgage-backed securities:					
U.S. government and agencies	7,236,917	483,612	–	7,689,634	7,206,022
Corporate	26,303,113	1,189,746	288,321	27,171,747	26,270,322
Preferred and common stock, including mutual funds	59,435,634	6,468,843	146,415	65,761,310	65,761,310
Total investments	$ 153,093,319	$ 10,171,201	$ 709,151	$ 162,421,203	$ 159,281,581

Audited Financial Report

4. Investments (continued)

A summary of the book/adjusted carrying value and fair value of The Health Plan's investments in bonds at December 31, 2011, by contractual maturity, is as follows:

	Book/Adjusted Carrying Value	Fair Value
Year of maturity:		
2012	$ 1,175,615	$ 1,179,502
2013–2017	23,175,189	23,633,630
2018–2022	21,515,610	22,388,661
After 2023	12,428,111	13,499,143
Mortgage-backed securities	34,933,809	37,044,832
Total	$ 93,228,334	$ 97,745,768

The expected maturities may differ from the contractual maturities because certain borrowers have the right to call or prepay obligations with or without call or prepayment penalties.

Management regularly reviews the value of The Health Plan's investments. If the value of any investment falls below its cost basis, the decline is analyzed to determine whether it is an other-than-temporary decline in value. To make this determination for each security, management considers how long and by how much the fair value of the security has been below its cost, the financial condition and near-term prospects of the issuer of the security, any downgrades of the security by a rating agency, and management's intent to hold the security long enough for it to recover its value.

Based on that analysis, management makes a judgment as to whether the loss is other-than-temporary. If the loss is other-than-temporary, an impairment charge is recorded within net realized investment gains (losses) in the statements of revenues, expenses, and changes in surplus in the period the determination is made.

Audited Financial Report

4. Investments (continued)

The following table represents the gross unrealized losses that were in existence less than 12 months and more than 12 months at December 31, 2011.

At December 31, 2011	Less Than 12 Months			12 Months or More			Total	
	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
U.S. government and agencies	$ 519,995	$ 215	2	$ –	$ –	–	$ 519,995	$ 215
Corporate bonds	8,413,430	288,726	41	830,037	37,982	3	9,243,467	326,708
Mortgage-related securities:								
Corporate	6,064,011	98,881	47	494,398	10,355	9	6,558,409	109,236
Preferred and common stock, including mutual funds	13,481,349	2,185,274	12	35,032,117	551,899	1	48,513,466	2,737,173
Totals	$ 28,478,785	$ 2,573,096	102	$ 36,356,552	$ 600,236	13	$ 64,835,337	$ 3,173,332

Management recorded approximately $369,000 and $601,000 of unrealized losses as an other-than-temporary decline in value in 2011 and 2010, respectively.

Proceeds from the sales of investments in 2011 and 2010 were approximately $360,597,000 and $382,267,000, respectively. Realized gains and losses (including amounts recorded as other-than-temporary declines) were approximately $5,772,000 and $1,847,000, respectively, for the year ended December 31, 2011, and $13,218,000 and $1,966,000, respectively, for the year ended December 31, 2010.

Audited Financial Report

5. Investments in Subsidiaries

Financial information of THP Insurance Company, which is a wholly owned insurance subsidiary, is summarized as follows:

	Summary of Balance Sheets (Statutory-Basis) December 31			Summary of Statements of Income (Loss) (Statutory-Basis) Year Ended December 31	
	2011	**2010**		**2011**	**2010**
Cash and investments	**$ 30,394,909**	$ 25,233,706	Revenues	**$ 41,502,201**	$ 45,120,638
Other assets	**520,818**	523,800	Expenses	**51,896,508**	48,971,386
Total admitted assets	**$ 30,915,727**	$ 25,757,506	Net loss	**$ (10,394,307)**	$ (3,850,748)
Medical costs payable	**$ 6,254,981**	$ 5,778,681			
Other liabilities	**3,606,597**	3,093,850			
Capital and surplus	**21,054,149**	16,884,975			
Total liabilities and surplus	**$ 30,915,727**	$ 25,757,506			

The Health Plan's investments in wholly owned subsidiaries, HP Agency, Inc.; Hometown Health Plan; and Hometown HHP Services, Inc., do not individually exceed 10% of admitted assets. These investments have been treated as nonadmitted assets.

Included in the change in net unrealized gains for the years ended December 31, 2011 and 2010, are $4,135,639 and $6,986,375, respectively, related to the change in the carrying value of the investment in subsidiaries.

The Health Plan did not recognize any impairment of its investments in subsidiaries, and controlled or affiliated companies during the years ended December 31, 2011 and 2010.

Audited Financial Report

6. Medical Costs Payable

The following table provides a reconciliation of medical costs payable, net of reinsurance receivable for 2011 and 2010:

	Year Ended December 31	
	2011	**2010**
Medical costs payable, net of reinsurance receivable, at beginning of year	**$ 39,478,507**	$ 39,913,433
Add provision for medical costs, net of reinsurance recoveries, occurring in:		
Current year	**350,906,780**	337,184,829
Prior years	**(849,777)**	528,575
Net incurred medical costs during the current year	**350,057,003**	337,713,404
Deduct payments for medical costs occurring in:		
Current year	**309,364,074**	297,881,874
Prior years	**38,522,745**	40,266,456
Net medical cost payments during the current year	**347,886,819**	338,148,330
Medical costs payable, net of reinsurance receivable, at end of year	**$ 41,648,691**	$ 39,478,507

The redundancy in the 2010 reserves of $849,777 occurred primarily from lower than expected utilization of medical services and is included as a decrease in net incurred medical costs for the year ended December 31, 2011. The shortfall in the reserves for 2009 resulted from higher than expected claims utilization of medical services and is included as an increase in net incurred medical costs for the year ended December 31, 2010.

7. Capital and Surplus

The Health Plan is subject to certain risk-based capital (RBC) requirements as specified by the NAIC. Under those requirements, the amount of surplus maintained by a health insurance company is to be determined based on the various factors related to underwriting, investments, and other risk factors. At December 31, 2011 and 2010, The Health Plan meets the RBC requirements.

Audited Financial Report

8. Pension Plan

All full-time Health Plan employees participate in a noncontributory defined contribution pension plan. The full-time employees of The Health Plan's subsidiaries are also participants in this plan. The Health Plan contributes 10% of salaries and wages for each employee who meets the eligibility requirements. Total plan contribution expense for the years ended December 31, 2011 and 2010, was approximately $1,479,000 and $1,510,000, respectively.

9. Other Postretirement Benefits

The Health Plan provides postretirement medical and life insurance benefits for all full-time employees. The Health Plan provides retirees with single coverage at no cost for the first 12 months of retirement. In subsequent years, the cost is shared by the retiree and The Health Plan based upon years of service with The Health Plan. Prior to January 1, 2006, the medical benefits were provided over the life of the retiree. The life insurance plan provides coverage of $5,000 and is provided by The Health Plan at no cost for ten years after retirement.

The accumulated benefit obligation for other postretirement benefits represents the present value of benefits earned as of December 31 based on service through December 31 of the respective year-end. The Health Plan's actuarially computed accumulated benefit obligation, which is the same as the projected benefit obligation, with respect to vested and nonvested employees of these postretirement benefits, none of which have been funded, is as follows:

	December 31	
	2011	**2010**
Retirees and dependents	**$ 99,144**	$ 42,421
Active plan participants:		
Fully eligible	**692,646**	532,485
Accrued postretirement benefit liability, included in accounts payable and accrued expenses	**791,790**	574,906
Nonvested employees	**1,691,841**	1,253,373
Accumulated postretirement benefit obligation	**$ 2,483,631**	$ 1,828,279

The projected benefit obligation for other postretirement benefits represents the present value of postretirement benefits deemed earned as of December 31, projected for estimated medical cost rate increases as of an assumed date with respect to retirement, termination, disability, or death.

Audited Financial Report

9. Other Postretirement Benefits (continued)

Net postretirement benefit cost includes the following components:

	Year Ended December 31	
	2011	**2010**
Service cost	**$ 130,886**	$ 130,799
Interest cost	**108,359**	97,296
Amortization of unrecognized actuarial gains (losses), net	**442,840**	(22,279)
Net postretirement benefit cost, included in administrative expenses	**$ 682,085**	$ 205,816

As of December 31, 2011, the accumulated postretirement benefit obligation was determined using an assumed health care cost trend rate of 8.0%, which is assumed to decrease uniformly to 5.0% over the next seven years. Increasing the assumed health care cost trend rates by one percentage point in each year would have resulted in an increase in the accumulated postretirement benefit obligation of approximately $41,000 and $27,000 as of December 31, 2011 and 2010, respectively, and an increase of approximately $31,000 and $30,000 in the aggregate of the service cost and interest cost components of net periodic postretirement benefit cost for the years ended December 31, 2011 and 2010, respectively. A weighted-average discount rate of 4.9% and 6% for the years ended December 31, 2011 and 2010, was used to determine the accumulated postretirement benefit obligation.

10. Reserve Requirements and Deposits

The DHHS, the State of West Virginia Insurance Commission, the Ohio Insurance Department, and the Commonwealth of Kentucky Insurance Department have various reserve requirements related to HMOs. A contingency reserve designation of surplus of $550,000 has been recorded in accordance with these reserve requirements at December 31, 2011 and 2010, and a deposit of the same amount has been set aside and is included in bonds in the investment portfolio.

Audited Financial Report

11. Contracts

The Health Plan has contracted with the Upper Ohio Valley Individual Practice Association, Inc. (IPA) to provide a significant portion of health care services to members. The Health Plan pays the IPA for health care services based on a fee schedule. Total medical costs of approximately $34,658,000 and $35,424,000 were paid for the years ended December 31, 2011 and 2010, respectively, to the IPA.

The Health Plan has an administrative service agreement with THP Insurance Company whereby The Health Plan provides certain management and administration services to THP Insurance Company. Expenses incurred and allocated to THP Insurance Company relating to this agreement amounted to $4,147,000 and $4,331,000 for the years ended December 31, 2011 and 2010, respectively.

On August 1, 2011, The Health Plan of the Upper Ohio Valley made a $5,000,000 capital contribution to THP to ensure there would not be a financial violation of the operating loss being greater than 50% of the remaining surplus. On December 22, 2011, The Health Plan of the Upper Ohio Valley made an additional $10,000,000 capital contribution to THP to ensure there would not be a financial violation of the December 31, 2011, operating loss being greater than 50% of the remaining surplus.

12. Leases

The Health Plan leases certain office equipment and vehicles. Future minimum payments, by year and in the aggregate of noncancelable operating leases with initial or remaining terms of one year or more consisted of the following at December 31, 2011:

2012	$ 586,939
2013	581,262
2014	525,549
2015	112,998
2016	6,553
After 2016	13,106
Total minimum lease payments	$ 1,826,407

Rent expense, which includes software license fees, approximated $1,350,000 and $1,247,000 for 2011 and 2010, respectively, and is included in administrative expenses in the statements of revenues, expenses, and changes in surplus.

Audited Financial Report

13. Contingencies

The Health Plan is involved in litigation arising in the normal course of business. Certain litigation is in the preliminary stages, and legal counsel is unable to estimate the potential effect, if any, upon operations or financial condition of The Health Plan. Management believes that these matters will be resolved without material adverse effect on The Health Plan's financial position, results of operations, or cash flows. However, the ultimate outcome and effect on The Health Plan's financial statements is unknown. During the year ended December 31, 2011, certain litigation was settled that resulted in approximately $5,600,000 of favorable settlements which is included in other income.

14. Administrative Expenses

The Health Plan performs administrative services for its affiliates in which the amounts to be paid are based on periodic studies. Administrative expenses for The Health Plan include $6,354,000 and $6,254,000 of claims adjustment expenses, $18,972,000 and $17,786,000 of general administrative expenses, and $697,000 and $736,000 of investment expenses for the years ended December 31, 2011 and 2010, respectively.

15. Administrative Service Only Plans

The Health Plan realized a gain from operations from Administrative Services Only (ASO) uninsured plans for the years ended December 31, 2011 and 2010. Amounts related to ASO operations, which are included in administrative expenses, are summarized as follows:

	December 31	
	2011	**2010**
Net reimbursement for administrative expenses, including administrative fees, in excess of actual expenses	**$ 1,371,418**	$ 1,427,107
Total net other income or expenses (including interest paid to or received from plans)	**546**	365
Net gain from ASO operations	**$ 1,371,964**	$ 1,427,472
Claim payment volume	**$ 31,619,391**	$ 34,706,042

16. Subsequent Event

Management of The Health Plan evaluated events and transactions occurring subsequent to December 31, 2011 through May 30, 2012. No subsequent events requiring disclosure in the financial statements were identified.

Audited Financial Report

Supplemental Financial Information

Audited Financial Report

The Health Plan of the Upper Ohio Valley, Inc.

Supplemental Investment Risk Interrogatories – Statutory Basis

December 31, 2011

1. The Health Plan's total admitted assets as reported on page three of its Annual Statement is $235,646,427.

2. Following are The Health Plan's ten largest exposures to a single issuer/borrower/investment, by investment category, excluding: (i) U.S. government, U.S. government agency securities, and those U.S. government money market funds listed in the Appendix to the *SVO Practices and Procedures Manual* as exempt, (ii) property occupied by The Health Plan, and (iii) policy loans:

Investment Category	Amount	Percentage of Total Admitted Assets
Pimco Short Term Fund	$ 35,032,116	14.9%
JP Morgan Chase MM Mutual Fund	24,515,223	10.4
Investment in THP Insurance Company	21,054,147	8.9
Dodge & Cox Intl Stock Fund	11,928,696	5.1
Vanguard 500 Index Fund	11,305,426	4.8
Fannie Mae	1,137,900	0.5
Fannie Mae	1,124,863	0.5
Fannie Mae	1,086,747	0.5
Energy Transfer Participant Notes	856,757	0.4
Fannie Mae	831,432	0.4

Audited Financial Report

3. The Health Plan's total admitted assets held in bonds and preferred stocks, by NAIC rating, are:

Bonds			Preferred Stocks		
NAIC Rating	Amount	Percentage of Total Admitted Assets	NAIC Rating	Amount	Percentage of Total Admitted Assets
NAIC-1	$ 54,244,786	23.02%	P/RP-1	$ 99,495	0.4%
NAIC-2	28,987,068	12.30%	P/RP-2	–	0.0%
NAIC-3	7,640,133	3.24%	P/RP-3	–	0.0%
NAIC-4	1,920,132	0.81%	P/RP-4	–	0.0%
NAIC-5	427,117	0.18%	P/RP-5	–	0.0%
NAIC-6	9,098	0.00%	P/RP-6	–	0.0%
	$ 93,228,334			$ 99,495	

4. The Health Plan's total admitted assets held in foreign investments are $7,567,618, which is 3.21% of the Health Plan's total admitted assets.

5. Following are The Health Plan's aggregate three largest foreign investment exposures categorized by NAIC sovereign rating:

Investment Category	Amount	Percentage of Total Admitted Assets
Countries rated NAIC-1	$ 7,106,070	3.02%
Countries rated NAIC-2	461,548	0.20
Countries rated NAIC-3 or below	–	–

6. Following are The Health Plan's largest foreign exposures by country, categorized by the country's NAIC sovereign rating:

Investment Category	Amount	Percentage of Total Admitted Assets
Countries rated NAIC-1:		
Canada	$ 1,585,609	0.67%
United Kingdom	1,247,794	0.53
Countries rated NAIC-2:		
Panama	168,470	0.07
Ireland	147,068	0.06
Countries rated NAIC-3 or below	–	–

Interrogatories 7 through 9 are not applicable to The Health Plan, as the Company does not have any unhedged foreign currency exposure.

Audited Financial Report

10. Following are The Health Plan's ten largest nonsovereign foreign issues:

Issuer	NAIC Rating	Amount	Percentage of Net Admitted Assets
Transalta Corp Notes (Canada)	2FE	$ 548,221	0.2%
Transalta Corp Notes (Canada)	2FE	527,770	0.2
Tyco Electronics Group Notes (Luxembourg)	2FE	467,787	0.2
United Business Media Notes (United Kingdom)	2FE	299,276	0.1
Ipic Limited Notes (United Arab Emirates)	1FE	294,242	0.1
Validus Holdings Notes (Bermuda)	2FE	264,608	0.1
HSBC Holdings Notes (United Kingdom)	1FE	249,458	0.1
Smart Trust Mtg 2011-2 CL A4A (Australia)	1FE	234,962	0.1
Virgin Media Sec. Fin. Notes (United Kingdom)	2FE	232,775	0.1
Rio Tinto Fin USA Notes (Australia)	1FE	209,462	0.1

11. Assets held in Canadian investments are less than 2.5% of The Health Plan's total assets.

12. Assets held in investments with contractual sales restrictions are less than 2.5% of The Health Plan's total admitted assets.

Audited Financial Report

13. The Health Plan's admitted assets held in the largest ten equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in the Appendix to the *SVO Practices and Procedures Manual* as exempt or Class 1) are:

Issuer	Amount	Percentage of Total Admitted Assets
Pimco Short Term Fund	$ 35,032,116	14.9%
JP Morgan Chase MM Mutual Fund	24,515,223	10.4
Investment in THP Insurance Company	21,054,147	8.9
Dodge & Cox Intl Stock Fund	11,928,696	5.1
Vanguard 500 Index Fund	11,305,426	4.8
Align Technology Inc.	598,463	0.3
Lifetime Fitness Inc.	521,263	0.2
Dealertrack Holdings Inc.	507,036	0.2
Corporate Executive Board Co.	499,110	0.2
Panera Bread Co.	456,176	0.2

14. Assets held in nonaffiliated, privately placed equities are less than 2.5% of The Health Plan's total admitted assets.

15. Assets held in general partnership interests are less than 2.5% of The Health Plan's total admitted assets.

Interrogatories 16 and 17 are not applicable to The Health Plan since mortgage loans reported in Schedule B are less than 2.5% of The Health Plan's total admitted assets.

18. The Health Plan does not own investments in one parcel or group of contiguous parcels of real estate reported in Schedule A, excluding property occupied by The Health Plan.

19. Investments held in mezzanine real estate loans are less than 2.5% of The Health Plan's total admitted assets.

20. The Health Plan's total admitted assets are not subject to securities lending, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements, or dollar reverse repurchase agreements.

21. The Health Plan did not own any warrants not attached to other financial instruments, options, caps, and floors at December 31, 2011.

22. The Health Plan's total admitted assets are not subject to potential exposure for collars, swaps, and forwards.

23. The Health Plan's total admitted assets are not subject to potential exposure for futures contracts.

Audited Financial Report

The Health Plan of the Upper Ohio Valley, Inc.

Supplemental Investment Schedule – Statutory Basis

December 31, 2011

Investment Categories	Gross Investment Holdings*	Admitted Assets as Reported in the Annual Statement
Bonds:		
U.S. Treasury securities	$ 7,602,674	$ 7,602,674
U.S. agency securities	–	–
Mortgage-backed securities (includes residential and commercial):		
Issued by FNMA and FHLMC	–	–
CMOs and REMICs:		
Issued or guaranteed by GNMA, FNMA, and FHLMC	19,424,103	19,424,103
All other privately issued	15,509,706	15,509,706
Other debt and fixed income securities	50,691,851	50,691,851
Unaffiliated foreign securities	–	–
Equity interest:		
Investments in mutual funds	82,781,461	82,781,461
Preferred stock	99,495	99,495
Publicly traded equity securities (excluding preferred stocks) – unaffiliated	12,619,169	12,619,169
Other equity securities – affiliated	23,376,745	21,054,147
Real estate	5,915,061	5,915,061
Cash and short-term investments	11,935,577	11,935,577
Total invested assets	$ 229,955,842	$ 227,633,244

*Gross Investment Holdings as valued in compliance with the NAIC's *Accounting Practices and Procedures Manual*.

The Health Plan of the Upper Ohio Valley, Inc.

Note to Supplemental Financial Information

December 31, 2011

Note – Basis of Presentation

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2011, and for the year then ended, for purposes of complying with paragraph 9 of the Annual Audited Report section of the National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual* and agree to or are included in the amounts reported in The Health Plan of the Upper Ohio Valley, Inc.'s 2011 Statutory Annual Statement as filed with the State of West Virginia Insurance Commission.