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

# FORM 10-Q

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

**For the quarterly period ended September 30, 2005**

**OR**

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

**For the transition period from _____ to _____**

**Commission file number 1-5975**

# HUMANA INC.

**(Exact name of registrant as specified in its charter)**

| **Delaware** | **61-0647538** |
|---|---|
| **(State or other jurisdiction of incorporation or organization)** | **(I.R.S. Employer Identification Number)** |

**500 West Main Street**
**Louisville, Kentucky 40202**
**(Address of principal executive offices, including zip code)**

**(502) 580-1000**
**(Registrant's telephone number, including area code)**

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

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes ☒ No ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

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

| **Class of Common Stock** | **Outstanding at October 31, 2005** |
|---|---|
| **$0.16 2/3 par value** | **162,788,934 shares** |

**Humana Inc.**
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**Humana Inc.**
**CONDENSED CONSOLIDATED BALANCE SHEETS**
**(Unaudited)**

| | September 30, 2005 | December 31, 2004 |
|---|---|---|
| | (in thousands, except share amounts) | |
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 978,936 | $ 580,079 |
| Investment securities | 2,228,424 | 2,145,645 |
| Receivables, less allowance for doubtful accounts of $33,481 in 2005 and $34,506 in 2004: | | |
| Premiums | 695,344 | 554,661 |
| Administrative services fees | 15,796 | 24,954 |
| Securities lending collateral | 117,553 | 77,840 |
| Other | 247,083 | 212,958 |
| Total current assets | 4,283,136 | 3,596,137 |
| Property and equipment, net | 457,078 | 399,506 |
| Other assets: | | |
| Long-term investment securities | 365,634 | 348,465 |
| Goodwill | 1,220,461 | 885,572 |
| Other | 506,112 | 427,937 |
| Total other assets | 2,092,207 | 1,661,974 |
| Total assets | $ 6,832,421 | $ 5,657,617 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Current liabilities: | | |
| Medical and other expenses payable | $ 1,817,226 | $ 1,422,010 |
| Trade accounts payable and accrued expenses | 509,438 | 488,332 |
| Book overdraft | 258,433 | 192,060 |
| Securities lending payable | 117,553 | 77,840 |
| Unearned revenues | 533,908 | 146,326 |
| Current portion of long-term debt | 302,366 | — |
| Total current liabilities | 3,538,924 | 2,326,568 |
| Long-term debt | 317,210 | 636,696 |
| Other long-term liabilities | 610,317 | 604,229 |
| Total liabilities | 4,466,451 | 3,567,493 |
| Commitments and contingencies | | |
| Stockholders' equity: | | |
| Preferred stock, $1 par; 10,000,000 shares authorized; none issued | — | — |
| Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 178,608,482 shares issued at September 30, 2005 and 176,044,649 shares issued at December 31, 2004 | 29,768 | 29,340 |
| Capital in excess of par value | 1,083,631 | 1,017,156 |
| Retained earnings | 1,473,699 | 1,229,823 |
| Accumulated other comprehensive (loss) income | (3,504) | 16,526 |
| Unearned stock compensation | (14,553) | (1,721) |
| Treasury stock, at cost, 15,840,173 shares at September 30, 2005 and 15,778,088 shares at December 31, 2004 | (203,071) | (201,000) |
| Total stockholders' equity | 2,365,970 | 2,090,124 |
| Total liabilities and stockholders' equity | $ 6,832,421 | $ 5,657,617 |

See accompanying notes to condensed consolidated financial statements.

**Humana Inc.**
**CONDENSED CONSOLIDATED STATEMENTS OF INCOME**
**(Unaudited)**

| | Three months ended September 30, | | Nine months ended September 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| | (in thousands, except per share results) | | | |
| Revenues: | | | | |
| Premiums | $3,712,364 | $3,083,554 | $10,449,198 | $9,566,447 |
| Administrative services fees | 63,817 | 59,837 | 190,454 | 219,420 |
| Investment and other income | 45,280 | 32,882 | 115,395 | 108,833 |
| Total revenues | 3,821,461 | 3,176,273 | 10,755,047 | 9,894,700 |
| Operating expenses: | | | | |
| Medical | 3,094,397 | 2,550,911 | 8,736,639 | 8,024,167 |
| Selling, general and administrative | 611,300 | 460,171 | 1,571,793 | 1,416,695 |
| Depreciation and amortization | 34,119 | 31,238 | 95,131 | 84,715 |
| Total operating expenses | 3,739,816 | 3,042,320 | 10,403,563 | 9,525,577 |
| Income from operations | 81,645 | 133,953 | 351,484 | 369,123 |
| Interest expense | 10,141 | 6,480 | 28,986 | 16,524 |
| Income before income taxes | 71,504 | 127,473 | 322,498 | 352,599 |
| Provision for income taxes | 21,560 | 43,170 | 78,622 | 119,713 |
| Net income | $ 49,944 | $ 84,303 | $ 243,876 | $ 232,886 |
| Basic earnings per common share | $ 0.31 | $ 0.53 | $ 1.51 | $ 1.45 |
| Diluted earnings per common share | $ 0.30 | $ 0.52 | $ 1.48 | $ 1.43 |

See accompanying notes to condensed consolidated financial statements.

**Humana Inc.**
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**
**(Unaudited)**

| | For the nine months ended September 30, | |
|---|---|---|
| | 2005 | 2004 |
| | (in thousands) | |
| **Cash flows from operating activities** | | |
| Net income | $ 243,876 | $ 232,886 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | |
| Depreciation and amortization | 95,131 | 84,715 |
| (Benefit) provision for deferred income taxes | (29,062) | 27,545 |
| Changes in operating assets and liabilities, net of effect of businesses acquired: | | |
| Receivables | (129,236) | 106,709 |
| Other assets | (31,287) | (18,776) |
| Medical and other expenses payable | 357,841 | 92,916 |
| Other liabilities | (4,162) | 26,675 |
| Unearned revenues | 367,809 | (204,426) |
| Other, net | 1,214 | (19,920) |
| Net cash provided by operating activities | 872,124 | 328,324 |
| **Cash flows from investing activities** | | |
| Acquisitions, net of cash acquired | (352,816) | (115,972) |
| Purchases of property and equipment | (112,318) | (72,900) |
| Proceeds from sales of property and equipment | 2,648 | 28,972 |
| Purchases of investment securities | (1,694,123) | (3,614,781) |
| Maturities of investment securities | 596,276 | 840,275 |
| Proceeds from sales of investment securities | 992,420 | 2,203,853 |
| Change in securities lending collateral | (39,713) | 4,149 |
| Net cash used in investing activities | (607,626) | (726,404) |
| **Cash flows from financing activities** | | |
| Borrowings under credit agreement | 294,000 | — |
| Repayments under credit agreement | (294,000) | — |
| Change in securities lending payable | 39,713 | (4,149) |
| Common stock repurchases | (2,071) | (64,472) |
| Change in book overdraft | 66,373 | (102,948) |
| Proceeds from stock option exercises and other | 30,344 | 13,335 |
| Net cash provided by (used in) financing activities | 134,359 | (158,234) |
| Increase (decrease) in cash and cash equivalents | 398,857 | (556,314) |
| Cash and cash equivalents at beginning of period | 580,079 | 931,404 |
| Cash and cash equivalents at end of period | $ 978,936 | $ 375,090 |
| **Supplemental cash flow disclosures:** | | |
| Interest payments | $ 33,903 | $ 22,663 |
| Income tax payments, net | $ 125,574 | $ 44,922 |

See accompanying notes to condensed consolidated financial statements.

**Humana Inc.**
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**
**Unaudited**

**(1) Basis of Presentation**

The accompanying condensed consolidated financial statements are presented in accordance with generally accepted accounting principles for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the disclosures normally required by accounting principles generally accepted in the United States of America, or those normally made in an Annual Report on Form 10-K. For further information, the reader of this Form 10-Q should refer to our Form 10-K for the year ended December 31, 2004, that was filed with the Securities and Exchange Commission, or the SEC, on March 2, 2005. References throughout this document to "we," "us," "our," the "Company," and "Humana," mean Humana Inc. and all entities we own.

The preparation of our condensed consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires us to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of medical expenses payable, the recognition of revenue, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. Although our estimates are based on knowledge of current events and anticipated future events, actual results may ultimately differ materially from those estimates. Refer to "Critical Accounting Policies and Estimates" in Humana's 2004 Annual Report on Form 10-K for information on accounting policies that the Company considers critical in preparing its consolidated financial statements.

The financial information has been prepared in accordance with our customary accounting practices and has not been audited. In our opinion, the information presented reflects all adjustments necessary for a fair statement of interim results. All such adjustments are of a normal and recurring nature.

**(2) Significant Accounting Policies**

*Stock-Based Compensation*

We have stock-based employee compensation plans, which are described more fully in Note 11 to the consolidated financial statements in Humana's 2004 Annual Report on Form 10-K. We account for stock options granted to our employees under Accounting Principles Board Opinion No. 25, *Accounting for Stock Issued to Employees* and related interpretations, or APB No. 25. No employee compensation cost is reflected in net income related to fixed-based stock option awards because these options had an exercise price equal to the market value of the underlying common stock on the date of grant. Generally, if a fixed-based stock option award is subsequently modified, compensation expense, if any, is recorded for the amount that the market price of Humana common stock exceeds the option's exercise price on the date the option is modified. Compensation expense for performance-based stock options is recognized over the performance period varying based on the market value of the underlying common stock at the end of each period. Compensation expense is recorded for restricted stock grants over their vesting periods based on fair value, which is equal to the market price of Humana common stock on the date of the grant.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

The effect on net income and earnings per common share if we had applied the fair value recognition provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation*, to our fixed-based stock option awards using the Black-Scholes pricing model was as follows for the three and nine months ended September 30, 2005 and 2004.

| | Three months ended September 30, | | Nine months ended September 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| | (in thousands, except per share results) | | | |
| Net income, as reported | $49,944 | $84,303 | $243,876 | $232,886 |
| Add: Stock-based employee compensation expense included in reported net income, net of related tax | 2,082 | 591 | 5,081 | 1,463 |
| Deduct: Total stock-based employee compensation expense determined under fair value based method for all awards, net of related tax | (5,219) | (3,216) | (14,000) | (9,334) |
| Adjusted net income | $46,807 | $81,678 | $234,957 | $225,015 |
| Earnings per common share: | | | | |
| Basic, as reported | $ 0.31 | $ 0.53 | $ 1.51 | $ 1.45 |
| Basic, pro forma | $ 0.29 | $ 0.51 | $ 1.45 | $ 1.40 |
| Diluted, as reported | $ 0.30 | $ 0.52 | $ 1.48 | $ 1.43 |
| Diluted, pro forma | $ 0.28 | $ 0.51 | $ 1.42 | $ 1.38 |

*Recently Issued Accounting Pronouncements*

In December 2004, the FASB issued Statement No. 123R, *Share-Based Payment*, or Statement 123R, which requires companies to expense the fair value of employee stock options and other forms of stock-based compensation. This requirement represents a significant change because fixed-based stock option awards, a predominate form of stock compensation for us, were not recognized as compensation expense under APB 25. Statement 123R requires that the cost of the award, as determined on the date of grant at fair value, be recognized over the period during which an employee is required to provide service in exchange for the award (usually the vesting period). The grant-date fair value of the award will be estimated using option-pricing models. We are required to adopt Statement 123R beginning January 1, 2006 under either a prospective or retrospective transition method. The effect of expensing stock options under a fair value approach using the Black-Scholes pricing model for the three and nine months ended September 30, 2005 and 2004 is disclosed above. We currently are evaluating the provisions of Statement 123R and the expected effect on us including, among other items, selecting an option pricing model. We anticipate using the retrospective transition model which we estimate would lower 2005 results by approximately $0.08 per diluted common share. We believe the impact of adopting Statement 123R would lower 2006 results approximately $0.10 per diluted common share, assuming a similar number and pattern of granting stock option awards as the current year, the use of the Black-Scholes pricing model with expected life and volatility assumptions similar to the current year, a stock price reflective of our current environment and a forfeiture rate as preliminarily calculated.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

**(3) Acquisitions**

On February 16, 2005, we acquired CarePlus Health Plans of Florida, or CarePlus, as well as its affiliated 10 medical centers and pharmacy company. CarePlus provides Medicare Advantage HMO plans and benefits to Medicare eligible members in Miami-Dade, Broward and Palm Beach counties. This acquisition enhances our Medicare market position in South Florida. We paid approximately $444.9 million in cash including transaction costs. We financed the transaction with $294.0 million of borrowings under our credit agreement and $150.9 million of cash on hand. The purchase price is subject to a balance sheet settlement process with a nine month claims run-out period. The fair value of the acquired tangible assets (liabilities) consisted of the following:

| | (in thousands) |
|---|---|
| Cash and cash equivalents | $ 92,116 |
| Premiums receivable and other current assets | 6,510 |
| Property and equipment and other assets | 21,315 |
| Medical and other expenses payable | (37,375) |
| Other current liabilities | (23,986) |
| Other liabilities | (3,995) |
| Net tangible assets acquired | $ 54,585 |

The purchase price exceeded the estimated fair value of the net tangible assets acquired by approximately $390.3 million. We allocated the excess purchase price over the fair value of the net tangible assets acquired to other intangible assets of $88.9 million and associated deferred tax liabilities of $33.5 million, and goodwill of $334.9 million. The other intangible assets, which consist primarily of subscriber contracts, have a weighted-average useful life of approximately 10 years. Approximately $46.9 million of the acquired goodwill is deductible for income tax purposes. We used an independent third party valuation specialist firm to assist us in evaluating the fair value of assets acquired.

On April 1, 2004, we acquired Ochsner Health Plan, or Ochsner, from the Ochsner Clinic Foundation for $157.1 million in cash.

The results of operations and financial condition of CarePlus and Ochsner have been included in our condensed consolidated statements of income and condensed consolidated balance sheets since the acquisition date. The pro forma financial information presented below assumes that the acquisitions of CarePlus and Ochsner had occurred as of the beginning of each respective period. The pro forma adjustments include the pro forma effect of amortization of other intangible assets arising from the purchase price allocation and interest expense related to the assumed financing of the cash purchase price and the associated income tax effects of the pro forma adjustments. The pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the CarePlus and Ochsner acquisitions been consummated at the beginning of the respective periods.

| | For the three months ended September 30, | | For the nine months ended September 30, | |
|---|---|---|---|---|
| | 2005 | 2004 (1) | 2005 (2) | 2004 (3) |
| | (in thousands, except per share results) | | | |
| Revenues | $3,821,461 | $3,299,049 | $10,827,598 | $ 10,441,797 |
| Net income | $ 49,944 | $ 89,974 | $ 247,187 | $ 251,487 |
| Earnings per common share: | | | | |
| Basic | $ 0.31 | $ 0.56 | $ 1.53 | $ 1.56 |
| Diluted | $ 0.30 | $ 0.56 | $ 1.50 | $ 1.55 |

(1) This period includes the pro forma impact of CarePlus only for three months.
(2) This period includes the pro forma impact of CarePlus only for approximately 1.5 months.
(3) This period includes the pro forma impact of CarePlus for nine months and Ochsner for three months.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

**(4) Goodwill and Other Intangible Assets**

Changes in the carrying amount of goodwill, by operating segment, for the nine months ended September 30, 2005 were as follows:

| | Commercial | Government | Total |
|---|---|---|---|
| | | (in thousands) | |
| Balance at December 31, 2004 | $698,430 | $187,142 | $ 885,572 |
| CarePlus acquisition | — | 334,889 | 334,889 |
| Balance at September 30, 2005 | $698,430 | $522,031 | $1,220,461 |

The following table presents details of our other intangible assets included in other long-term assets in the accompanying condensed consolidated balance sheets at September 30, 2005 and December 31, 2004:

| | | September 30, 2005 | | | December 31, 2004 | | |
|---|---|---|---|---|---|---|---|
| | Weighted Average Life at 9/30/05 | Cost | Accumulated Amortization | Net | Cost | Accumulated Amortization | Net |
| | | | | (in thousands) | | | |
| Other intangible assets: | | | | | | | |
| Subscriber contracts | 9.8 yrs | $181,256 | $ 98,357 | $ 82,899 | $ 97,256 | $ 82,343 | $14,913 |
| Provider contracts | 9.6 yrs | 22,428 | 13,158 | 9,270 | 22,428 | 11,022 | 11,406 |
| Licenses and other | 18.3 yrs | 10,690 | 2,485 | 8,205 | 5,790 | 1,787 | 4,003 |
| Total other intangible assets | 10.1 yrs | $214,374 | $ 114,000 | $100,374 | $125,474 | $ 95,152 | $30,322 |

Amortization expense for other intangible assets was approximately $18.8 million for the nine months ended September 30, 2005 and $8.1 million for the nine months ended September 30, 2004. The following table presents our estimate of amortization expense for the remaining three months of 2005, and for each of the five next succeeding fiscal years:

| | (in thousands) |
|---|---|
| For the three month period ending December 31, 2005 | $ 4,959 |
| For the years ending December 31,: | |
| 2006 | $ 17,290 |
| 2007 | $ 14,074 |
| 2008 | $ 11,474 |
| 2009 | $ 7,652 |
| 2010 | $ 7,155 |

**(5) Comprehensive Income**

The following table presents details supporting the computation of comprehensive income for the three and nine months ended September 30, 2005 and 2004:

| | Three months ended September 30, | | Nine months ended September 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| | | | (in thousands) | |
| Net income | $ 49,944 | $ 84,303 | $243,876 | $232,886 |
| Net unrealized investment (losses) gains, net of tax | (16,619) | 30,553 | (20,030) | (3,112) |
| Comprehensive income, net of tax | $ 33,325 | $114,856 | $223,846 | $229,774 |

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

**(6) Earnings Per Common Share**

We compute basic earnings per common share on the basis of the weighted average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and unvested restricted shares using the treasury stock method. There were no adjustments required to be made to net income for purposes of computing basic or diluted earnings per common share.

The following table presents details supporting the computation of basic and diluted earnings per common share for the three and nine months ended September 30, 2005 and 2004:

| | Three months ended September 30, | | Nine months ended September 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| | (in thousands, except per share results) | | | |
| Net income available for common stockholders | $ 49,944 | $ 84,303 | $243,876 | $232,886 |
| Weighted average outstanding shares of common stock used to compute basic earnings per common share | 162,048 | 159,308 | 161,484 | 160,697 |
| Dilutive effect of: | | | | |
| Employee stock options | 3,852 | 1,662 | 3,487 | 1,824 |
| Restricted stock | 137 | 27 | 70 | 43 |
| Shares used to compute diluted earnings per common share | 166,037 | 160,997 | 165,041 | 162,564 |
| Basic earnings per common share | $ 0.31 | $ 0.53 | $ 1.51 | $ 1.45 |
| Diluted earnings per common share | $ 0.30 | $ 0.52 | $ 1.48 | $ 1.43 |
| Number of antidilutive stock options excluded from computation | 35 | 4,105 | 12 | 2,833 |

**(7) Income Taxes**

The effective income tax rate was 30.2% for the three months ended September 30, 2005 and 24.4% for the nine months ended September 30, 2005 compared to 33.9% for the three months ended September 30, 2004 and 34.0% for the nine months ended September 30, 2004. The lower effective tax rate in 2005 primarily reflects the favorable impact from the resolution of a contingent gain of $22.8 million during the first quarter of 2005 in connection with the expiration of the statute of limitations on an uncertain tax position related to the 2000 tax year.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

**(8) Long-term Debt**

Long-term debt outstanding was as follows at September 30, 2005 and December 31, 2004:

| | September 30, 2005 | December 31, 2004 |
|---|---|---|
| | (in thousands) | |
| Long-term debt: | | |
| 6.30% senior, unsecured notes due Aug. 1, 2018, net of unamortized discount of $737 at September 30, 2005 and $780 at December 31, 2004 | $ 299,263 | $ 299,220 |
| 7.25% senior, unsecured notes due Aug. 1, 2006, net of unamortized discount of $123 at September 30, 2005 and $231 at December 31, 2004 | 299,877 | 299,769 |
| Fair value of interest rate swap agreements | 7,916 | 17,082 |
| Deferred gain from interest rate swap exchange | 8,718 | 16,338 |
| Total senior notes | 615,774 | 632,409 |
| Credit agreement | — | — |
| Other long-term borrowings | 3,802 | 4,287 |
| Total debt | 619,576 | 636,696 |
| Less: Current portion of long-term debt | 302,366 | — |
| Total long-term debt | $ 317,210 | $ 636,696 |

*Swap Agreements*

In order to hedge the risk of changes in the fair value of our $300 million 6.30% senior notes and our $300 million 7.25% senior notes attributable to fluctuations in interest rates, we entered into interest rate swap agreements. Interest rate swap agreements, which are considered derivatives, are contracts that exchange interest payments on a specified principal amount, or notional amount, for a specified period. The interest rate swap agreements, which have the same critical terms as our 6.30% senior notes and our 7.25% senior notes, are designated fair value hedges. Changes in the fair value of the 6.30% or 7.25% senior notes and the swap agreements due to changing interest rates are assumed to offset each other completely, resulting in no impact to earnings from hedge ineffectiveness. Our swap agreements are recognized in our consolidated balance sheet at fair value with an equal and offsetting adjustment to the carrying value of our senior notes. The fair values of our interest rate swap agreements are estimated based on quoted market prices of comparable agreements, and reflect the amounts we would receive (or pay) to terminate the agreements at the reporting date.

Our interest rate swap agreements exchange the fixed interest rate under our 6.30% and 7.25% senior notes for a variable interest rate based on LIBOR. At September 30, 2005, the effective interest rate was 4.95% for the 6.30% senior notes and 5.79% for the 7.25% senior notes, including the amortization of the deferred swap gain. The $300 million swap agreements for the 6.30% senior notes mature on August 1, 2018, and the $300 million swap agreements for the 7.25% senior notes mature on August 1, 2006, and each has the same critical terms as the related senior notes.

At September 30, 2005, the fair value of our swap agreements related to the 6.30% senior notes was in our favor by $14.1 million and is included in other long-term assets and the fair value of our swap agreements related to the 7.25% senior notes was out of our favor by $6.2 million and is included in other current liabilities. Likewise, the carrying value of our senior notes has been increased $7.9 million to reflect their fair value. The counterparties to our swap agreements are major financial institutions with which we also have other financial relationships.

In June 2003, we recorded a deferred gain and received proceeds of $31.6 million in exchange for new swap agreements discussed above related to our 7.25% senior notes. The corresponding deferred swap gain of $31.6 million is being amortized to reduce interest expense over the remaining term of the 7.25% senior notes. Amortization of the deferred swap gain reduced interest expense $2.6 million for the three months ended September 30, 2005 and $2.5 million for the three months ended September 30, 2004. Amortization of the deferred swap gain reduced interest expense $7.6 million for the nine months ended September 30, 2005 and $7.3 million for the nine months ended September 30, 2004.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

*Credit Agreement*

The 5-year $600 million unsecured revolving credit agreement expires in September 2009. Under the agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion of the agreement bears interest at either a fixed rate or floating rate based on LIBOR plus a spread. The spread, which varies depending on our credit ratings, ranges from 50 to 112.5 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 12.5 and 37.5 basis points, depending upon our credit ratings. In addition, a utilization fee of 12.5 basis points is payable for any day in which borrowings under the facility exceed 50% of the total $600 million commitment. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate basis, at our option.

The 5-year $600 million credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of net worth, minimum interest coverage, and maximum leverage ratios. At September 30, 2005, we were in compliance with all applicable financial covenant requirements. The terms of this credit agreement also include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow. We have not experienced a material adverse effect, and we know of no circumstances or events which would be reasonably likely to result in a material adverse effect. We do not believe the material adverse effect clause poses a material funding risk to Humana in the future. We have other relationships, including financial advisory and banking, with some of the parties to the credit agreement.

On February 16, 2005, we borrowed $294.0 million under the credit agreement to finance the CarePlus acquisition. Since the CarePlus transaction, we have repaid the $294.0 million under the credit agreement. In addition, we have outstanding letters of credit of $35.1 million secured under the credit agreement. No amounts have ever been drawn on these letters of credit. As of September 30, 2005, we had $564.9 million of remaining borrowing capacity under the credit agreement.

*Commercial Paper Program*

We maintain and may issue short-term debt securities under a commercial paper program when market conditions allow. The program is backed by our credit agreement described above. Aggregate borrowings under both the credit agreement and commercial paper program generally will not exceed $600 million.

At September 30, 2005, we had no commercial paper borrowings outstanding.

*Other Borrowings*

Other borrowings of $3.8 million at September 30, 2005 represent financing for the renovation of a building, bear interest at 2% per annum, are collateralized by the building, and are payable in various installments through 2014.

*Shelf Registration*

Our universal shelf registration with the Securities and Exchange Commission allows us to register debt or equity securities, from time to time, with the amount, price and terms to be determined at the time of the sale. We have up to $300 million remaining from a total of $600 million under the universal shelf registration. The universal shelf registration allows us to use the net proceeds from any future sales of our securities for our operations and for other general corporate purposes, including repayment or refinancing of borrowings, working capital, capital expenditures, investments, acquisitions, or the repurchase of our outstanding securities.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

**(9) Guarantees and Contingencies**

*Indemnifications and Guarantees*

Our operating lease of an airplane, which expires January 1, 2010, provides for a residual value payment guarantee of no more than $4.8 million at the end of the lease term. At the end of the lease term, we have the right to exercise a purchase option or the airplane can be sold to a third party. If we decide not to exercise our purchase option, we must pay the lessor a maximum amount of $4.8 million. This amount will be reduced by the net sales proceeds in excess of $4.2 million from the sale of the airplane to a third party.

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our TRICARE subsidiary.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial and accordingly, no amounts have been accrued at September 30, 2005.

*Government Contracts*

Our Medicare business, which accounted for approximately 32% of our total premiums and ASO fees for the nine months ended September 30, 2005, primarily consisted of HMO, PPO and Fee-For-Service products covered under the Medicare Advantage contracts with the federal government. The contracts are renewed for a one-year term each December 31 unless notice of termination is received at least 90 days prior thereto. No termination notices have been received in 2005 in connection with our existing contracts.

Our TRICARE business, which accounted for approximately 18% of our total premiums and ASO fees for the nine months ended September 30, 2005, primarily consisted of the South Region contract. The 5-year South Region contract is subject to annual renewals at the Government's option and expires March 31, 2009. This contract also is generally subject to frequent change from events and circumstances such as the escalated conflict in the Middle East. These changes may include a reduction or increase in the number of persons enrolled or eligible to enroll, in the revenue we receive or in our administrative or health care costs. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs could have a material adverse effect on our business.

Our Medicaid business, which accounted for approximately 4% of our total premiums and ASO fees for the nine months ended September 30, 2005, consisted of contracts in Puerto Rico, Florida and Illinois. Our contracts with the Puerto Rico Health Insurance Administration, which accounted for approximately 3% of our total premium and ASO fees for the nine months ended September 30, 2005, were scheduled to expire on June 30, 2005. We currently are negotiating the terms of an amendment to the contracts that will extend the contracts until June 30, 2006. We have finalized rates for the 2005-2006 contract year and are in the process of finalizing the amendments to the contracts. The government of Puerto Rico has indicated that it must consider the impact of the new Medicare legislation on the Medicaid contracts in order to complete the arrangements for 2006. At this time we are unable to predict the ultimate impact that any government policy decisions might have on our Medicaid contracts in Puerto Rico.

Our other Medicaid contract is in Florida, and is an annual contract. Due to continual decreases in the reimbursement from the state of Illinois, we exited the Illinois Medicaid market effective July 31, 2005. The Illinois and Florida Medicaid contracts accounted for approximately 1% of our total premiums and ASO fees for the nine months ended September 30, 2005, and therefore were not material to our results of operations, financial position, or cash flows.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

Other than as described herein, the loss of any of the contracts above or significant changes in these programs as a result of legislative action, including reductions in premium payments to us, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our financial position, results of operations, and cash flows.

*Legal Proceedings*

*Managed Care Industry Purported Class Action Litigation*

From 1999 to 2005, we were involved in several purported class action lawsuits that were part of a wave of generally similar actions targeting the health care payer industry and particularly managed care companies. These included a lawsuit against us and originally nine of our competitors that purported to be brought on behalf of physicians who treated our members from January 1, 1990, forward. These cases were consolidated in the United States District Court for the Southern District of Florida, and styled *In re Managed Care Litigation*.

On October 17, 2005, we and representatives of over 700,000 physicians and several state medical societies reached an agreement ("Settlement Agreement") to settle the lawsuit by payment of $40 million for the physicians and an amount up to $18 million for the plaintiffs' attorneys, subject to approval by the Court. The Settlement Agreement recognizes that we have undertaken certain initiatives to facilitate relationships with and payments to physicians and provides for additional initiatives over its four-year term. The Court preliminarily approved the Settlement Agreement on October 19, 2005, and set a Settlement Hearing for March 6, 2006.

Four other defendants, Aetna Inc., Cigna Corporation, Health Net, Inc. and The Prudential Insurance Company of America previously entered into settlement agreements which have been approved by the Court. Wellpoint, Inc. (formerly WellPoint Health Networks, Inc. and Anthem, Inc.) announced a settlement agreement on July 11, 2005.

In connection with the settlement and other related litigation costs, we recorded pretax administrative expense of $71.9 million ($44.8 million after taxes, or $0.27 per diluted common share) in the third quarter of 2005.

*Other Litigation and Proceedings*

In July 2000, the Office of the Florida Attorney General initiated an investigation, apparently relating to some of the same matters that are involved in the managed care industry purported class action litigation described above. On September 21, 2001, the Texas Attorney General initiated a similar investigation. No actions have been filed against us by either state.

In addition, our business practices are subject to review by various state insurance and health care regulatory authorities and federal regulatory authorities. There has been increased scrutiny by these regulators of the managed health care companies' business practices, including allegations of anticompetitive and unfair business activities, claims payment practices, commission payment practices, and utilization management practices. We have been and continue to be subject to such reviews. Some of these have resulted in fines and could require changes in some of our practices and could also result in additional fines or other sanctions.

We also are involved in other lawsuits that arise in the ordinary course of our business operations, including claims of medical malpractice, bad faith, nonacceptance or termination of providers, improper rate setting, failure to disclose network discounts and various other provider arrangements, as well as challenges to subrogation practices. We also are subject to claims relating to performance of contractual obligations to providers, members, and others, including failure to properly pay claims and challenges to the use of certain software products in processing claims. Pending state and federal legislative activity may increase our exposure for any of these types of claims.

In addition, some courts have issued rulings which make it easier to hold plans liable for medical negligence on the part of network providers on the theory that providers are agents of the plans and that the plans are therefore vicariously liable for the injuries to members by providers.

Personal injury claims and claims for extracontractual damages arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

The outcome of current suits or likelihood or outcome of future suits or governmental investigations, cannot be accurately predicted with certainty. In addition, the potential for increased liability for medical negligence arising from claims adjudication, along with the increased litigation that has accompanied the negative publicity and public

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

perception of our industry, adds to this uncertainty. Therefore, such legal actions and government audits and investigations could have a material adverse effect on our financial position, results of operations, and cash flows.

**(10) Segment Information**

We manage our business with two segments: Government and Commercial. The Government segment consists of members enrolled in government-sponsored programs, and includes three lines of business: Medicare Advantage, Medicaid, and TRICARE. The Commercial segment consists of members enrolled in products marketed to employer groups and individuals, and includes three lines of business: fully insured medical, administrative services only, or ASO, and specialty. We identified our segments in accordance with the aggregation provisions of Statement of Financial Accounting Standards No. 131, *Disclosures About Segments of an Enterprise and Related Information* which is consistent with information used by our Chief Executive Officer in managing our business. The segment information aggregates products with similar economic characteristics. These characteristics include the nature of customer groups and pricing, benefits and underwriting requirements.

The results of each segment are measured by income before income taxes. We allocate all selling, general and administrative expenses, investment and other income, interest expense, and goodwill, but no other assets or liabilities, to our segments. Members served by our two segments generally utilize the same medical provider networks, enabling us to obtain more favorable contract terms with providers. Our segments also share overhead costs and assets. As a result, the profitability of each segment is interdependent.

**Humana Inc.**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)**
**Unaudited**

Our segment results for the three and nine months ended September 30, 2005 and 2004 are as follows:

| | Government Segment | | | |
|---|---|---|---|---|
| | Three months ended September 30, | | Nine months ended September 30, | |
| | 2005 | 2004 | 2005 | 2004 |
| | (in thousands) | | | |
| Revenues: | | | | |
| Premiums: | | | | |
| Medicare Advantage | $1,296,743 | $ 814,612 | $3,372,326 | $2,295,534 |
| TRICARE | 659,019 | 386,439 | 1,832,526 | 1,651,844 |
| Medicaid | 139,961 | 131,318 | 409,105 | 377,895 |
| Total premiums | 2,095,723 | 1,332,369 | 5,613,957 | 4,325,273 |
| Administrative services fees | 8,821 | 18,513 | 34,084 | 95,632 |
| Investment and other income | 9,341 | 5,656 | 20,405 | 20,032 |
| Total revenues | 2,113,885 | 1,356,538 | 5,668,446 | 4,440,937 |
| Operating expenses: | | | | |
| Medical | 1,729,902 | 1,086,677 | 4,700,028 | 3,624,743 |
| Selling, general and administrative | 276,799 | 168,466 | 654,795 | 542,655 |
| Depreciation and amortization | 15,449 | 11,436 | 39,476 | 32,448 |
| Total operating expenses | 2,022,150 | 1,266,579 | 5,394,299 | 4,199,846 |
| Income from operations | 91,735 | 89,959 | 274,147 | 241,091 |
| Interest expense | 2,178 | 1,192 | 8,274 | 3,196 |
| Income before income taxes | $ 89,557 | $ 88,767 | $ 265,873 | $ 237,895 |

| | Commercial Segment | | | |
|---|---|---|---|---|
| | Three months ended September 30, | | Nine months ended September 30, | |
| | 2005 | 2004 | 2005 | 2004 |
| | (in thousands) | | | |
| Revenues: | | | | |
| Premiums: | | | | |
| Fully insured | | | | |
| PPO | $ 905,475 | $ 945,906 | $2,719,961 | $2,831,450 |
| HMO | 614,496 | 717,457 | 1,829,682 | 2,149,792 |
| Total fully insured | 1,519,971 | 1,663,363 | 4,549,643 | 4,981,242 |
| Specialty | 96,670 | 87,822 | 285,598 | 259,932 |
| Total premiums | 1,616,641 | 1,751,185 | 4,835,241 | 5,241,174 |
| Administrative services fees | 54,996 | 41,324 | 156,370 | 123,788 |
| Investment and other income | 35,939 | 27,226 | 94,990 | 88,801 |
| Total revenues | 1,707,576 | 1,819,735 | 5,086,601 | 5,453,763 |
| Operating expenses: | | | | |
| Medical | 1,364,495 | 1,464,234 | 4,036,611 | 4,399,424 |
| Selling, general and administrative | 334,501 | 291,705 | 916,998 | 874,040 |
| Depreciation and amortization | 18,670 | 19,802 | 55,655 | 52,267 |
| Total operating expenses | 1,717,666 | 1,775,741 | 5,009,264 | 5,325,731 |

| | | | | |
|---|---|---|---|---|
| (Loss) income from operations | (10,090) | 43,994 | 77,337 | 128,032 |
| Interest expense | 7,963 | 5,288 | 20,712 | 13,328 |
| (Loss) income before income taxes | $ (18,053) | $ 38,706 | $ 56,625 | $ 114,704 |

**Humana Inc.**
**MANAGEMENT'S DISCUSSION AND ANALYSIS OF**
**FINANCIAL CONDITION AND RESULTS OF OPERATIONS**

*The condensed consolidated financial statements of Humana Inc. in this document present the Company's financial position, results of operations and cash flows, and should be read in conjunction with the following discussion and analysis. References to "we," "us," "our," "Company," and "Humana" mean Humana Inc. and its subsidiaries. This discussion includes forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. When used in filings with the Securities and Exchange Commission, in our press releases, investor presentations, and in oral statements made by or with the approval of one of our executive officers, the words or phrases like "expects," "anticipates," "intends," "likely will result," "estimates," "projects" or variations of such words and similar expressions are intended to identify such forward–looking statements. These forward–looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, information set forth in the "Cautionary Statements" section of this document. In light of these risks, uncertainties and assumptions, the forward–looking events discussed in this document might not occur. There may also be other risks that we are unable to predict at this time. Any of these risks and uncertainties may cause actual results to differ materially from the results discussed in the forward–looking statements.*

**Overview**

Headquartered in Louisville, Kentucky, Humana Inc. is one of the nation's largest publicly traded health benefits companies, based on our 2004 revenues of $13.1 billion. We offer coordinated health insurance coverage and related services through a variety of traditional and Internet-based plans for employer groups, government-sponsored programs, and individuals. As of September 30, 2005, we had approximately 7.0 million members in our medical insurance programs, as well as approximately 1.9 million members in our specialty products programs.

We manage our business with two segments: Government and Commercial. The Government segment consists of members enrolled in government-sponsored programs, and includes three lines of business: Medicare Advantage, TRICARE, and Medicaid. The Commercial segment consists of members enrolled in products marketed to employer groups and individuals, and includes three lines of business: fully insured medical, administrative services only, or ASO, and specialty. We identified our segments in accordance with the aggregation provisions of Statement of Financial Accounting Standards No. 131, *Disclosures About Segments of an Enterprise and Related Information* which is consistent with information used by our Chief Executive Officer in managing our business. The segment information aggregates products with similar economic characteristics. These characteristics include the nature of customer groups and pricing, benefits and underwriting requirements.

The results of each segment are measured by income before income taxes. We allocate all selling, general and administrative expenses, investment and other income, interest expense, and goodwill, but no other assets or liabilities, to our segments. Members served by our two segments often utilize the same medical provider networks, enabling us to obtain more favorable contract terms with providers. Our segments also share overhead costs and assets. As a result, the profitability of each segment is interdependent. We draw revenues from group, individual, Medicare, Medicaid and military business lines. We believe that it is difficult to time market cycles and external influences on various parts of our businesses. By remaining committed to varied lines of business with a long-term view, we may benefit through short-term market cycles. We believe our diversification across segments and products allows us to increase our chances of success.

Our results are impacted by many factors, but most notably are influenced by our ability to establish and maintain a competitive and efficient cost structure and to accurately and consistently establish competitive premium, ASO fee, and plan benefit levels that are commensurate with our medical and administrative costs. Medical costs are subject to a high rate of inflation due to many forces, including new technologies and medical procedures, increasing capacity and supply of medical services, new prescription drugs and therapies, an aging population, the tort liability system, and government regulations.

In our Government segment, the passage of the Medicare Modernization Act, or MMA, in December 2003 demonstrated the federal government's commitment to providing health benefits and options to seniors and has started the resurgence of Medicare as a business line that should bring us accelerating growth in 2005 and 2006. The MMA established new product opportunities in the form of private fee-for-service (PFFS) plans and local PPOs. Our current Medicare presence today includes 503,100 members in 12 HMO markets, 33 local PPO markets, and 35 states in which we have a private fee-for-service offering. Medicare Private Fee-For-Service plans generally offer

additional benefits compared to traditional Medicare in exchange for a monthly premium paid by the member. These plans typically include a prescription drug benefit with no provider network restrictions. Local Medicare PPO plans typically offer an even higher level of benefits to members, including a prescription drug benefit and a lower level of member cost-sharing on many benefits while seeking medical services from in-network providers. On December 31, 2005, we anticipate having approximately 540,000 to 550,000 Medicare Advantage members.

We also have positioned ourselves to participate in Medicare Regional PPO plans and the Medicare Prescription Drug Plan, or PDP, as established by the MMA, beginning January 1, 2006. As a long-time successful participant in the Medicare program, we believe that we possess (1) business competencies and management experience with senior product design, (2) a robust and scalable multi-channel distribution system, (3) an established and competitive network including a national retail pharmacy network, and (4) an established brand awareness with seniors; all of which will enable us to compete for market share in this expanding business line over the next several years. Accordingly, we anticipate significant increases in Medicare membership, revenues, and earnings for 2006.

In our TRICARE business, after being awarded the South Region contract in 2003, we transitioned our TRICARE business during 2004 to one of three newly-created regions under the government's revised TRICARE program. We started the second option year under the South Region contract on April 1, 2005.

Our strategy to drive Commercial segment profitability focuses on providing solutions for employers to the rising cost of health care through the use of a variety of innovative and consumer-choice product designs. These products are supported by electronic informational capabilities, including education, tools, and technologies provided primarily through the Internet. To that end, we have developed an innovative suite of products styled as "Smart" products. We believe that these Smart products offer the best solution for many employers to the problem of quickly rising health care costs for their employees. Membership in our Smart products and other consumer-choice health plans exceeded 350,000 members at September 30, 2005, increasing approximately 43% since December 31, 2004. We believe that growth in these products, which are offered both on a fully-insured and ASO basis and competitively priced to produce higher margins, is a key component, among other items, for further improvement in the results of our Commercial segment. Additionally, we have increased the diversification of our commercial membership base, not only through our consumer-choice products, but also by (1) expanding our ASO membership in the mid-market group segment to take advantage of our network discounts and (2) launching our HumanaOne individual product to address an increasing migration of insureds from small group. While we expect our consumer-choice products to become a driver of growth in the years ahead as health care inflation persists, we also are enhancing the traditional products which comprise the bulk of our commercial portfolio today by applying our consumer-choice innovation.

Other important factors which impact our Commercial segment profitability are both the competitive pricing environment and market conditions. With respect to pricing, there is a tradeoff between sustaining or increasing underwriting margins versus increasing or decreasing enrollment. We have experienced a decline in our membership in the 2 to 300 life group size as a result of pricing actions by some competitors who we perceive as desiring to gain market share in certain markets. With respect to market conditions, we are impacted by economies of scale on administrative overhead. As a result of a decline in preference for tightly-managed HMO products, medical costs have become increasingly comparable among the larger competitors. Product design and consumer involvement have become more important drivers of medical services consumption, and administrative expense efficiency is becoming a more significant driver of commercial margin sustainability. Consequently, we continually evaluate our administrative expense structure and realize administrative expense savings through productivity gains. Additionally, because our Commercial segment shares overhead costs with our Government segment, an increase or decrease in the size of our Government operations impacts our Commercial segment profitability.

Other highlights since December 31, 2004, our most recent year end, include the following:

- In the Government segment, the Centers for Medicare and Medicaid Services, or CMS, approved all the 2006 Medicare contracts we applied for, giving us a wide array of products to sell and increasing the number of states where we sell them.
- We completed the acquisition of CarePlus Health Plans of Florida, increasing our Medicare presence in South Florida. This transaction is more fully-described below and in Note 3 to the condensed consolidated financial statements.
- Membership in Medicare Advantage products grew by 125,900 members from December 31, 2004, including 50,400 members from the acquisition of CarePlus and 75,500 members in our existing products.
- In the Commercial segment, fully-insured membership declined 279,100 members, or 12.2%, since December 31, 2004 due to continued competitive pricing pressures. This decline was partially offset by an increase of 151,900 ASO members.

- We reached an agreement with representatives of more than 700,000 physicians to settle a nationwide class action suit. This transaction is more fully-described below and under "Legal Proceedings" in Note 9 to the condensed consolidated financial statements.
- Certain of our operations, primarily the Louisiana market, were negatively affected by the impact of Hurricane Katrina in August 2005. This is more fully-described below.
- The resolution of a contingent tax gain during the first quarter of 2005 contributed to the lower effective tax rate of 24.4% during the first nine months of 2005 compared to 34.0% during the first nine months of 2004.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from quarter to quarter, and the primary factors that accounted for those changes, as well as how certain critical accounting principles and estimates impact our financial statements.

*Settlement of Class Action Litigation*

On October 17, 2005, we reached an agreement with representatives of more than 700,000 physicians to settle a nationwide class action suit. In connection with the settlement and other related litigation costs, we recorded pretax administrative expenses of $71.9 million ($44.8 million after taxes, or $0.27 per diluted common share) in the third quarter of 2005. Of the $71.9 million, $33.4 million is included in the Government segment results and the remaining $38.5 million is included in the Commercial segment results. The settlement is more fully-described under "Legal Proceedings" in Note 9 to the condensed consolidated financial statements.

*Hurricane Katrina*

Certain of our operations, primarily the Louisiana market, were negatively affected by the impact of Hurricane Katrina in August 2005. Expenses related to Hurricane Katrina primarily stem from our efforts, in cooperation with Departments of Insurance in the affected states, to help our members by offering participating-provider benefits at non-participating providers, paying claims for members who are unable at this time to meet their premium obligations and similar measures. In connection with Hurricane Katrina, we recorded pretax medical and administrative expenses of $6.7 million ($4.2 million after taxes, or $0.03 per diluted common share) during the third quarter of 2005. Of the $6.7 million, $1.5 million is included in the Government segment results and the remaining $5.2 million is included in the Commercial segment results. We expect additional costs during the fourth quarter of 2005 of approximately $0.07 per diluted common share.

*Recent Acquisitions*

On February 16, 2005, we acquired CarePlus Health Plans of Florida, or CarePlus, as well as its affiliated 10 medical centers and pharmacy company for approximately $444.9 million in cash including transaction costs, adding approximately 50,400 Medicare eligible beneficiaries in Miami-Dade, Broward and Palm Beach counties. This acquisition enhances our Medicare market position in South Florida. This transaction is more fully described in Note 3 to the condensed consolidated financial statements.

On April 1, 2004, we acquired Ochsner Health Plan, or Ochsner, from the Ochsner Clinic Foundation for $157.1 million in cash. Ochsner, a Louisiana health plan, added approximately 152,600 commercial medical members, primarily in fully insured large group accounts, and approximately 33,100 members in the Medicare Advantage program.

*Recently Issued Accounting Pronouncements*

In December 2004, the FASB issued Statement No. 123R, *Share-Based Payment*, or Statement 123R, which requires companies to expense the fair value of employee stock options and other forms of stock-based compensation. This requirement represents a significant change because fixed-based stock option awards, a predominate form of stock compensation for us, were not recognized as compensation expense under APB 25. Statement 123R requires that the cost of the award, as determined on the date of grant at fair value, be recognized over the period during which an employee is required to provide service in exchange for the award (usually the vesting period). The grant-date fair value of the award will be estimated using option-pricing models. We are required to adopt Statement 123R beginning January 1, 2006 under either a prospective or retrospective transition method. The effect of expensing stock options under a fair value approach using the Black-Scholes pricing model for the three and nine months ended September 30, 2005 and 2004 is disclosed in Note 2 of the condensed consolidated financial statements. We currently are evaluating the provisions of Statement 123R and the expected effect on us including, among other items, selecting an option pricing model. We anticipate using the retrospective transition model which we estimate would lower 2005 results by approximately $0.08 per diluted common share.

We believe the impact of adopting Statement 123R would lower 2006 results approximately $0.10 per diluted common share, assuming a similar number and pattern of granting stock option awards as the current year, the use of the Black-Scholes pricing model with expected life and volatility assumptions similar to the current year, a stock price reflective of our current environment and a forfeiture rate as preliminarily calculated.

**Comparison of Results of Operations**

The following discussion primarily deals with our results of operations for the three months ended September 30, 2005, or the 2005 quarter, the three months ended September 30, 2004, or the 2004 quarter, the nine months ended September 30, 2005, or the 2005 period, and the nine months ended September 30, 2004, or the 2004 period.

The following table presents certain financial data for our two segments:

| | For the three months ended September 30, | | Change | |
|---|---|---|---|---|
| | 2005 | 2004 | Dollars | Percentage |
| | (in thousands, except ratios) | | | |
| Premium revenues: | | | | |
| Medicare Advantage | $1,296,743 | $ 814,612 | $ 482,131 | 59.2% |
| TRICARE | 659,019 | 386,439 | 272,580 | 70.5% |
| Medicaid | 139,961 | 131,318 | 8,643 | 6.6% |
| Total Government | 2,095,723 | 1,332,369 | 763,354 | 57.3% |
| Fully insured | 1,519,971 | 1,663,363 | (143,392) | (8.6)% |
| Specialty | 96,670 | 87,822 | 8,848 | 10.1% |
| Total Commercial | 1,616,641 | 1,751,185 | (134,544) | (7.7)% |
| Total | $3,712,364 | $3,083,554 | $ 628,810 | 20.4% |
| Administrative services fees: | | | | |
| Government | $ 8,821 | $ 18,513 | $ (9,692) | (52.4)% |
| Commercial | 54,996 | 41,324 | 13,672 | 33.1% |
| Total | $ 63,817 | $ 59,837 | $ 3,980 | 6.7% |
| Income (loss) before income taxes: | | | | |
| Government | $ 89,557 | $ 88,767 | $ 790 | 0.9% |
| Commercial | (18,053) | 38,706 | (56,759) | (146.6)% |
| Total | $ 71,504 | $ 127,473 | $ (55,969) | (43.9)% |
| Medical expense ratios (a): | | | | |
| Government | 82.5% | 81.6% | | 0.9 |
| Commercial | 84.4% | 83.6% | | 0.8 |
| Total | 83.4% | 82.7% | | 0.7 |
| SG&A expense ratios (b): | | | | |
| Government | 13.2% | 12.5% | | 0.7 |
| Commercial | 20.0% | 16.3% | | 3.7 |
| Total | 16.2% | 14.6% | | 1.6 |

(a) Represents total medical expenses as a percentage of premium revenues. Also known as MER.

(b) Represents total selling, general, and administrative expenses as a percentage of premium revenues and administrative services fees. Also known as the SG&A expense ratio.

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| | For the nine months ended September 30, | | Change | |
|---|---|---|---|---|
| | 2005 | 2004 | Dollars | Percentage |
| | (in thousands, except ratios) | | | |
| Premium revenues: | | | | |
| Medicare Advantage | $ 3,372,326 | $2,295,534 | $1,076,792 | 46.9% |
| TRICARE | 1,832,526 | 1,651,844 | 180,682 | 10.9% |
| Medicaid | 409,105 | 377,895 | 31,210 | 8.3% |
| Total Government | 5,613,957 | 4,325,273 | 1,288,684 | 29.8% |
| Fully insured | 4,549,643 | 4,981,242 | (431,599) | (8.7)% |
| Specialty | 285,598 | 259,932 | 25,666 | 9.9% |
| Total Commercial | 4,835,241 | 5,241,174 | (405,933) | (7.7)% |
| Total | $10,449,198 | $9,566,447 | $ 882,751 | 9.2% |
| Administrative services fees: | | | | |
| Government | $ 34,084 | $ 95,632 | $ (61,548) | (64.4)% |
| Commercial | 156,370 | 123,788 | 32,582 | 26.3% |
| Total | $ 190,454 | $ 219,420 | $ (28,966) | (13.2)% |
| Income before income taxes: | | | | |
| Government | $ 265,873 | $ 237,895 | $ 27,978 | 11.8% |
| Commercial | 56,625 | 114,704 | (58,079) | (50.6)% |
| Total | $ 322,498 | $ 352,599 | $ (30,101) | (8.5)% |
| Medical expense ratios (a): | | | | |
| Government | 83.7% | 83.8% | | (0.1) |
| Commercial | 83.5% | 83.9% | | (0.4) |
| Total | 83.6% | 83.9% | | (0.3) |
| SG&A expense ratios (b): | | | | |
| Government | 11.6% | 12.3% | | (0.7) |
| Commercial | 18.4% | 16.3% | | 2.1 |
| Total | 14.8% | 14.5% | | 0.3 |

(a) Represents total medical expenses as a percentage of premium revenues. Also known as MER.

(b) Represents total selling, general, and administrative expenses as a percentage of premium revenues and administrative services fees. Also known as the SG&A expense ratio.

Medical membership was as follows at September 30, 2005 and 2004:

| | | | Change | |
|---|---|---|---|---|
| | 2005 | 2004 | Members | Percentage |
| Government segment medical members: | | | | |
| Medicare Advantage | 503,100 | 371,300 | 131,800 | 35.5% |
| TRICARE | 1,747,100 | 1,138,600 | 608,500 | 53.4% |
| TRICARE ASO | 1,127,300 | 674,700 | 452,600 | 67.1% |
| Medicaid | 459,400 | 475,800 | (16,400) | (3.4)% |
| Total Government | 3,836,900 | 2,660,400 | 1,176,500 | 44.2% |
| Commercial segment medical members: | | | | |
| Fully insured | 2,007,400 | 2,296,400 | (289,000) | (12.6)% |
| ASO | 1,170,500 | 1,018,800 | 151,700 | 14.9% |
| Total Commercial | 3,177,900 | 3,315,200 | (137,300) | (4.1)% |

| | | | | |
|---|---|---|---|---|
| Total medical membership | 7,014,800 | 5,975,600 | 1,039,200 | 17.4% |

***Summary***

Net income was $49.9 million, or $0.30 per diluted common share in the 2005 quarter compared to $84.3 million, or $0.52 per diluted common share in the 2004 quarter. Net income was $243.9 million, or $1.48 per diluted common share in the 2005 period compared to $232.9 million, or $1.43 per diluted common share in the 2004 period. The 2005 quarter and period included expenses resulting from the physician class action settlement ($44.8 million after taxes, or $0.27 per diluted common share) and costs associated with Hurricane Katrina ($4.2 million after taxes, or $0.03 per diluted common share). The 2005 period also included the beneficial effect of an effective tax rate of approximately 24.4% compared to 34.0% in the 2004 period, primarily due to the resolution of a contingent gain during the first quarter of 2005 in connection with the expiration of the statute of limitations on an uncertain tax position related to the 2000 tax year.

Our Government segment results included $34.9 million and our Commercial segment results included $43.7 million of pretax expenses associated with the physician class action settlement and costs associated with Hurricane Katrina. Excluding these items, improved earnings in the Government segment more than offset a decline in the Commercial segment. Enrollment growth in our Medicare Advantage products drove the improved earnings in the Government segment.

***Premium Revenues and Medical Membership***

Premium revenues increased 20.4% to $3.71 billion for the 2005 quarter, compared to $3.08 billion for the 2004 quarter. For the 2005 period, premium revenues were $10.45 billion, an increase of 9.2% compared to $9.57 billion for the 2004 period. Higher premium revenues resulted primarily from enrollment growth in our Medicare Advantage products partially offset by a decrease in fully-insured commercial membership.

Government segment premium revenues increased $763.4 million, or 57.3% to $2.10 billion for the 2005 quarter, compared to $1.33 billion for the 2004 quarter. For the 2005 period, Government segment premium revenues were $5.61 billion, an increase of $1.28 billion, or 29.8% compared to $4.33 billion for the 2004 period. This increase primarily was attributable to our Medicare Advantage operations and the effects of transitioning to the TRICARE South contract during the 2004 quarter. Medicare Advantage membership was 503,100 at September 30, 2005, compared to 371,300 at September 30, 2004, an increase of 131,800 members, or 35.5%. This increase was due to expanded participation in various Medicare Advantage programs and geographic markets, and the CarePlus acquisition. The February 16, 2005 CarePlus acquisition added 50,400 members. The April 1, 2004 Ochsner acquisition also contributed $97.2 million to the increase in Medicare premium revenues for the 2005 period. Per member premiums for our Medicare Advantage business increased approximately 20% for the 2005 quarter and increased approximately 13% for the 2005 period. These per member premium increases reflect a shift in our Medicare membership mix to higher reimbursement markets, due primarily to the CarePlus acquisition, and reflect the effects of the risk adjustment settlement process with CMS. For the full year 2005, we expect premium increases per member in the range of 12% to 14%. Medicare Advantage geographic expansions during 2005 are anticipated to contribute to continued enrollment growth, with projected membership in the range of 540,000 to 550,000 by December 31, 2005. TRICARE premium revenues increased 70.5% for the 2005 quarter and 10.9% for the 2005 period, reflecting the transition to the new South Region contract during the 2004 quarter. Medicaid membership declined by approximately 20,000 members on August 1, 2005 as we did not renew our participation in the Medicaid program for the State of Illinois. The Illinois Medicaid business was not material to our results of operations, financial position, or cash flows.

Commercial segment premium revenues decreased 7.7% to $1.62 billion for the 2005 quarter, compared to $1.75 billion for the 2004 quarter. For the 2005 period, commercial segment premium revenues were $4.84 billion, a decrease of 7.7% compared to $5.24 billion for the 2004 period. Lower premium revenues primarily resulted from a reduction of fully-insured membership partially offset by increases in per member premiums. Our fully insured membership decreased 12.6%, or 289,000 members, to 2,007,400 at September 30, 2005 compared to 2,296,400 at September 30, 2004. The decrease is primarily due to the relinquishment of an 89,000-member unprofitable account on January 1, 2005 and continued attrition due to the ongoing competitive environment within the small to mid-market fully-insured group accounts, partially offset by membership gains in the individual and consumer-choice product lines. For the full year 2005, we expect fully insured commercial per member premiums to increase in the 7% to 9% range for our commercial group accounts.

***Administrative Services Fees***

Our consolidated administrative services fees for the 2005 quarter were $63.8 million, an increase of $4.0 million, or 6.7%, from $59.8 million for the 2004 quarter. For the 2005 period, administrative services fees were $190.5 million, a decrease of 13.2% compared to $219.4 million for the 2004 period.

Administrative services fees for the Government segment decreased $9.7 million, or 52.4%, from $18.5 million for the 2004 quarter to $8.8 million for the 2005 quarter, and decreased $61.5 million, or 64.4%, from $95.6 million to $34.1 million when comparing the 2005 period to the 2004 period. This decline resulted from the transition to the new South Region contract which carved out certain government programs including the administration of pharmacy and medical benefits to senior members over the age of 65. We transitioned services under these separate programs to other providers during 2004.

For the Commercial segment, administrative services fees increased $13.7 million, or 33.1%, from $41.3 million for the 2004 quarter to $55.0 million for the 2005 quarter, and increased $32.6 million, or 26.3%, from $123.8 million to $156.4 million when comparing the 2005 period to the 2004 period. This increase resulted from increased membership and higher rates. ASO membership of 1,170,500 at September 30, 2005 increased 14.9% compared to 1,018,800 at September 30, 2004.

***Investment and Other Income***

Investment and other income totaled $45.3 million for the 2005 quarter, an increase of $12.4 million from $32.9 million for the 2004 quarter. For the 2005 period, investment and other income totaled $115.4 million, an increase of $6.6 million from $108.8 million for the 2004 period. The increase for the quarter was primarily attributable to increased investment income from higher capital gains, interest rates and average invested balances. The increase for the period primarily was attributed to an increase in other income. Higher revenues from our ancillary TRICARE contracts contributed to an increase in other income.

***Medical Expense***

Total medical expenses as a percentage of premium revenues, or medical expense ratio (MER), for the 2005 quarter was 83.4%, increasing 70 basis points from 82.7% for the 2004 quarter. The MER was 83.6% for the 2005 period, decreasing 30 basis points from 83.9% for the 2004 period.

The Government segment's MER for the 2005 quarter was 82.5%, increasing 90 basis points from the 2004 quarter of 81.6%, and a decrease of 10 basis points from 83.8% to 83.7% was experienced comparing the 2005 period to the 2004 period. The increase in the 2005 quarter was primarily driven by an unusually low MER in the 2004 quarter resulting from the TRICARE contract transition timing. The decrease in the 2005 period MER primarily was attributable to the increase in Medicare revenues as a percentage of the total revenues. Medicare medical cost trends are expected to increase in the range of 9% to 11% for 2005.

The Commercial segment's MER for the 2005 quarter was 84.4%, increasing 80 basis points from the 2004 quarter of 83.6%, and a decrease of 40 basis points from 83.9% to 83.5% was experienced comparing the 2005 period to the 2004 period. Higher medical expenses from Hurricane Katrina increased the 2005 quarter MER 30 basis points and the 2005 period MER 10 basis points. After considering the effect of Hurricane Katrina, the increase in the 2005 quarter reflects the impact of the competitive pricing environment. The decrease in MER for the 2005 period reflects the absence of the unprofitable 89,000-member large group account that lapsed on January 1, 2005. For the full year 2005, we expect our fully insured commercial medical cost trends to rise in the range of 7% to 9% for our group accounts.

***SG&A Expense***

Total selling, general and administrative, or SG&A, expenses as a percentage of premium revenues and administrative services fees, or SG&A expense ratio, for the 2005 quarter was 16.2%, increasing 160 basis points from the 2004 quarter of 14.6%. For the 2005 period, the SG&A expense ratio was 14.8%, increasing 30 basis points when compared to the 2004 period of 14.5%. Expenses related to the litigation settlement and Hurricane Katrina increased the SG&A expense ratio 200 basis points for the 2005 quarter and 70 basis points for the 2005 period. After considering the effect of the litigation and hurricane expenses, the SG&A expense ratio improvements resulted as the increase in premium revenues outpaced administrative expense trends despite increased spending on new Medicare opportunities. We anticipate our consolidated SG&A expense ratio to be approximately 15% for the full year of 2005, including the impact of our estimated spending for our 2006 Medicare expansion initiatives, and 50 basis points related to litigation and hurricane expenses.

The Government segment SG&A expense ratio increased 70 basis points from 12.5% to 13.2% for the 2005 quarter versus the 2004 quarter. For the 2005 period, the Government segment SG&A expense ratio was 11.6%, decreasing 70 basis points from the 2004 period of 12.3%. Expenses related to the litigation settlement and Hurricane Katrina increased the SG&A expense ratio 170 basis points for the 2005 quarter and 60 basis points for the 2005 period. After considering the effect of the litigation and hurricane expenses, the decrease in the

Government segment SG&A expense ratio was attributable to the transition to the TRICARE South Region contract partially offset by increased spending associated with the 2006 Medicare expansion.

The Commercial segment SG&A expense ratio increased 370 basis points from 16.3% to 20.0% for the 2005 quarter versus the 2004 quarter. For the 2005 period, the Commercial segment SG&A expense ratio was 18.4%, increasing 210 basis points from the 2004 period of 16.3%. Expenses related to the litigation settlement and Hurricane Katrina increased the SG&A expense ratio 230 basis points for the 2005 quarter and 80 basis points for the 2005 period. After considering the effect of the litigation and hurricane expenses, this increase resulted from a mix shift to a greater percentage of ASO members as well as a higher proportion of fixed overhead cost relative to revenues due to a reduction in membership.

Depreciation and amortization for the 2005 quarter totaled $34.1 million compared to $31.2 million for the 2004 quarter, an increase of $2.9 million, or 9.2%. For the 2005 period, depreciation and amortization totaled $95.1 million compared to $84.7 million for the 2004 period, an increase of $10.4 million, or 12.3%. Amortization of other intangible assets increased $4.7 million for the 2005 quarter and $10.8 million for the 2005 period primarily as a result of intangible assets recorded in connection with the CarePlus acquisition.

***Interest Expense***

Interest expense was $10.1 million for the 2005 quarter, compared to $6.5 million for the 2004 quarter, an increase of $3.6 million. For the 2005 period, interest expense was $29.0 million, increasing $12.5 million compared to $16.5 million for the 2004 period. This increase primarily resulted from higher interest rates and higher average outstanding debt. The borrowing of $294 million under our credit agreement to finance the February 16, 2005 CarePlus acquisition increased interest expense $1.2 million during the 2005 quarter and $4.9 million during the 2005 period. The average interest rate during the 2005 period of 5.0% increased 130 basis points compared to 3.7% during the 2004 period.

***Income Taxes***

On an interim basis, the provision for income taxes is provided for at the anticipated effective tax rate for the year. Our effective tax rate for the 2005 quarter was approximately 30.2%, compared to 33.9% for the 2004 quarter. For the 2005 period, the effective tax rate was 24.4%, compared to 34.0% for the 2004 period. The lower effective tax rate for the 2005 quarter primarily was attributable to a higher proportion of tax-exempt investment income to total pretax income due to the litigation and hurricane expenses recorded in the 2005 quarter. The effective tax rate for the 2005 period reflects the favorable impact from the resolution of a contingent gain of $22.8 million during the first quarter of 2005 in connection with the expiration of the statute of limitations on an uncertain tax position related to the 2000 tax year. We expect our effective tax rate will be in the range of 34% to 36% for the fourth quarter of 2005 and in the range of 27% to 28% for the year.

***Membership***

The following table presents our medical and specialty membership at September 30, 2005, June 30, 2005, March 31, 2005, and at the end of each quarter in 2004:

| | 2005 | | | 2004 | | | |
|---|---|---|---|---|---|---|---|
| | Sept. 30 | June 30 | March 31 | Dec. 31 | Sept. 30 | June 30 | March 31 |
| **Medical Membership:** | | | | | | | |
| Government segment: | | | | | | | |
| Medicare Advantage | 503,100 | 474,300 | 449,900 | 377,200 | 371,300 | 367,900 | 333,200 |
| TRICARE | 1,747,100 | 1,733,600 | 1,723,400 | 1,789,400 | 1,138,600 | 1,856,900 | 1,860,100 |
| TRICARE ASO | 1,127,300 | 1,142,800 | 1,148,400 | 1,082,400 | 674,700 | 786,000 | 1,057,900 |
| Medicaid | 459,400 | 477,900 | 477,200 | 478,600 | 475,800 | 466,400 | 468,200 |
| Total Government | 3,836,900 | 3,828,600 | 3,798,900 | 3,727,600 | 2,660,400 | 3,477,200 | 3,719,400 |
| Commercial segment: | | | | | | | |
| Fully insured | 2,007,400 | 2,021,300 | 2,039,300 | 2,286,500 | 2,296,400 | 2,407,700 | 2,298,600 |
| ASO | 1,170,500 | 1,178,400 | 1,180,100 | 1,018,600 | 1,018,800 | 996,700 | 997,000 |
| Total Commercial | 3,177,900 | 3,199,700 | 3,219,400 | 3,305,100 | 3,315,200 | 3,404,400 | 3,295,600 |
| Total medical members | 7,014,800 | 7,028,300 | 7,018,300 | 7,032,700 | 5,975,600 | 6,881,600 | 7,015,000 |
| **Specialty Membership:** | | | | | | | |
| Commercial segment | 1,855,500 | 1,836,100 | 1,824,100 | 1,708,200 | 1,714,300 | 1,691,400 | 1,703,200 |

**Liquidity**

Our primary sources of cash include receipts of premiums, administrative services fees, investment income, and proceeds from the sale or maturity of our investment securities and from borrowings. Our primary uses of cash include disbursements for claims payments, administrative expenses, interest expense, taxes, purchases of investment securities, capital expenditures, and payments on borrowings. Because premiums generally are collected in advance of claim payments by a period of up to several months in many instances, our business should normally produce strong cash flows during a period of increasing enrollment. Conversely, cash flows would be negatively impacted during a period of shrinking enrollment.

Cash and cash equivalents increased to $978.9 million at September 30, 2005 from $580.1 million at December 31, 2004. The change in cash and cash equivalents for the nine months ended September 30, 2005 and 2004 is summarized as follows:

| | 2005 | 2004 |
|---|---|---|
| | (in thousands) | |
| Net cash provided by operating activities | $ 872,124 | $ 328,324 |
| Net cash used in investing activities | (607,626) | (726,404) |
| Net cash provided by (used in) financing activities | 134,359 | (158,234) |
| Increase (decrease) in cash and cash equivalents | $ 398,857 | $(556,314) |

*Cash Flow from Operating Activities*

The comparison of our operating cash flows for the 2005 and 2004 periods were significantly impacted by the timing of the monthly Medicare Advantage premium remittance. We received ten monthly Medicare Advantage premium receipts during the 2005 period compared to only eight premium receipts received during the 2004 period because the January 1, 2004 premium receipt of $211.9 million was received in December 2003 and the October 1, 2005 premium receipt of $384.8 million was received in September 2005.

Other than the impact from the timing of the Medicare Advantage premium receipts, higher earnings contributed to increased operating cash flows during the 2005 period compared to the 2004 period. Comparisons of our operating cash flows also are impacted by changes in our working capital. The most significant drivers of changes in our working capital are typically the timing of receipts for premiums and administrative services fees and payments of medical expenses. We illustrate these changes with the following summary of receivables and medical and other expenses payable.

The detail of total net receivables was as follows at September 30, 2005 and December 31, 2004:

| | September 30, 2005 | December 31, 2004 | Change |
|---|---|---|---|
| | | (in thousands) | |
| TRICARE: | | | |
| Base receivable | $ 479,493 | $ 396,355 | $ 83,138 |
| Bid price adjustments (BPAs) | — | 25,601 | (25,601) |
| Change orders | 17,680 | 6,021 | 11,659 |
| TRICARE subtotal | 497,173 | 427,977 | 69,196 |
| Medicare Advantage | 61,905 | 213 | 61,692 |
| Commercial and other | 185,543 | 185,931 | (388) |
| Allowance for doubtful accounts | (33,481) | (34,506) | 1,025 |
| Total net receivables | $ 711,140 | $ 579,615 | 131,525 |
| Reconciliation to cash flow statement: | | | |
| Receivables from acquisition | | | (2,289) |
| Change in receivables in cash flow statement | | | $129,236 |

The delivery of health care services under the TRICARE South region contract results in (1) a lag between the time the service is provided and the claim is paid by us, generally three months, and (2) a lag between the time the claim is paid by us and ultimately reimbursed by the federal government, generally 15 calendar days. Thus, the claims reimbursement component of TRICARE base receivables is generally collected over a three to four month period.

The $83.1 million increase in TRICARE base receivables primarily resulted from an increase in claims inventory at our third party claims processing vendor during the last week of September 2005. This also resulted in a corresponding increase in the IBNR component of TRICARE's claims payable as discussed below.

The $61.7 million increase in Medicare Advantage receivables resulted from estimating revenues associated with CMS's risk adjustment model. CMS has implemented a risk adjustment model which apportions premiums paid to all health plans, including Humana, according to health severity. This model pays more for enrollees with predictably higher costs. Under this risk adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk adjusted premium payment to us. We collect, capture and submit the necessary diagnosis data to CMS weekly. We estimate risk adjustment revenues based upon the diagnosis data we submitted to CMS. This also resulted in a corresponding increase in the capitation payable to physicians under risk sharing arrangements discussed below.

The detail of medical and other expenses payable was as follows at September 30, 2005 and December 31, 2004:

| | September 30, 2005 | December 31, 2004 | Change |
|---|---|---|---|
| | | (in thousands) | |
| IBNR (1) | $1,359,285 | $1,164,518 | $194,767 |
| Reported claims in process (2) | 54,907 | 97,801 | (42,894) |
| Other medical expenses payable (3) | 403,034 | 159,691 | 243,343 |
| Total medical and other expenses payable | $1,817,226 | $1,422,010 | 395,216 |
| Reconciliation to cash flow statement: | | | |
| Medical and other expenses payable from acquisition | | | (37,375) |
| Change in medical and other expenses payable in cash flow statement | | | $357,841 |

(1) IBNR represents an estimate of medical expenses payable for claims incurred but not reported (IBNR) at the balance sheet date. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling.

(3) Other medical expenses payable includes capitation, risk share, and pharmacy payables. The balance due to our pharmacy benefit administrator fluctuates due to bi-weekly payments and the month-end cutoff.

Medical and other expenses payable primarily increased during the 2005 period due to (1) medical claims inflation, (2) an increase in the TRICARE payable from an increase in claims inventory at our third party claims processing vendor during the last week of September 2005 as discussed above, and (3) an increase in the capitation payable to physicians under risk sharing arrangements.

*Cash Flow from Investing Activities*

During 2005, we paid $444.9 million to acquire CarePlus, net of $92.1 million of cash acquired.

Our ongoing capital expenditures primarily relate to our technology initiatives and administrative facilities necessary for activities such as claims processing, billing and collections, medical utilization review, and customer service. Total capital expenditures, excluding acquisitions, were $112.3 million for the 2005 period and $72.9 million for the 2004 period. The increased spending resulted from our 2006 Medicare expansion initiatives. Excluding acquisitions, we expect our total capital expenditures in 2005 to range between $155 million and $165 million, increasing from the full year 2004 spending of $114.1 million due to our 2006 Medicare expansion initiative.

During the 2004 period, proceeds from the sale of the Jacksonville service center building increased investing cash flows $14.8 million.

*Cash Flow from Financing Activities*

During the 2005 period, we borrowed $294 million under our 5-year $600 million credit agreement to finance the CarePlus acquisition. Since the CarePlus acquisition, we have repaid the $294 million under the credit agreement. The remainder of the cash provided by financing activities in the 2005 and 2004 periods resulted primarily from the change in the book overdraft, the change in the securities lending payable, and proceeds from stock option exercises.

*Long-term Debt*

Long-term debt outstanding was as follows at September 30, 2005 and December 31, 2004:

| | September 30, 2005 | December 31, 2004 |
|---|---|---|
| | (in thousands) | |
| Long-term debt: | | |
| 6.30% senior, unsecured notes due Aug. 1, 2018, net of unamortized discount of $737 at September 30, 2005 and $780 at December 31, 2004 | $ 299,263 | $ 299,220 |
| 7.25% senior, unsecured notes due Aug. 1, 2006, net of unamortized discount of $123 at September 30, 2005 and $231 at December 31, 2004 | 299,877 | 299,769 |
| Fair value of interest rate swap agreements | 7,916 | 17,082 |
| Deferred gain from interest rate swap exchange | 8,718 | 16,338 |
| Total senior notes | 615,774 | 632,409 |
| Credit agreement | — | — |
| Other long-term borrowings | 3,802 | 4,287 |
| Total debt | 619,576 | 636,696 |
| Less: Current portion of long-term debt | 302,366 | — |
| Total long-term debt | $ 317,210 | $ 636,696 |

*Swap Agreements*

In order to hedge the risk of changes in the fair value of our $300 million 6.30% senior notes and our $300 million 7.25% senior notes attributable to fluctuations in interest rates, we entered into interest rate swap agreements. Interest rate swap agreements, which are considered derivatives, are contracts that exchange interest payments on a specified principal amount, or notional amount, for a specified period. The interest rate swap agreements, which have the same critical terms as our 6.30% senior notes and our 7.25% senior notes, are designated fair value hedges. Changes in the fair value of the 6.30% or 7.25% senior notes and the swap agreements due to changing interest rates are assumed to offset each other completely, resulting in no impact to earnings from hedge ineffectiveness. Our swap agreements are recognized in our consolidated balance sheet at fair value with an equal and offsetting adjustment to the carrying value of our senior notes. The fair values of our interest rate swap agreements are estimated based on quoted market prices of comparable agreements, and reflect the amounts we would receive (or pay) to terminate the agreements at the reporting date.

Our interest rate swap agreements exchange the fixed interest rate under our 6.30% and 7.25% senior notes for a variable interest rate based on LIBOR. At September 30, 2005, the effective interest rate was 4.95% for the 6.30% senior notes and 5.79% for the 7.25% senior notes, including the amortization of the deferred swap gain. The $300 million swap agreements for the 6.30% senior notes mature on August 1, 2018, and the $300 million swap agreements for the 7.25% senior notes mature on August 1, 2006, and each has the same critical terms as the related senior notes.

At September 30, 2005, the fair value of our swap agreements related to the 6.30% senior notes was in our favor by $14.1 million and is included in other long-term assets and the fair value of our swap agreements related to the 7.25% senior notes was out of our favor by $6.2 million and is included in other long-term liabilities. Likewise, the carrying value of our senior notes has been increased $7.9 million to reflect their fair value. The counterparties to our swap agreements are major financial institutions with which we also have other financial relationships.

In June 2003, we recorded a deferred gain and received proceeds of $31.6 million in exchange for new swap agreements discussed above related to our 7.25% senior notes. The corresponding deferred swap gain of $31.6 million is being amortized to reduce interest expense over the remaining term of the 7.25% senior notes. Amortization of the deferred swap gain reduced interest expense $2.6 million for the three months ended September 30, 2005 and $2.5 million for the three months ended September 30, 2004. Amortization of the deferred swap gain reduced interest expense $7.6 million for the nine months ended September 30, 2005 and $7.3 million for the nine months ended September 30, 2004.

*Credit Agreement*

The 5-year $600 million unsecured revolving credit agreement expires in September 2009. Under the agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion of the agreement bears interest at either a fixed rate or floating rate based on LIBOR plus a

spread. The spread, which varies depending on our credit ratings, ranges from 50 to 112.5 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 12.5 and 37.5 basis points, depending upon our credit ratings. In addition, a utilization fee of 12.5 basis points is payable for any day in which borrowings under the facility exceed 50% of the total $600 million commitment. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate basis, at our option.

The 5-year $600 million credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of net worth, minimum interest coverage, and maximum leverage ratios. At September 30, 2005, we were in compliance with all applicable financial covenant requirements. The terms of this credit agreement also include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow. We have not experienced a material adverse effect, and we know of no circumstances or events which would be reasonably likely to result in a material adverse effect. We do not believe the material adverse effect clause poses a material funding risk to Humana in the future. We have other relationships, including financial advisory and banking, with some of the parties to the credit agreement.

On February 16, 2005, we borrowed $294.0 million under the credit agreement to finance the CarePlus acquisition. Since the CarePlus transaction, we have repaid the $294.0 million under the credit agreement. In addition, we have outstanding letters of credit of $35.1 million secured under the credit agreement. No amounts have ever been drawn on these letters of credit. As of September 30, 2005, we had $564.9 million of remaining borrowing capacity under the credit agreement.

*Commercial Paper Program*

We maintain and may issue short-term debt securities under a commercial paper program when market conditions allow. The program is backed by our credit agreement described above. Aggregate borrowings under both the credit agreement and commercial paper program generally will not exceed $600 million.

At September 30, 2005, we had no commercial paper borrowings outstanding.

*Other Borrowings*

Other borrowings of $3.8 million at September 30, 2005 represent financing for the renovation of a building, bear interest at 2% per annum, are collateralized by the building, and are payable in various installments through 2014.

*Shelf Registration*

Our universal shelf registration with the Securities and Exchange Commission allows us to register debt or equity securities, from time to time, with the amount, price and terms to be determined at the time of the sale. We have up to $300 million remaining from a total of $600 million under the universal shelf registration. The universal shelf registration allows us to use the net proceeds from any future sales of our securities for our operations and for other general corporate purposes, including repayment or refinancing of borrowings, working capital, capital expenditures, investments, acquisitions, or the repurchase of our outstanding securities.

*Regulatory Requirements*

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

As of September 30, 2005, we maintained aggregate statutory capital and surplus of $1,136.4 million in our state regulated health insurance subsidiaries. Each of these subsidiaries was in compliance with applicable statutory requirements which aggregated $802.2 million. Although the minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Given our anticipated Medicare growth in premium revenues in 2006, we expect additional required capital ranging from $450 million to $650 million in 2006. In addition, most states rely on risk-based capital requirements, or RBC, to define the required levels of equity. RBC is a model developed by the National Association of Insurance Commissioners to monitor an entity's solvency. This calculation indicates recommended minimum levels of required capital and surplus and signals regulatory measures should actual surplus fall below

these recommended levels. If RBC were adopted by all states at September 30, 2005, we would be required to fund $15.2 million in our two Puerto Rico subsidiaries to meet all requirements. After this funding, we would have $288.1 million of aggregate capital and surplus above any of the levels that require corrective action under RBC.

**Cautionary Statements**

This document includes both historical and forward-looking statements. The forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, the information discussed below. In making these statements, we are not undertaking to address or update each factor in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

***If the premiums we charge are insufficient to cover the cost of health care services delivered to our members, or if our estimates of medical claim reserves based upon our estimates of future medical claims are inadequate, our profitability could decline.***

We use a significant portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments, allocations of some centralized expenses and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our medical cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future medical claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record medical claims reserves for future payments. We continually review estimates of future payments relating to medical claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, increases in the use or cost of services by our members, competition, government regulations and many other factors may and often do cause actual health care costs to exceed what was estimated and reflected in premiums.

These factors may include:

- increased use of medical facilities and services, including prescription drugs;
- increased cost of such services;
- the Company's membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- membership in markets lacking adequate provider networks;
- changes in the demographic characteristics of an account or market;
- termination of capitation arrangements resulting in the transfer of membership to fee-for-service arrangements;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- possible changes in our pharmacy rebate program with drug manufacturers;
- catastrophes, including acts of terrorism, epidemics, or severe weather, including the recent hurricanes;
- the introduction of new or costly treatments, including new technologies;
- medical cost inflation; and
- government mandated benefits or other regulatory changes.

Failure to adequately price our products or estimate sufficient medical claim reserves may result in a material adverse effect on our financial position, results of operations and cash flows.

***If we do not design and price our products properly and competitively, our membership and profitability could decline.***

We are in a highly competitive industry. Many of our competitors are more established in the health care industry in terms of a larger market share and greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare Advantage program and in consumer-choice health plans, such as high deductible health plans with Health Savings Accounts ("HSAs"). We believe that barriers to entry in many markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs. The commercial pricing environment, particularly in the 2 to 300 member groups, is extremely competitive, and several of our competitors, including public and not-for-profit companies, are pricing aggressively to gain market share.

Premium increases, introduction of new product designs, and our relationship with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include the possible exit of or entrance to Medicare Advantage or Commercial markets.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, or if it declines, or if we lose accounts with favorable medical cost experience while retaining or increasing membership in accounts with unfavorable medical cost experience, our business and results of operations could be materially adversely affected.

***If we fail to effectively implement our operational and strategic initiatives, our business could be materially adversely affected.***

Our future performance depends in large part upon our management team's ability to execute our strategy to position the Company for the future. This strategy includes opportunities created with the new Medicare Advantage products. In December 2003, the Medicare Modernization Act, or MMA, was signed into law. We believe MMA offers new opportunities in our Medicare programs, including our HMO, PPO, Prescription Drug Coverage (PDP) and Private Fee-For-Service products. We have made additional investments in the Medicare Advantage program to enhance our ability to participate in these expanded programs. We have announced plans to double the size of our Medicare geographic reach through expanded Medicare Advantage product offerings. We intend to offer both the stand-alone Medicare Prescription Drug Coverage (PDP) and Medicare Advantage Health Plan with Prescription Drug Coverage (MA-PD) in addition to our current product offerings. Our current Medicare presence today includes 503,100 members in 12 HMO markets, 33 local PPO markets, and 35 states in which we have a private fee-for-service offering. Enrollment in the new Part D prescription drug plans will begin on November 15, 2005, with the plans becoming effective January 1, 2006. We have been approved to offer the Medicare prescription drug plan in 46 states and the District of Columbia.

Additionally, our strategy includes the growth of our Commercial segment business, with emphasis on our ASO and individual products, introduction of new products and benefit designs, including our Smart, consumer-choice products such as Health Savings Accounts (HSAs) as well as the adoption of new technologies and the integration of acquired businesses and contracts. We believe that by combining our abilities in product design, clinical programs and consumer engagement, we can achieve cost savings for our customers and our company.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives that are intended to position the Company for future growth or that the products we design will be accepted. Failure to implement this strategy may result in a material adverse effect on our financial position, results of operations and cash flows.

***If we fail to properly maintain the integrity of our data, or to strategically implement new information systems, or to protect our proprietary rights to our systems, our business could be materially adversely affected.***

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use

products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. We are in the process of changing vendors in our pharmacy benefits program. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which could adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our process of improving existing systems, developing new systems to support our operations, integrating new systems, protecting our proprietary information, and improving service levels will not be delayed or that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data may result in a material adverse effect on our financial positions, results of operations and cash flows.

***We are involved in various legal actions, which, if resolved unfavorably to us, could result in substantial monetary damages.***

We are a party to a variety of legal actions that affect our business, including employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for our providers' alleged malpractice;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts;
- disputes related to self-funded business, including actions alleging claim administration errors;
- claims related to the failure to disclose some business practices; and
- claims relating to customer audits and contract performance.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, RICO and other statutes may be sought. While 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. Additionally, the cost of business insurance coverage has increased significantly. As a result, we have increased the amount of risk that we self-insure, particularly with respect to matters incidental to our business. We believe that we are adequately insured for claims in excess of our self-insurance. However, some types of damages, like punitive damages, may not be covered by insurance, particularly in those jurisdictions in which coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

A description of material legal actions in which we are currently involved is included under "Legal Proceedings" in Note 9 to the condensed consolidated financial statements. We cannot predict the outcome of these suits with certainty, and we are incurring expenses in the defense of these matters. Therefore, these legal actions could have a material adverse effect on our financial position, results of operations and cash flows.

***As a government contractor, we are exposed to additional risks that could adversely affect our business or our willingness to participate in government health care programs.***

A significant portion of our revenues relates to federal and state government health care coverage programs, including the TRICARE, Medicare Advantage, and Medicaid programs. These programs involve various risks, including:

- at September 30, 2005, under our contracts with the Centers for Medicare and Medicaid Services, or CMS, we provided health insurance coverage to approximately 290,900 members in Florida. These contracts accounted for approximately 20% of our total premiums and ASO fees for the nine months ended September 30, 2005. The loss of these and other CMS contracts or significant changes in the Medicare Advantage program as a result of legislative or administrative action, including reductions in payments to us or increases in benefits to members without corresponding increases in payments, may have a material adverse effect on our financial condition, results of operations and cash flows;
- at September 30, 2005, our TRICARE business, which accounted for approximately 18% of our total premiums and ASO fees during the nine months ended September 30, 2005, primarily consisted of the South Region contract. The South Region contract is a five-year contract, subject to annual renewals at the Government's option that covers approximately 2.9 million beneficiaries. This contract also is generally subject to frequent change from events and circumstances such as the escalated conflict in the Middle East. These changes may include a reduction or increase in the number of persons enrolled or eligible to enroll, in the revenue we receive or in our administrative or health care costs. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs could have a material adverse effect on our business. The loss of our current TRICARE contract would have a material adverse effect on our financial position, results of operations and cash flows;
- at September 30, 2005, under our contract with the Puerto Rico Health Insurance Administration, we provided health insurance coverage to approximately 396,100 Medicaid members in Puerto Rico. This contract, accounted for approximately 3% of our total premiums and ASO fees for the nine months ended September 30, 2005. We currently have Medicaid contracts with the Puerto Rico Health Insurance Administration that were scheduled to expire on June 30, 2005. We currently are negotiating the terms of a contract amendment that will extend the contract until June 30, 2006. The government of Puerto Rico has indicated that it must consider the impact of the new Medicare legislation on the Medicaid contract in order to complete the arrangements for 2006. The loss of this contract or significant changes in the Puerto Rico Medicaid program as a result of legislative or administrative action, including reductions in payments to us or increases in benefits to members without corresponding increases in payments, may have a material adverse effect on our financial condition, results of operations and cash flows;
- the possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act;
- CMS has implemented a risk adjustment model which apportions premiums paid to Medicare health plans according to health severity. A risk adjustment model thus pays more for enrollees with predictably higher costs. Under the new risk adjustment methodology, Humana and all Medicare health plans must collect, capture and submit the necessary diagnosis code information to CMS at least twice a year. The CMS risk

adjustment model uses the diagnosis data from inpatient and ambulatory treatment settings to calculate the risk adjusted premium payment to Medicare health plans. The risk adjustment model is being phased in. The portion of the risk adjusted payment was increased from 10% in 2003 to 30% in 2004. The portion of risk adjusted payment for 2005 is 50%, increasing to 75% in 2006 and 100% beginning in 2007. As a result of the CMS payment methodology described above, the amount and timing of our CMS monthly premium payments per member may change materially, either favorably or unfavorably;

- changes to these government programs in the future may also affect our ability or willingness to participate in these programs;
- higher comparative medical costs;
- government regulatory and reporting requirements; and
- higher marketing and advertising costs per member as a result of marketing to individuals as opposed to groups.

***Our industry is currently subject to substantial government regulation, which, along with possible increased governmental regulation or legislative reform, increases our costs of doing business and could adversely affect our profitability.***

The health care industry in general, and health insurance, particularly health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs, are subject to substantial federal and state government regulation, including:

- regulation relating to minimum net worth;
- licensing requirements;
- privacy issues;
- approval of policy language and benefits;
- mandated benefits and processes;
- provider compensation arrangements;
- approval of entry, withdrawal or re-entry into a state or market;
- premium rates; and
- periodic examinations by state and federal agencies.

State regulations require our licensed, operating subsidiaries to maintain minimum net worth requirements and restrict some investment activities. Additionally, those regulations may restrict the ability of our subsidiaries to make dividend payments, loans, loan repayments or other payments to us.

In recent years, significant federal and state legislation affecting our business has been enacted. State and federal governmental authorities are continually considering changes to laws and regulations applicable to us and are currently considering regulations relating to:

- rules tightening time periods in which claims must be paid;
- medical malpractice reform;
- health insurance access and affordability;
- e-connectivity;
- disclosure of provider fee schedules and other data about payments to providers, sometimes called transparency;
- product flexibility and use of innovative technology;
- disclosure of provider quality information;
- health plan liability to members who fail to receive appropriate care;
- disclosure and composition of physician networks;

- formation of regional/national association health plans for small employers; and
- mental health parity.

All of these proposals could apply to us.

There can be no assurance that we will be able to continue to obtain or maintain required governmental approvals or licenses or that legislative or regulatory change will not have a material adverse effect on our business. Delays in obtaining or failure to obtain or maintain required approvals could adversely affect entry into new markets, our revenues or the number of our members, increase costs or adversely affect our ability to bring new products to market as forecasted.

The National Association of Insurance Commissioners, or NAIC, has adopted risk-based capital requirements, also known as RBC, which is subject to state-by-state adoption and to the extent implemented, sets minimum capitalization requirements for insurance and HMO companies. The NAIC recommendations for life insurance companies were adopted in all states and the prescribed calculation for HMOs has been adopted in most states in which we operate. The HMO rules may increase the minimum capital required for some of our subsidiaries.

The use of individually identifiable data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers and seeking protections for confidentiality and security of patient data.

Regulations issued in February 2003 set standards for the security of electronic health information. Violations of these rules will subject us to significant penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. The final rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent. HIPAA could also expose us to additional liability for violations by our business associates.

Another area receiving increased focus is the time in which various laws require the payment of health care claims. Many states already have legislation in place covering payment of claims within a specific number of days. However, due to provider groups advocating for laws or regulations establishing even stricter standards, procedures and penalties, we expect additional regulatory scrutiny and supplemental legislation with respect to claims payment practices. The provider-sponsored bills are characterized by stiff penalties for late payment, including high interest rates payable to providers and costly fines levied by state insurance departments and attorneys general. This legislation and possible future regulation and oversight could expose our Company to additional liability and penalties.

We are also subject to various governmental audits and investigations. These can include audits and investigations by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, the Defense Contract Audit Agency, and state Departments of Insurance and Departments of Health. Several Attorneys General are currently investigating the practices of insurance brokers, including those of certain of the companies in the health care industry. All of these activities could result in the loss of licensure or the right to participate in various programs, or the imposition of fines, penalties and other sanctions. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

***Our ability to manage administrative costs could hamper profitability***

The level of our administrative expenses can affect our profitability. While we attempt to effectively manage such expenses, increases in staff-related expenses, investment in new products, greater emphasis on small group and individual health insurance products, acquisitions, and implementation of regulatory requirements, among others, may occur from time to time.

There can be no assurance that we will be able to successfully contain our administrative expenses in line with our membership which may result in a material adverse effect on our financial position, results of operations and cash flows.

***If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business could be adversely affected.***

We contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. These providers may share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may, in some cases, compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be adversely affected.

In some situations, we have contracts with individual or groups of primary care physicians for an actuarially determined, fixed, per-member-per-month fee under which physicians are paid an amount to provide all required medical services to our members (i.e. capitation). The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us, even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have an adverse effect on the provision of services to our members and our operations.

***If we fail to manage prescription drug costs successfully, our financial results could suffer.***

In general, prescription drug costs have been rapidly rising over the past few years. These increases are due to the introduction of new drugs costing significantly more than existing drugs, direct to consumer advertising by the pharmaceutical industry that creates consumer demand for particular brand-name drugs, and members seeking medications to address lifestyle changes. In order to control prescription drug costs, we have implemented multi-tiered copayment benefit designs for prescription drugs, including our four-tiered copayment benefit design, Rx4 and an Rx allowance program organized by evidence based impact. We cannot assure that these efforts will be successful in controlling costs. Failure to control these costs could have a material adverse effect on our financial position, results of operations and cash flows.

***Our ability to obtain funds from our subsidiaries is restricted.***

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., the parent company. These subsidiaries generally are regulated by states' Departments of Insurance. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depends primarily upon the volume of premium generated. A significant increase in premium volume will require additional capitalization from Humana Inc. We anticipate additional required capital ranging from $450 million to $650 million in 2006. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts, or, in some states, any amount. In addition, we normally notify the state Departments of Insurance prior to making payments that do not require approval.

***Debt ratings are an important factor in our competitive position.***

Claims paying ability, financial strength, and debt ratings by recognized rating organizations have become an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers, and our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect

each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such. Downgrades in our ratings, should they occur, may adversely affect our business, financial condition and results of operations.

***Increased litigation and negative publicity could increase our cost of doing business.***

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation and governmental review of industry practices. These factors may adversely affect our ability to market our products or services, may require us to change our products or services, may increase the regulatory burdens under which we operate and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

**Item 3. Quantitative and Qualitative Disclosure about Market Risk**

No material changes have occurred in our exposures to market risk since the date of our Annual Report on Form 10-K for the fiscal year ended December 31, 2004.

**Item 4. Controls and Procedures**

Under the supervision and with the participation of our Chief Executive Officer, or CEO, our Chief Financial Officer, or CFO, and our principal accounting officer, we carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures for the quarter ended September 30, 2005.

Based on our evaluation, our CEO, CFO and principal accounting officer concluded that our disclosure controls and procedures are effective, with reasonable assurance, in timely alerting them to material information required to be included in our periodic Securities and Exchange Commission reports.

As permitted by the SEC, our evaluation did not include the disclosure controls and procedures of the acquired operations of CarePlus Health Plans of Florida (CarePlus), which is included in the Company's consolidated financial statements as of September 30, 2005 and for the period from February 17, 2005 through September 30, 2005. Consolidated operations of CarePlus constituted approximately $653.9 million, or 10% of the Company's total assets as of September 30, 2005, and approximately $353.1 million, or 3% of the Company's revenues for the period from February 17, 2005 through September 30, 2005.

Changes to certain financial processes, information technology systems, and other components of internal control over financial reporting in regards to the February 2005 acquisition of CarePlus may occur and will be evaluated by management as such integration activities are implemented. Other than the acquisition described above, there has been no change in the Company's internal control over financial reporting that occurred during the Company's last fiscal quarter that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

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**Part II. Other Information**

Item 1: Legal Proceedings
For a description of the litigation and legal proceedings pending against us, see "Legal Proceedings" in Note 9 to the condensed financial statements beginning on page 14 of this Form 10-Q.

Item 2: Unregistered Sales of Equity Securities and Use of Proceeds
None.

Item 3: Defaults Upon Senior Securities
None.

Item 4: Submission of Matters to a Vote of Security Holders
None.

Item 5: Other Information
None.

Item 6: Exhibits

10.1 Form of CMS Coordinated Care Plan Agreement

10.2 Form of CMS Private Fee for Service Agreement

10.3 Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan

10.4 Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan

10.5 Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan

10.6 Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan

12 Computation of ratio of earnings to fixed charges.

31.1 CEO certification pursuant to Section 302 of Sarbanes–Oxley Act of 2002.

31.2 CFO certification pursuant to Section 302 of Sarbanes–Oxley Act of 2002.

32 CEO and CFO certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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SIGNATURES

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

HUMANA INC.
(Registrant)

Date: November 7, 2005 By: /S/ STEVEN E. MCCULLEY
Steven E. McCulley
Vice President and Controller
(Principal Accounting Officer)

Date: November 7, 2005 By: /S/ ARTHUR P. HIPWELL
Arthur P. Hipwell
Senior Vice President and
General Counsel

**Exhibit 10.1**

**Explanatory Note regarding Medicare Contracts between Humana and CMS**

Recently, various subsidiaries of Humana Inc. and the Centers for Medicaid and Medicare Services entered into some 28 separate contracts that allow Humana to provide Medicare services under 42 CFR Part 422. In each case, the relevant contract designates the participating Humana entity as a Medicare Advantage Organization ("MA"). One form of contract provides for the operation of one of three kinds of coordinated care plans (health maintenance organization ("HMO"), regional preferred provider organization ("RPPO"), or local preferred provider organization ("LPPO")). Exhibit 10.1 is the form of coordinated care contract. Twenty-four of the 28 Humana/CMS agreements are coordinated care agreements.

Exhibits 10.3, 10.4 and 10.5 are forms of addenda to the base contract which provide more specificity as to the types of services offered. Exhibit 10.3 provides for the operation of a Medicare Prescription Drug Plan; Exhibit 10.4 provides for the operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan; and Exhibit 10.5 provides for the operation of an Employer/Union-only Group Medicare Advantage Health Plan. Exhibit 10.6 is another form of addendum that allows for the operation of a regional PPO plan. Exhibit 10.6 is relevant to only one contract, R5286

The following chart summarizes the 24 individual contracts by type and entity:

| Contract | Participating Humana Entity | Product | Applicable Addenda |
|---|---|---|---|
| 1. R5286 | Humana Insurance Company | RPPO | 10.3, 10.4, 10.5, 10.6 |
| 2. H4520 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 3. H0317 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 4. H1418 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 5. H1716 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 6. H1806 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 7. H3619 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 8. H5214 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 9. H0623 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 10. H4408 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 11. H5216 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 12. H4606 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 13. H3405 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 14. H1510 | Humana Insurance Company | LPPO | 10.3, 10.4, 10.5 |
| 15. H5415 | HHIC of Florida | LPPO | 10.3, 10.4, 10.5 |
| 16. H1905 | HHBP of Louisiana | LPPO | 10.3, 10.4, 10.5 |
| 17. H1019 | CarePlus Health Plans | HMO | 10.3 |
| 18. H0307 | Humana Health Plan | HMO | 10.3, 10.4, 10.5 |
| 19. H1406 | Humana Health Plan | HMO | 10.3, 10.4, 10.5 |
| 20. H2649 | Humana Health Plan | HMO | 10.3, 10.4, 10.5 |
| 21. H1951 | HHBP of Louisiana | HMO | 10.3, 10.4, 10.5 |
| 22. H1036 | Humana Medical Plan | HMO | 10.3, 10.4, 10.5 |
| 23. H4510 | HHP of Texas | HMO | 10.3, 10.4, 10.5 |
| 24. H4007 | HHP of Puerto Rico | HMO | 10.3, 10.4, 10.5 |

Contract with Eligible Medicare Advantage (MA) Organization Pursuant to
Sections 1851 through 1859 of the Social Security Act for the Operation
of a Medicare Advantage Coordinated Care Plan(s)

CONTRACT (#_____ )

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

_____
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR 422.503, agree to the following for the purposes of sections 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

**You must check off AND initial each required Addendum type to reflect the coverage offered under the H (or R) number associated with this contract**

| Addendum Type | Initials |
|---|---|
| ☐ **Part D Addendum** | _____ |
| ☐ **Employer-Only MA-PD Addendum (800 Series)** | _____ |
| ☐ **Employer-Only MA Only Addendum (800 Series)** | _____ |
| ☐ **Variances/Waivers (Provided directly to Demonstration Organizations by CMS)** | _____ |
| ☐ **Regional Preferred Provider Organization Addendum (Provided directly to RPPOs by CMS)** | _____ |

Article I

Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2006, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR 422.505(c) and as discussed in Paragraph A in Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D also must execute an Addendum to the Medicare Managed Care Contract Pursuant to Sections 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II

Coordinated Care Plan

A. The Medicare Advantage Organization agrees to operate one or more coordinated care plans as defined in 42 CFR 422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies.

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

Article III

Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under §422.101 and, to the extent applicable, supplemental benefits under §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as

required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a skilled nursing home facility according to the requirements of section 1852(l) of the Act and §422.133. A skilled nursing home facility is a facility in which an MA enrollee resided at the time of admission to the hospital, a facility that provides services through a continuing care retirement community, a facility in which the spouse of the enrollee is residing at the time of the enrollee's discharge from the hospital, or hospital, or wherever the enrollee resides immediately before admission for extended care services. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422.

2. The MA Organization shall comply with the provisions of §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in subpart M of part 422, governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this section, CMS may provide—

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with Section 1852(e) of the Social Security Act and 42 CFR 422.152.

2. Chronic Care Improvement Program

(a) Each MA organization (other than MA private-fee-for-service plans) must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review

The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and §422.118, the anti-discrimination requirements of §1852(b) of the Act and §422.110, the access to services requirements of §1852(d) of the Act and §422.112, and the advance directives requirements of §1852(i) of the Act and §422.128, the

provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart F, and the applicable requirements described in §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR 422.80(b) and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with §422.80. The file and use process set out at §422.80(a)(2) must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR 422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation Section 1851(h) of the Act

and 42 CFR §§422.80, 422.111 and 423.50. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV

CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. Methodology. CMS agrees to pay the MA Organization under this contract in accordance with the provisions of section 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. Attestation of payment data (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis. (NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to (based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must similarly attest to (*based on best knowledge, information, and belief, as of the date specified on the attestation form*) the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (which is attached hereto requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of

one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.502(l)]**

## Article V

## MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

(2) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

(1) Enrollee protection provisions that provide—

(a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III(C), provision for the continuation of benefits.

(2) Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.

(3) A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

(1) Written arrangements must specify delegated activities and reporting responsibilities.

(2) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

(3) Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

(4) Written arrangements must specify that either—

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

(5) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

(1) Agrees that any physician incentive plan it operates meets the requirements of §422.208, and

(2) Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with §422.208(f). **[422.208]**

Article VI

Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and six prior periods.

(iii) Federal income tax or informational returns for the current contract period and six prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means —

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.502(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in paragraph (2)(a)(v) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty-five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty-five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (2)(a)(iv) must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in paragraph (2)(a)(v) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities.

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.502(f)(1)(ii)]**

(c) Patterns of utilization of the MA Organization's services.

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(e) Information about beneficiary appeals and their disposition;

(f) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(g) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.502(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under §422.64 and, upon an enrollee's, request, the financial disclosure information required under §422.516. **[422.502(f)(3)]**

5. Reporting and disclosure under ERISA.

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

Article VII

Renewal of the MA Contract

A. Renewal of contract: In accordance with §422.505, following the initial contract period, this contract is renewable annually only if-

(1) The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

(2) CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

(3) CMS informs the MA Organization that it authorizes a renewal.

B. Nonrenewal of contract

(1) Nonrenewal by the Organization.

(a) In accordance with §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in subparagraphs (b) and (c) of this paragraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to §422.506

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a CMS-approved notice in one or more newspapers of general circulation in each community located in the MA Organization's service area.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if —

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) and (1)(b)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under subparagraph (1), CMS will not enter into a contract with the Organization for 2 years from the date of contract separation unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

(2) CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) The MA Organization's level of enrollment, growth in enrollment, or insufficient number of contracted providers is determined by CMS to threaten the viability of the organization under the MA program and or be an indicator of beneficiary dissatisfaction with the MA plan(s) offered by the organization.

(ii) For any of the reasons listed in §422.510(a) [Article VIII, section (B)(1)(a) of this contract], which would also permit CMS to terminate the contract.

(iii) The MA Organization has committed any of the acts in §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iv) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by May 1 of the contract year, except in the event of (2)(a)(iv) above, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) To the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with § 422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in section (A)(2) of this Article, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in section B(2)(b)(ii) and B(2)(b)(iii) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in section B of this article. **[422.508(b)]**

B. Termination of the Contract by CMS or the MA Organization

1. Termination by CMS.

(a) CMS may terminate a contract for any of the following reasons:

(i) The MA Organization has failed substantially to carry out the terms of its contract with CMS.

(ii) The MA Organization is carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of 42 CFR Part 422.

(iii) CMS determines that the MA Organization no longer meets the requirements of 42 CFR Part 422 for being a contracting organization.

(iv) There is credible evidence that the MA Organization committed or participated in false, fraudulent or abusive activities affecting the Medicare program, including submission of false or fraudulent data.

(v) The MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) The MA Organization substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) The MA Organization fails to provide CMS with valid risk adjustment data as required under §422.310 and 423.329(b)(3).

(viii) The MA Organization fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) The MA Organization substantially fails to comply with the prompt payment requirements in §422.520.

(x) The MA Organization substantially fails to comply with the service access requirements in §422.112.

(xi) The MA Organization fails to comply with the requirements of §422.208 regarding physician incentive plans.

(xii) The MA Organization substantially fails to comply with the marketing requirements in 422.80.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in section (B)(1)(a) above, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Immediate termination of contract by CMS.

(i) For terminations based on violations prescribed in paragraph (B)(1)(a)(v) of this article, CMS will notify the MA Organization in writing that its contract has been terminated effective the date of the termination decision by CMS. If termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before terminating a contract for reasons other than the grounds specified in section (B)(1)(a)(v) of this article, CMS will provide the MA Organization with reasonable opportunity, not to exceed time frames specified at 42 CFR Part 422 Subpart N, to develop and receive CMS approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exception. If a contract is terminated under section (B)(1)(a)(v) of this article, the MA Organization will not have the opportunity to submit a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX

Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC 3729 et seq.) , and the anti-kickback statute (section 1128B(b) of the Act): and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. **[422.504(h)]**

B. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

C. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X

Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI

Miscellaneous

A. Definitions. Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. Alteration to Original Contract Terms. The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. Approval to Begin Marketing and Enrollment. The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. Incorporation of Applicable Addenda. All addenda checked off and initialed on the cover sheet of this contract by the MA Organization are hereby incorporated by reference.

In witness whereof, the parties hereby execute this contract.

FOR THE MA ORGANIZATION

| | |
|---|---|
| Stefen F. Brueckner | Vice President, Senior Products |
| Printed Name | Title |
| /s/ Stefen F. Brueckner | September-October, 2005 |
| Signature | Date |
| (See Chart) | |
| Organization | Address |

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

| | |
|---|---|
| /s/ David Lewis | September-October, 2005 |
| **Patricia P. Smith**<br>**Director** | Date |

Medicare Advantage Group
Center for Beneficiary Choices

**Exhibit 10.2**

**Explanatory Note regarding Medicare Contracts between Humana and CMS**

Recently, various subsidiaries of Humana Inc. and the Centers for Medicaid and Medicare Services entered into some 28 separate contracts that allow Humana to provide Medicare services under 42 CFR Part 422. In each case, the relevant contract designates the participating Humana entity as a Medicare Advantage Organization ("MA"). One form of contract is for private fee-for-service plans ("PFFS"). Exhibit 10.2 is the form of PFFS contract. Four of the 28 Humana/CMS agreements are PFFS agreements.

Exhibits 10.3, 10.4 and 10.5 are forms of amendment to the base contract which provide more specificity as to the types of services offered. Exhibit 10.3 provides for the operation of a Medicare Prescription Drug Plan; Exhibit 10.4 provides for the operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan; and Exhibit 10.5 provides for the operation of an Employer/Union-only Group Medicare Advantage Health Plan.

The following chart summarizes the 4 individual contracts by type and entity:

| Contract | Humana Entity | Product | Amendments |
|---|---|---|---|
| 1. H1407 | Humana Insurance Company | PFFS | 10.3 |
| 2. H1804 | Humana Insurance Company | PFFS | 10.3, 10.4, 10.5 |
| 3. H4008 | Humana Insurance of Puerto Rico | PFFS | 10.3, 10.4, 10.5 |
| 4. H1906 | HHBP of Louisiana | PFFS | 10.3, 10.4, 10.5 |

Contract with Eligible Medicare Advantage Organization Pursuant to
Sections 1851 through 1859 of the Social Security Act for the Operation
of a Medicare Advantage Private Fee-For-Service Plan(s)

CONTRACT (#H_____)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

_____
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR 422.503, agree to the following for the purposes of sections 1851 through 1859 the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

**You must check off AND initial each required Addendum type to reflect the coverage offered under the H (or R) number associated with this contract**

| Addendum Type | Initials |
|---|---|
| ☐ **Part D Addendum** | _____ |
| ☐ **Employer-Only MA-PD Addendum (800 Series)** | _____ |
| ☐ **Employer-Only MA Only Addendum (800 Series)** | _____ |
| ☐ **Variances/Waivers (Provided directly to Demonstration Organizations by CMS)** | _____ |

Article I

Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2006, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR 422.505(c). **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to Sections 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II

Private Fee-For-Service Plan

A. The MA Organization agrees to operate one or more private fee-for-service plans (as defined in 42 CFR 422.4(a)(3)), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies.

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C.CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

Article III

Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under §422.101 and, to the extent applicable, supplemental benefits under §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in The MA Organization Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in §422.114. The MA Organization agrees to

provide post-hospital extended care services, should an MA enrollee elect such coverage, through a skilled nursing facility according to the requirements of section 1852(l) of the Act and §422.133. A home skilled nursing facility is a facility in which an MA enrollee resided at the time of admission to the hospital, a facility that provides services through a continuing care retirement community, or a facility in which the spouse of the enrollee is residing at the time of the enrollee's discharge from the hospital, or hospital, or wherever the enrollee resides immediately before admission for extended care services. **[422.133; 422.504(a)(3)]**

2. The MA Organization shall authorize benefits according to the local medical review policies (LMRPs) for services provided in geographic areas where the LMRPs represent an expansion of Medicare coverage policies as compared to national Medicare coverage policies. **[422.101(b)(2)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422.

2. The MA Organization shall comply with the provisions of §422.110 concerning prohibitions against discrimination in beneficiary enrollment. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in subpart M of part 422 governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in §422.118.

3. Beneficiary Financial Protection. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual (including deemed contracts under §422.216) or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. This provision does not apply to providers operating under deemed contracts under §422.216. **[422.504(g)(1)]**

(iii) Ensure that in the MA Organization's terms and conditions of payment to hospitals, if balance billing is imposed, the hospitals are obligated to provide notice to enrollees of their potential liability for services where balance billing could amount to not less than $500. This notice shall be provided according to the requirements of §422.216(d)(2).

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of a MA PFFS plan or are for claims for services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts, deemed contracts, or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this section, CMS may provide—

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

3. Payment Rates:

(a) The MA Organization shall make payments to providers according to the requirements of §422.114.

(b) CMS and the MA Organization shall reach agreement, on or before the effective date of this contract, on provider payment methodologies, which shall include provider payment proxies, also described as estimated Original Medicare payment amounts.

(c) The MA Organization agrees to implement revised provider payment schedules on the same date that such changes are required of contractors administering the Original Medicare benefit.

(d) The MA Organization agrees that it shall revise its provider payment schedule to reflect the requirements of legislative or regulatory changes made during the term of this contract. Also, the MA Organization agrees that CMS may require the MA Organization to revise its provider payment schedule if CMS determines that the existing schedule does not comply with the provisions of §422.114(a)(2). **[422.114]**

(e) The MA Organization agrees that it shall establish and maintain a payment appeal system under which MA plan providers may have their payment claims reviewed in the event that the provider believes he was paid less than he would have been paid under Original Medicare. Under such a system, if a provider reasonably demonstrates that they have not received proper payment, the MA Organization shall pay the provider the difference between what the provider had received and what he would have received under Original Medicare.

(f) The MA Organization agrees to make its provider payment schedule available to the public in such a manner as to allow providers a reasonable opportunity to be informed about payment methodologies under the MA plan. This includes posting the schedule on a Web site maintained by the Organization.

E. QUALITY REQUIREMENTS

The MA Organization agrees to comply with quality requirements as described in §422.152(f).

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION: CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and §422.118, the anti-discrimination requirements of §1852(b) of the Act and §422.110, the access to services requirements of §1852(d) of the Act and §422.112, the advance directives requirements of §1852(i) of the Act and §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart F, and the applicable requirements described in §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In

providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR 422.80(b) and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with §422.80. The file and use process set out at §422.80(a)(2) must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR 422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation Section 1851(h) of the Act and 42 CFR §§422.80, 422.111 and 423.50. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

## Article IV

## CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. Methodology. CMS agrees to pay the MA Organization under this contract in accordance with the provisions of section 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. Attestation of payment data (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), or chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) hereto which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

1. Attachment A requires that the CEO, or CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis. (NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

2. Attachment B requires that the CEO, or CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to (based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must similarly *attest to* (*based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (which is attached hereto) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.502(l)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. All references to "contracts" and "contractors" in this Article shall include deemed contracts (where applicable) and deemed contract providers (where applicable) as defined in §422.216(f).

B. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

C. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

D. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III(C), provision for the continuation of benefits.

2. Accountability provisions that indicate that—

(a) The MA Organization oversees and is accountable to CMS for any functions or responsibilities that are described in these standards; and

(b) The MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.

3. A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS. **[422.504(i)(3)]**

E. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Written arrangements must specify delegated activities and reporting responsibilities.

2. Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Written arrangements must specify that either—

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The provider verification process will be reviewed and approved by the MA Organization and the MA Organization must audit the provider verification process on an ongoing basis. The provider verification process will consist, at a minimum, of ensuring that providers have a state license to operate and be eligible for payment by Medicare.

5. All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

F. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

## Article VI

## Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means —

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor (including deemed contract providers as defined in §422.216(f)), subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.502(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in paragraph (2)(a)(v) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty-five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty-five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (2)(a)(iv) must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in paragraph (2)(a)(v) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities.

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.502(f)(1)(ii)]**

(c) Patterns of utilization of the MA Organization's services.

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(e) Information about beneficiary appeals and their disposition;

(f) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(g) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.502(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under §422.64 and, upon an enrollee's, request, the financial disclosure information required under §422.516. **[422.502(f)(3)]**

5. Reporting and disclosure under ERISA.

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

## Article VII

## Renewal of the MA Contract

A. Renewal of contract: In accordance with §422.505, following the initial contract period, this contract is renewable annually only if-

(1) The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

(2) CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422 Subpart F; and **[422.505(d)]**

(3) CMS informs the MA Organization that it authorizes a renewal.

B. Nonrenewal of contract

(1) Nonrenewal by the Organization.

(a) In accordance with §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in subparagraphs (b) and (c) of this paragraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to §422.506;

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a CMS-approved notice in one or more newspapers of general circulation in each community located in the MA Organization's service area.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if —

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) and (1)(b)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under subparagraph (1), CMS will not enter into an MA contract with the Organization for 2 years from the date of contract separation unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

(2) CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) The MA Organization's level of enrollment, growth in enrollment, or insufficient number of contracted providers is determined by CMS to threaten the viability of the organization under the MA program and or be an indicator of beneficiary dissatisfaction with the MA plan(s) offered by the organization.

(ii) For any of the reasons listed in §422.510(a) [Article VIII, section (B)(1)(a) of this contract], which would also permit CMS to terminate the contract.

(iii) The MA Organization has committed any of the acts in §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iv) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable.

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by May 1 of the contract year, except in the event of (2)(a)(iv) above, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) To the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with §422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in section (A)(2) of this Article, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in section B(2)(b)(ii) and B(2)(b)(iii) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in section B of this article. **[422.508(b)]**

B. Termination of the Contract by CMS or the MA Organization

1. Termination by CMS.

(a) CMS may terminate a contract for any of the following reasons:

(i) The MA Organization has failed substantially to carry out the terms of its contract with CMS.

(ii) The MA Organization is carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of 42 CFR Part 422.

(iii) CMS determines that the MA Organization no longer meets the requirements of 42 CFR Part 422 for being a contracting organization.

(iv) There is credible evidence that the MA Organization committed or participated in false, fraudulent or abusive activities affecting the Medicare program, including submission of false or fraudulent data.

(v) The MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) The MA Organization substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) The MA Organization fails to provide CMS with valid risk adjustment data as required under §422.310 and 423.329(b)(3).

(viii) The MA Organization substantially fails to comply with the prompt payment requirements in §422.520.

(ix) The MA Organization substantially fails to comply with the service access requirements in §422.114.

(x) The MA Organization fails to comply with the requirements of §422.208 regarding physician incentive plans.

(xi) The MA Organization substantially fails to comply with the marketing requirements in §422.80.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in section (B)(1)(a) above, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Immediate termination of contract by CMS.

(i) For terminations based on violations prescribed in paragraph (B)(1)(a)(v) of this article, CMS will notify the MA Organization in writing that its contract has been terminated effective the date of the termination decision by CMS. If termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before terminating a contract for reasons other than the grounds specified in section (B)(1)(a)(v) of this article, CMS will provide the MA Organization with reasonable opportunity, not to exceed time frames specified at 42 CFR Part 422 Subpart N, to develop and receive CMS approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exception. If a contract is terminated under section (B)(1)(a)(v) of this article, the MA Organization will not have the opportunity to submit a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

## Article IX

## Restrictions on Use of Data

The MA Organization agrees that its use of the data it is authorized to collect to carry out the terms of this contract shall be used exclusively for the purpose of operating its MA private fee-for-service plan. The MA Organization may not use data collected under this contract in the operation of any other line of business offered by the MA Organization or its related entities, contractors, or subcontractors.

Article X

Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act): and

(2) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

C. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article XI

Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XII

Miscellaneous

A. Definitions. Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. Alteration to Original Contract Terms. The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. Approval to Begin Marketing and Enrollment. The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price

comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. Incorporation of Applicable Addenda. All addenda checked off and initialed on the cover sheet of this contract by the MA Organization are hereby incorporated by reference.

In witness whereof, the parties hereby execute this contract.

FOR THE MA ORGANIZATION

| | |
|---|---|
| Stefen F. Brueckner | Vice President, Senior Products |
| Printed Name | Title |
| /s/ Stefen F. Brueckner | September-October, 2005 |
| Signature | Date |
| (See Chart) | |
| Organization | Address |

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

| | |
|---|---|
| /s/ David Lewis | September-October, 2005 |
| **Patricia Smith**<br>**Director** | Date |

Medicare Advantage Group
Center for Beneficiary Choices

**Exhibit 10.3**

**ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-42 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and (See Chart), a Medicare managed care organization (hereinafter referred to as the MA-PD Sponsor) agree to amend the contract (*INSERT "H" OR "R" NUMBER)* governing the MA-PD Sponsor's operation of a Part C plan described in Section 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") or a Medicare cost plan to include this addendum under which the MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to sections 1860D-1 through 1860D-42 (with the exception of section 1860D-22 and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an "MA-PD Sponsor" or "MA-PD Plan" is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

**Article I**
**Medicare Voluntary Prescription Drug Benefit**

A. The MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials, including but not limited to all the attestations contained therein and all supplemental guidance, for Medicare approval and in compliance with the provisions of this addendum, which incorporates in its entirety the Solicitation For Applications from Prescription Drug Plans released on January 21, 2005 (as revised on March 9, 2005) [applicable to Medicare Part C contractors] or the Solicitation for Applications from Cost Plan Sponsors released on January 21, 2005 (as revised on March 9, 2005) [applicable to Medicare cost plan contractors] (hereinafter collectively referred to as "the addendum"). The MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR §423.1 through 42 CFR §423.910 (with the exception of Subparts Q, R, and S), sections 1860D-1 through 1860D-42 (with the exception of sections 1860D-22(a) and 1860D-31) of the Social Security Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this addendum and any regulations or policies implementing or interpreting such statutory provisions.

B. CMS agrees to perform its obligations to the MA-PD Sponsor consistent with the regulations at 42 CFR §423.1 through 42 CFR §423.910 (with the exception of Subparts Q, R, and S), sections 1860D-1 through 1860D-42 (with the exception of sections 1860D-22(a) and 1860D-31) of the Social Security Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on the MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to the MA-PD Sponsor and CMS.

**Article II**
**Functions to be Performed by the MA-PD Sponsor**

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor's Part C or Section 1876 benefit.

2. If the MA-PD Sponsor is a cost plan sponsor, the MA-PD Sponsor acknowledges that its Section 1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in the MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.

3. If the MA-PD Sponsors is a cost plans sponsor, it acknowledge that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.

2. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §§423.128 and 423.50 and in the "Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs)."

3. MA-PD Sponsor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Marketing Materials Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

MA-PD Sponsor agrees to operate quality assurance, cost, and utilization management, medication therapy management programs, and support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to the MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

1. MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 CFR Part 423.

2. If the MA-PD Sponsor is participating in the Part D Reinsurance Payment Demonstration, described in 70 FR 9360 (Feb. 25, 2005), it affirms that it will not seek payment under the demonstration for services provided to employer group enrollees.

G. BID SUBMISSION AND REVIEW

If the MA-PD Sponsor intends to participate in the Part D program for the future year, MA-PD Sponsor agrees to submit a future year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and the MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.

2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. The MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.

2. The MA-PD Sponsor agrees to ensure adequate access to Part D-covered drugs at out-of-network pharmacies according to 42 CFR §423.124.

3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets the MA-PD Sponsor's reasonable and relevant standard terms and conditions. If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by the MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan.

5. The provisions of 42 CFR §423.120(a) concerning the TRICARE retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by the MA-PD Sponsor. MA-PD Sponsors excused from meeting the TRICARE standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor.

J. COMPLIANCE PLAN/PROGRAM INTEGRITY

MA-PD Sponsor agrees that it will develop and implement a compliance plan that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

The MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of the MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH RELATED ENTITIES, CONTRACTORS, AND SUBCONTRACTORS

1. The MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. The MA-PD Sponsor shall ensure that any contracts or agreements with subcontractors or agents performing functions on the MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance 42 CFR §423.50(k).

**Article III**
**Record Retention and Reporting Requirements**

A. MAINTENANCE OF RECORDS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§423.504(d) and 505(d) and (e).

B. GENERAL REPORTING REQUIREMENTS

The MA-PD Sponsor agrees to submit to information to CMS according to 42 CFR §§423.505(f), 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS License For Use of Plan Formulary

PDP Sponsor agrees to submit to CMS each plan's formulary information, including any changes to its formularies, and hereby grants to the Government[, and any person or entity who might receive the formulary from the Government,] a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

**Article IV**
**HIPAA Transactions/Privacy/Security**

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

## Article V
## Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2006. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506. MA-PD Sponsor shall not conduct Part D-related marketing activities prior to October 1, 2005 and shall not process enrollment applications prior to November 15, 2005. MA-PD Sponsor shall begin delivering Part D benefit services on January 1, 2006.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, the MA-PD Sponsor will be determined qualified to renew this addendum annually only if—
   (a) CMS informs the MA-PD Sponsor that it is qualified to renew its addendum; and
   (b) The MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.
2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if the MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article XI for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

## Article VI
## Nonrenewal of Addendum

A. NONRENEWAL BY THE MA-PD SPONSOR

1. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR 423.507(a).
2. If the MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 CFR 423.507(b). (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

**Article VII**
**Modification or Termination of Addendum by Mutual Consent**

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

**Article VIII**
**Termination of Addendum by CMS**

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

**Article IX**
**Termination of Addendum by the MA-PD Sponsor**

A. The MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.

B. CMS will not enter into a Part D addendum with an organization that has terminated its addendum within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

C. If the addendum is terminated under section A of this Article, the MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

**Article X**
**Relationship Between Addendum and Part C Contract or 1876 Cost Contract**

A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such non-renewal or termination prevents the MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article X.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents the MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.

C. In the event that the MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, the MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

**Article XI**
**Intermediate Sanctions**

The MA-PD Sponsor shall be subject to sanctions and civil monetary penalties, consistent with Subpart O of 42 CFR Part 423.

**Article XII**
**Severability**

Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

**Article XIII**
**Miscellaneous**

A. DEFINITIONS: Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS: The MA-PD Sponsor agrees that it has not altered in any way the terms of the MA-PD addendum presented for signature by CMS. MA-PD Sponsor agrees that any alterations to the original text the MA-PD Sponsor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS: The MA-PD Sponsor agree to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).

D. CMS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES: The MA-PD Sponsor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS approval to begin MA-PD plan marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on MA-PD Sponsor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the PDP Sponsor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

MA-PD EMPLOYER/UNION-ONLY GROUP CONTRACT ADDENDUM

**EMPLOYER/UNION-ONLY GROUP ADDENDUM TO CONTRACT WITH APPROVED ENTITY PURSUANT TO SECTIONS 1851 THROUGH 1859 AND 1860D-1 THROUGH 1860D-42 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and (See Chart), a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract _____(*INSERT "H" OR "R" NUMBER)* governing the MA Organization's operation of a Medicare Advantage plan described in section 1851(a)(2)(A) or section 1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this Addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-PD Plans (hereinafter referred to as "employer/union-only group MA-PDs") in accordance with the waivers granted by CMS under section 1857(i) of the Act. The terms of this Addendum shall only apply to MA-PD plans offered exclusively to employers/unions.

This Addendum is made pursuant to Subparts K of 42 CFR Parts 422 and 423.

**ARTICLE I**
**EMPLOYER/UNION-ONLY GROUP MEDICARE ADVANTAGE**
**PRESCRIPTION DRUG PLANS**

A. MA Organization agrees to operate one or more employer/union-only group MA-PDs in accordance with the terms of this Addendum, the Medicare Advantage contract, which incorporates in its entirety the Solicitation For Applications from Prescription Drug Plans released on January 21, 2005 (as revised on March 9, 2005), as modified by the 2006 Part D Application Instructions for Employer/Union Sponsored Retiree Group Plans (as revised April 19, 2005) (except for requirements contained therein that are expressly waived or modified by this Addendum), all provisions of Federal statutes, regulations, and policies applicable to MA organizations and MA plans (except to the extent any such provisions are expressly waived or modified by this Addendum), and any employer/union-only group waiver guidance. MA Organization also agrees to operate one or more employer/union-only group MA-PDs in accordance with 42 CFR Parts 422 and 423 (with the exception of Subparts Q, R, and S), sections 1851 through 1859 and 1860D-1 through 1860D-42 of the Act (with the exception of 1860D-22(a) and 1860D-31), and the solicitation, as well as all other applicable Federal statutes, regulations, and policies, including any employer/union-only group waiver guidance.

B. This Addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

C. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

D. This Addendum is in no way intended to supersede or modify 42 CFR Parts 422 and 423 or sections 1851 through 1859 and 1860D-1 through D-42 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

E. The provisions of this Addendum apply to all employer/union-only group MA-PDs offered by the MA Organization. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

**ARTICLE II**
**FUNCTIONS TO BE PERFORMED BY THE MEDICARE ADVANTAGE ORGANIZATION**

A. PROVISION OF MA BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group MA-PDs the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS.

2. MA Organization may swap different types of mandatory supplemental benefits and optional supplemental benefits (as defined in 42 CFR §422.2) (hereinafter referred to as "supplemental benefits") of equal actuarial value in employer/union-only group MA-PDs.

3. MA Organization may modify the cost sharing (e.g., coinsurance, copayments, deductibles) of basic and supplemental benefits offered in employer/union-only group MA-PDs by providing a higher benefit level and/or a modified premium to employer/union-only groups contracting with MA Organization. The uniformity of premium, benefits, and cost-sharing requirement of 42 CFR §422.100(d)(2) shall not apply to such modifications. The overall value of each modified benefit offered to employer/union-only groups must be actuarially equivalent to the basic and/or supplemental benefit offered in the employer/union-only group MA-PD and the modification must not have the effect of denying or discouraging access to covered medically-necessary health care items and services as set forth in 42 CFR §422.100(f)(2).

4. The requirements in section 1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in section 1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA-PD are waived for employer/union-only group MA-PD enrollees who are not entitled to Medicare Part A.

5. For employer/union-only group MA-PDs offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

   (a) Applications, bids, and other submissions to CMS must be submitted on a calendar year basis; and

   (b) CMS payments will be determined on a calendar year basis.

6. For MA-PDs that have a monthly beneficiary rebate described in 42 CFR § 422.266:

(a) MA Organization may vary the form of rebate allocation so that the rebates vary between employer/union groups within the plan benefit package for an employer/union group to whom MA Organization offers the plan, with the exception of a rebate credited toward the reduction of the Part B premium. Any reduction of the Part B premium through crediting of the rebate must be available to all members of the plan at the same level, regardless of the enrollee's employer/union group affiliation; and

(b) MA Organization must:

(i) ensure Part B premium buy-downs are the same for all enrollees;

(ii) ensure that the total monthly rebate amount for the plan total rebates per enrollee are uniform across employer groups in the plan and that all rebates are accounted for and used only for the purposes provided in the Act; and

(iii) retain documentation that supports the use of all of the rebates on a detailed basis and must provide access to this documentation in accordance with the requirements of 42 CFR §422.501.

B. PROVISION OF PRESCRIPTION DRUG BENEFITS

1. (a) Except as provided in II.B.1(b), MA Organization agrees to provide basic prescription drug coverage, as defined under 42 CFR §423.100, under any employer/union-only group MA-PD, in accordance with Subpart C of 42 CFR Part 423. MA Organization also agrees to provide Part D benefits under any employer/union-only group MA-PD as described in MA Organization's bid approved each year by CMS.

(b) CMS agrees that MA Organization will not be subject to the actuarial equivalence requirement set forth in 42 CFR §423.104(e)(5) with respect to any employer/union-only group MA-PD and may provide less than the defined standard coverage between the deductible and initial coverage limit. MA Organization agrees that its basic prescription drug coverage under any employer/union-only group MA-PD will satisfy all of the other actuarial equivalence standards set forth in 42 CFR §423.104, including but not limited to the requirement set forth in 42 CFR §423.104(e)(3) that the plan has a total or gross value that is at least equal to the total or gross value of defined standard coverage.

(c) CMS agrees that nothing in this Addendum prevents MA Organization from offering benefits in addition to basic prescription drug coverage to employers/unions. Such additional benefits offered pursuant to private

agreements between MA Organization and employers/unions will be considered non-Medicare Part D benefits. MA Organization agrees that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude enrollees from realizing the full value of such basic prescription drug coverage). MA Organization may charge employers/unions up to 100% of the value of the additional benefits as part of the monthly beneficiary premium.

(d) MA Organization agrees that any additional non-Medicare Part D benefits offered to an employer/union will always pay primary to the subsidies provided by CMS to low-income individuals under Subpart P of 42 CFR Part 423 (the "Low-Income Subsidy").

2. MA Organization agrees enrollees of employer/union-only group MA-PDs will not be permitted to make payment of premiums under 42 CFR §423.293(a) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

3. MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth in (a) through (e) below. MA Organization agrees to retain these written agreements with employers/unions and provide access to these written agreements to CMS in accordance with 42 CFR §§423.504(d) and 423.505(d) and (e).

   (a) The employer/union can subsidize different amounts for different classes of enrollees in the employer/union-only group MA-PD provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

   (b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

   (c) The employer/union cannot charge an enrollee for prescription drug coverage provided under the plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).

   (d) For all enrollees eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the enrollee, with any remaining portion of the premium subsidy amount then applied

toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the employer/union.

(e) If the low income premium subsidy amount for which an enrollee is eligible is less than the portion of the monthly beneficiary premium paid by the enrollee, then the employer/union should communicate to the enrollee the financial consequences for the beneficiary of enrolling in the employer/union-only group MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

4. For non-calendar year employer/union-only group MA-PDs, MA Organization may determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(a) Applications, formularies, bids and other submissions to CMS must be submitted on a calendar year basis;

(b) The employer/union-only group MA-PD must be actuarially equivalent to defined standard coverage for the portion of its plan year that falls in a given calendar year. An employer/union-only group MA-PD will meet this standard if it is actuarially equivalent for the calendar year in which the plan year starts and no design change is made for the remainder of the plan year. In no event can MA Organization increase during the plan year the annual out-of-pocket threshold;

(c) After an enrollee's incurred costs exceed the annual out-of-pocket threshold, the employer/union-only group MA-PD must provide coverage that is at least actuarially equivalent to that provided under standard prescription drug coverage; eligibility for such coverage can be determined on a plan year basis.

C. ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group MA-PD to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group MA-PD to all Medicare eligible beneficiaries residing in its service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll individuals eligible for its employer/union-only group MA-PD through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60 and §423.32(b). MA Organization agrees that all individuals eligible for its employer/union-only group MA-PD will be advised that the employer/union contracting with MA Organization to offer an employer/union-only group MA-PD (hereinafter referred to as "employer/union") intends to enroll them into the

plan through a group enrollment process unless the individual affirmatively opts out of such enrollment. MA Organization agrees that all such individuals will be provided this information at least 30 days prior to the effective date of the individual's enrollment in the employer/union-only group MA-PD. MA Organization agrees the information must include a summary of benefits offered under the employer/union-only group MA-PD, an explanation of how to get more information on such plan, and an explanation of how to contact Medicare for information on other MA-PD plans that might be available to the individual. In addition, MA Organization agrees that all information necessary to effectuate enrollment must be submitted electronically to CMS, consistent with CMS instructions.

D. BENEFICIARY PROTECTIONS

1. MA Organization's employer/union-only group MA-PDs will not be subject to the marketing requirements set forth in 42 CFR §422.80 and §423.50 or the information requirements of 42 CFR §423.48.

2. CMS agrees that the disclosure requirements set forth in 42 CFR §§423.128 and in the "Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs)," will not apply with respect to any employer/union-only group MA-PD when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. MA Organization agrees to provide beneficiary plan documents, including summary plan descriptions and all other beneficiary communications that provide descriptions of the benefit offerings, to CMS at the time of use and to current and/or potential enrollees on a timely basis. CMS may review these documents in the event of beneficiary complaints or for other reasons and require changes if CMS determines that such changes are necessary.

E. SERVICE AREA, FORMULARIES AND PHARMACY ACCESS

1. CMS agrees that employer/union-only group Local MA-PDs that provide coverage to individuals in any part of a State can offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that State. CMS also agrees that employer/union-only group Regional MA-PDs that provide coverage to individuals in any part of a Region can offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that Region.

2. CMS agrees that Regional MA-PDs and non-network Private Fee-for-Service employer/union-only group MA-PDs may extend coverage beyond their designated service areas to all enrollees of a particular employer/union-only group plan, regardless of where they reside in the nation, when the most substantial portion of the employer's employees (or in the case of a union, the union's participants) reside in the service area where the MA Organization, either itself or

through subcontractors or other partners, is a provider of non-group MA-PD coverage. The MA Organization agrees to conduct an actual review of where the substantial portion of the employer's/union's employees/participants reside and to maintain adequate supporting documentation of such review (including the date of such review, by whom the review was conducted, and any other relevant documentation to substantiate the review), and to permit CMS to audit and review such documentation. Such expanded service areas must have convenient Part D pharmacy access sufficient to meet the needs of enrollees wherever they reside.

3. MA Organization agrees to utilize, as the formulary for any employer/union-only group MA-PD, a base formulary that has received approval from CMS, in accordance with CMS formulary guidance, for use in a non-group MA-PD offered by MA Organization. Except as set forth in 42 CFR §423.120(b) and sub-regulatory guidance, MA Organization may not modify the approved base formulary used for any employer/union-only group MA-PD by removing drugs, adding additional utilization management restrictions, or increasing the cost-sharing status of a drug from the base formulary. Enhancements that are permitted to the base formulary include adding additional drugs, removing utilization management restrictions, and improving the cost-sharing status of drugs.

4. For any employer/union-only group MA-PD, MA Organization agrees to provide Part D benefits in the plan's service area utilizing a pharmacy network and formulary that meets the requirements of 42 CFR §423.120, with the following exception: CMS agrees that the retail pharmacy access requirements set forth in 42 CFR §423.120(a) ("Tricare" standards) will not apply when the employer/union-only group MA-PD's pharmacy network is sufficient to meet the needs of its enrollees throughout the employer/union-only group MA-PD's service area, as determined by CMS. CMS may periodically review the adequacy of the employer/union-only group MA-PD's pharmacy network and require the employer/union-only group MA-PD to expand access if CMS determines that such expansion is necessary in order to ensure that the employer/union-only group MA-PD's network is sufficient to meet the needs of its enrollees.

F. PAYMENT TO MA ORGANIZATION

Except as provided in II.F.1 through 4, payment under this Addendum will be governed by the rules of Subparts G and J of 42 CFR Part 423.

1. MA Organization acknowledges that the risk sharing, plan entry and retention bonus provisions of section 1858 of the Act and 42 CFR §422.458 shall not apply to any employer/union-only group Regional MA-PDs.

2. MA Organization acknowledges that the risk-sharing payment adjustment described in 42 CFR §423.336 is not applicable for any employer/union-only group MA-PD enrollee.

3. MA Organization will receive a monthly direct subsidy under 42 CFR Subpart G for each employer/union-only group MA-PD enrollee equal to the amount of the national average monthly bid amount (not its approved standardized bid), adjusted for health status (as determined under 42 CFR §423.329(b)(1)) and reduced by the base beneficiary premium for the employer/union-only group MA-PD, as adjusted under 42 CFR §423.286(d)(3), if applicable. The further adjustments to the base beneficiary premium contained in 42 CFR §423.286(d)(1) and (2) will not apply.

4. MA Organization will not receive monthly reinsurance payment amounts in the manner set forth in 42 CFR §423.329(c)(2)(i) for any employer/union-only group MA-PD enrollee, but instead will receive the full reinsurance payment following the end of year reconciliation as described in 42 CFR §423.329(c)(2)(ii).

5. For non-calendar year plans:

(a) CMS payments will be determined on a calendar year basis;

(b) Low income subsidy payments and reconciliations will be determined based on the calendar year for which the payments are made; and

(c) MA Organization acknowledges that it will not receive reinsurance payments under 42 CFR §423.329(c).

## ARTICLE III
## RECORD RETENTION AND REPORTING REQUIREMENTS

A. GENERAL REPORTING REQUIREMENTS

CMS agrees that MA Organization is not subject to the general public reporting requirements contained in 42 CFR §422.516(a) and §423.514(a) for its employer/union-only group MA-PDs to the extent that: (1) such information is required to be reported to enrollees and to the general public by other law (including ERISA or securities laws) or by a separate contractual agreement and (2) MA Organization fully complies with such requirements.

MA-ONLY EMPLOYER/ UNION-ONLY GROUP CONTRACT ADDENDUM

**EMPLOYER/UNION-ONLY GROUP PART C ADDENDUM TO CONTRACT WITH APPROVED ENTITY PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and (See Chart), a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract (See Chart) (*INSERT "H" OR "R" NUMBER)* governing the MA Organization's operation of a Medicare Advantage plan described in section 1851(a)(2)(A) or section 1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this Addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-Only Plans (hereinafter referred to as "employer/union-only group health plans") in accordance with the waivers granted by CMS under section 1857(i) of the Act. The terms of this Addendum shall only apply to MA-only health plans offered exclusively to employers/unions.

This Addendum is made pursuant to Subpart K of 42 CFR Part 422.

## Article I
## Employer/Union-Only Group Medicare Advantage Health Plan

A. MA Organization agrees to operate one or more employer/union-only group health plans in accordance with the terms of this Addendum, the Medicare Advantage contract (except for requirements contained therein that are expressly waived or modified by this Addendum), all provisions of Federal statutes, regulations, and policies applicable to MA organizations or MA plans (except to the extent any such provisions are expressly waived or modified by this Addendum), and any employer/union-only group waiver guidance.

B. This Addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

C. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

D. This Addendum is in no way intended to supersede or modify 42 CFR Part 422 or sections 1851 through 1859 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

E. The provisions of this Addendum apply to all employer/union-only group health plans offered by MA Organization. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

## Article II
## Functions to be Performed by the Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group health plans the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS.

2. MA Organization may swap different types of mandatory supplemental benefits and optional supplemental benefits (as defined in 42 CFR §422.2) (hereinafter referred to as "supplemental benefits") of equal actuarial value in employer/union-only group health plans.

3. MA Organization may modify the cost sharing (e.g., coinsurance, copayments, deductibles) of basic and supplemental benefits offered in employer/union-only group health plans by providing a higher benefit level and/or a modified premium to employer/union-only groups contracting with MA Organization. The uniformity of premium, benefits, and cost-sharing requirement of 42 CFR §422.100(d)(2) shall not apply to such modifications. The overall value of each modified benefit offered to employer/union-only groups must be actuarially equivalent to the basic and/or supplemental benefit offered in the employer/union-only group health plan and the modification must not have the effect of denying or discouraging access to covered medically-necessary health care items and services as set forth in 42 CFR §422.100(f)(2).

4. The requirements in section 1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in section 1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA plan are waived for employer/union-only group health plan enrollees who are not entitled to Medicare Part A.

5. For employer/union-only group health plans offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

   (a) Applications, bids, and other submissions to CMS must be submitted on a calendar year basis; and

   (b) CMS payments will be determined on a calendar year basis.

6. For employer/union-only group health plans that have a monthly beneficiary rebate described in 42 CFR §422.266:

   (a) MA Organization may vary the form of rebate allocation so that the rebates vary between employer/union groups within the plan benefit package for an employer/union group to whom MA Organization offers the plan, with the exception of a rebate credited toward the reduction of the Part B premium. Any reduction of the Part B premium through crediting of the rebate must be available to all members of the plan at the same level, regardless of the enrollee's employer/union group affiliation; and

(b) MA Organization must:

(a) ensure Part B premium buy-downs are the same for all enrollees;

(b) ensure that the total monthly rebate amount for the plan total rebates per enrollee are uniform across employer groups in the plan and that all rebates are accounted for and used only for the purposes provided in the Act; and

(c) retain documentation that supports the use of all of the rebates on a detailed basis and must provide access to this documentation in accordance with the requirements of 42 CFR §422.501.

B. ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group health plan to those individuals eligible for the employer's/union's employment-based group coverage.
2. MA Organization will not be subject to the requirement set forth in 42 CFR §422.50 to offer the employer/union-only group health plan to all eligible beneficiaries residing in the plan's service area.
3. If an employer/union elects to enroll individuals eligible for its employer/union-only group health plan through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that all individuals eligible for its employer/union-only group health plan will be advised that the employer/union contracting with MA Organization to offer an employer/union-only group health plan (hereinafter referred to as "employer/union") intends to enroll them into the plan through a group enrollment process unless the individual affirmatively opts out of such enrollment. MA Organization agrees that all such individuals will be provided this information at least 30 days prior to the effective date of the individual's enrollment in the employer/union-only group health plan. MA Organization agrees the information must include a summary of benefits offered under the employer/union-only group health plan, an explanation of how to get more information on such plan, and an explanation of how to contact Medicare for information on other MA plans that might be available to the individual. In addition, MA Organization agrees that all information necessary to effectuate enrollment must be submitted electronically to CMS, consistent with CMS instructions.

C. BENEFICIARY PROTECTIONS

1. MA Organization's employer/union-only group health plans will not be subject to the marketing requirements set forth in 42 CFR §422.80.
2. CMS agrees that the disclosure requirements set forth in 42 CFR §§422.111 will not apply with respect to any employer/union-only group health plan when the

employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. MA Organization agrees to provide beneficiary plan documents, including summary plan descriptions and all other beneficiary communications that provide descriptions of the benefit offerings, to CMS at the time of use and to current and/or potential enrollees on a timely basis. CMS may review these documents in the event of beneficiary complaints or for other reasons and require changes if CMS determines that such changes are necessary.

D. SERVICE AREA

1. CMS agrees that Local employer/union-only group health plans that provide coverage to individuals in any part of a State can offer coverage to individuals eligible for the employer/union-only group throughout that State.

2. CMS agrees that Regional employer/union-only group health plans and non-network Private Fee-for-Service employer/union-only group health plans may extend coverage beyond their designated service areas to all enrollees of a particular employer/union-only group plan, regardless of where they reside in the nation, when the most substantial portion of the employer's employees (or in the case of a union, the union's participants) reside in the service area where the MA Organization, either itself or through subcontractors or other partners, is a provider of non-group MA coverage. The MA Organization agrees to conduct an actual review of where the substantial portion of the employer's/union's employees/participants reside and to maintain adequate supporting documentation of such review (including the date of such review, by whom the review was conducted, and any other relevant documentation to substantiate the review), and to permit CMS to audit and review such documentation.

F. PAYMENT TO MA ORGANIZATION

MA Organization acknowledges that the risk sharing, plan entry and retention bonus provisions of section 1858 of the Act and 42 CFR §422.458 shall not apply to Regional employer/union-only group health plans.

**Article III**
**Record Retention and Reporting Requirements**

A. GENERAL REPORTING REQUIREMENTS

MA Organization is not subject to the general public reporting requirements contained in 42 CFR §422.516(a) for its employer/union-only group plans to the extent that: (1) such information is required to be reported to enrollees and to the general public by other law (including ERISA or securities laws) or by a separate contractual agreement and (2) MA Organization fully complies with such requirements.

**Exhibit 10.6**

ADDENDUM TO MEDICARE CONTRACT WITH APPROVED ENTITY
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY
ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE REGIONAL
COORDINATED CARE PLAN(S)

I. Risk Sharing Reconciliation Submission

A. A Medicare Advantage (MA) Organization offering an MA regional plan shall disclose to CMS such information as CMS determines necessary to carry out the risk sharing reconciliation under subsection 1858(c) of the Act - including notification to CMS of **actual allowed medical costs and actual allowed medical revenues and supporting data** for the contract year under the plan by such date and in such format as CMS specifies - in order to determine whether there are payment adjustments for the effective contract year in accordance with Section 1858(c)(2) of the Act.

B. Information disclosed or obtained pursuant to this requirement may be used by officers, employees, and contractors of CMS only for the purposes of, and to the extent necessary in, carrying out this subsection.

C. The risk sharing reconciliation submission under subsection 1858(c) must be audited by an independent Certified Public Accountant at the expense of the MA organization, and the results of the audit plus additional information to be specified at a later date must be submitted to CMS for our approval. Further, CMS reserves the right conduct an independent audit of the information, at its own expense.

II. Organizational and Financial Requirements

A. In accordance with subsection 1858(d) of the Act, an MA organization that is offering a regional plan in a multi-state region and is not licensed in each State in which it offers such a regional plan, may obtain a temporary waiver of state licensure from CMS for a period of time that CMS determines appropriate for the timely processing of the application by the State or States.

1. To obtain the waiver, the MA organization that is offering a multi-state regional plan must:

(a) demonstrate to CMS that it has filed the necessary state licensing application in each state in the multi-state region where a license is not held.

(b) notify CMS when each of the state licenses for which an application has been filed is approved or denied.

2. In the case of a denied state license application, CMS may extend the licensing waiver through the end of the plan year or as CMS determines appropriate to provide for a transition.

B. An MA organization that is offering a multi-state regional plan, and which is licensed in more than one state of that region, and which has been granted a waiver of licensure pending approval of one or more state license applications, must select one of the states in the region in which it is licensed in the region, and the rules for that state will apply for

the period of the waiver to the other state or states in the region in which it is not licensed.

III. Coverage of Entire MA Region

In accordance with paragraph 1858(a)(1) of the Act, an MA organization that is offering a regional plan must cover the entire MA regional service area (as defined in §422.)]. The MA organization offering a regional plan must not segment any of it regions as described in §422.262(c)(2).

IV. Special Cost-Sharing Rules for MA Regional Plans

In accordance with paragraph 1858 (b)(2) of the Act, MA regional plans must provide for a single deductible related to original Medicare Part A and Part B services, if any deductible is imposed, as well as for an in-network and total catastrophic limit on beneficiary out-of-pocket expenditures for benefits under the original Medicare program. The MA regional plan must track the deductible (if any) and catastrophic limits and notify members and health care providers when the deductible (if any) or a limit has been reached as described in §422.101(d)(4).

V. Election of Uniform Coverage Determination

A. In accordance with subsection 1858 (g) of the Act, an MA organization offering an MA regional plan may elect to have a local coverage determination for part of such region be the local coverage determination applied for the entire MA region, as selected by the organization as described in §422.101(b).

B. An MA regional plan that applies a uniform local coverage determination for the entire MA region must make information on the selected local coverage policy readily available, including through the Internet, to enrollees and health care providers as described at §422.101(b)(5) and §422.111.

VI. Assuring Network Adequacy and Disclosure to Enrollees

A. In accordance with subsection 1858(h) of the Act and §422.112(a)(1)(ii), an MA Organization offering an MA regional plan may meet provider access to care requirements through methods other than written agreements that establish that access requirements have been met. The MA regional plan may rely on this exception in seeking to designate a non-contracting hospital as an “essential hospital” following requirements described in §422.112(c).

B. In accordance with subsection 1858(h), an MA regional plan must disclose to its enrollees the process enrollees should follow to secure in-network cost sharing when covered services are not readily available from contracted network providers, as described in §422.111(b)(3)(ii).

Humana Inc.
Computation of Ratio of Earnings to Fixed Charges

Exhibit 12

| | For the nine months ended September 30, | For the twelve months ended December 31, | | | | |
|---|---|---|---|---|---|---|
| | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 |
| | (Dollars in thousands) | | | | | |
| Income before income taxes | $ 322,498 | $415,850 | $344,716 | $209,934 | $183,080 | $113,990 |
| Fixed charges | 48,588 | 49,246 | 40,972 | 44,349 | 52,010 | 52,843 |
| Total earnings | $ 371,086 | $465,096 | $385,688 | $254,283 | $235,090 | $166,833 |
| Interest charged to expense | $ 28,986 | $ 23,172 | $ 17,367 | $ 17,252 | $ 25,302 | $ 28,615 |
| One-third of rent expense | 19,602 | 26,074 | 23,605 | 27,097 | 26,708 | 24,228 |
| Total fixed charges | $ 48,588 | $ 49,246 | $ 40,972 | $ 44,349 | $ 52,010 | $ 52,843 |
| Ratio of earnings to fixed charges (1)(2) | 7.6x | 9.4x | 9.4x | 5.7x | 4.5x | 3.2x |

Notes

(1) For the purposes of determining the ratio of earnings to fixed charges, earnings consist of income or loss before income taxes and fixed charges. Fixed charges include gross interest expense, amortization of deferred financing expenses and an amount equivalent to interest included in rental charges. One-third of rental expense represents a reasonable approximation of the interest amount.

(2) There are no shares of preferred stock outstanding.

**Exhibit 31.1**

**CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002**

I, Michael B. McCallister, principal executive officer of Humana Inc., certify that:

1. I have reviewed this Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending September 30, 2005;

2. Based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this quarterly report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of the annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 7, 2005

Signature: /s/ Michael B. McCallister
Michael B. McCallister
Principal Executive Officer

**Exhibit 31.2**

**CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002**

I, James H. Bloem, principal financial officer of Humana Inc., certify that:

1. I have reviewed this Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending September 30, 2005;

2. Based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this quarterly report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of the annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 7, 2005

Signature: /s/ James H. Bloem
James H. Bloem
Principal Financial Officer

**Exhibit 32**

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

In connection with the Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending September 30, 2005 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934; and

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

/s/ Michael B. McCallister

Michael B. McCallister
Principal Executive Officer

November 7, 2005

/s/ James H. Bloem

James H. Bloem
Principal Financial Officer

November 7, 2005

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.