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

FORM 10-K

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

For the fiscal year ended December 31, 2020

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 of organization)	(I.R.S. Employer Identification No.)

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

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

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol	Name of exchange on which registered
Common stock, $0.16 2/3 par value	**HUM**	**New York Stock Exchange**

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☑	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☑

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2020 was $50,711,683,757 calculated using the average price on June 30, 2020 of $384.15 per share.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2021 was 128,861,929.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Definitive Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 22, 2021. Such Definitive Proxy Statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2020

Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These 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, or the Exchange Act. 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 the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

As of December 31, 2020, we had approximately 17 million members in our medical benefit plans, as well as approximately 5 million members in our specialty products. During 2020, 83% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 728,300 members as of December 31, 2020.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2020 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2020 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, include comprehensive managed care benefits generally through a participating network of physicians, hospitals, and other providers. Preferred provider organizations, or PPOs, provide members the freedom to choose any health care provider. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2020:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 51,697	68.0 %
Group Medicare Advantage	7,774	10.2 %
Medicare stand-alone PDP	2,742	3.6 %
Total Retail Medicare	62,213	81.8 %
State-based Medicaid	4,223	5.6 %
Medicare Supplement	688	0.9 %
Total premiums	67,124	88.3 %
Services	19	— %
Total premiums and services revenue	$ 67,143	88.3 %

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, Private Fee-For-Service, or PFFS, and Special Needs Plans, including Dual Eligible Special Needs, or D-SNP, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data

analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. For more information refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2020, we provided health insurance coverage under CMS contracts to approximately 3,962,700 individual Medicare Advantage members, including approximately 728,300 members in Florida. These Florida contracts accounted for premiums revenue of approximately $10.9 billion, which represented approximately 21.1% of our individual Medicare Advantage premiums revenue, or 14.4% of our consolidated premiums and services revenue for the year ended December 31, 2020.

Our individual Medicare Advantage products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2021, and all of our product offerings filed with CMS for 2021 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2021, and all of our product offerings filed with CMS for 2021 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products are primarily offered as PPO plans on the same Medicare platform as individual Medicare Advantage plans. These plans offer the same types of benefits and services available to members in our individual Medicare plans discussed previously, however, group Medicare Advantage plans typically have richer benefit offerings than individual Medicare Advantage plans, including prescription drug coverage in the gap, for instance, due to the desire of many customers to closely match their pre-retirement benefit structure.

Medicare Supplement

We also offer Medicare supplement products that helps pay the medical expenses that Medicare FFS does not cover, such as copayments, coinsurance and deductibles.

State-based Medicaid Contracts

Through our state-based contracts, we serve members enrolled in Medicaid, a program funded by both the federal and state governments and administered by states to care for their most vulnerable populations. Within federal guidelines, states determine whom to cover, but general categories for traditional Medicaid programs include: children and some adults receiving assistance through Temporary Assistance to Needy Families, or TANF, and Aged, Blind, and Disabled, or ABD, adults. Through the Long-Term Support Services, or LTSS, program, states offer programs to deliver support services to people who receive home and community or institution-based services for long-term care.

We have contracts in several states to serve Medicaid-eligible members. In Florida, we cover the traditional programs (TANF and ABD members), as well as provide LTSS services. In Kentucky, we serve the traditional programs. Originally, our Kentucky Medicaid contract was subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource; however, effective January 1, 2020, we terminated the reinsurance agreement with CareSource and assumed full administration and financial risk. In 2021, our Medicaid business significantly expanded in several states, including in Wisconsin with the acquisition of iCare on

January 1, 2021, in Oklahoma with a new contract award; and in South Carolina with the approval to participate in its traditional managed Medicaid program.

We also serve members who qualify for both Medicaid and Medicare, referred to as “dual eligible," through our Medicaid, Medicare Advantage, and stand-alone prescription drug plans. As the dual eligible population represents a disproportionate share of costs, Humana is participating in varied integration models designed to improve health outcomes and reduce avoidable costs. These programs largely operate separately from traditional Medicaid and LTSS programs. We currently serve dual eligible members under CMS’s dual eligible demonstration program in Illinois, and have been approved to participate in South Carolina’s dual demonstration program starting in January 2022.

As part of our individual Medicare Advantage products, we also offer D-SNP plans. In connection with offering a D-SNP plan in a particular state, we are required to enter into a special coordinating contract with the applicable state Medicaid agency. To meet federal requirements that took effect in 2021, states have begun to implement new D-SNP requirements to strengthen Medicaid-Medicare integration requirements for D-SNPs. Some states are also moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2020:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 4,761	6.3 %
Specialty	1,699	2.2 %
Total premiums	6,460	8.5 %
Services	780	1.0 %
Total premiums and services revenue	$ 7,240	9.5 %
Intersegment services revenue	$ 29	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts.

Our ASO products are offered to small group and large group employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing the costs of health benefits, with large group customers retaining a greater share

and small group customers a smaller share of the cost of health benefits. All small group ASO customers and many large group ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2020:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 24,587	n/a
Provider services	2,266	n/a
Clinical care services	566	n/a
Total intersegment revenue	$ 27,419	
External services revenue:		
Pharmacy solutions	$ 581	0.8 %
Provider services	328	0.4 %
Clinical care services	107	0.1 %
Total external services revenue	$ 1,016	1.3 %

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc.

Provider services

We operate full-service, multi-specialty medical centers in a number of states, including Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, and Texas, staffed by primary care providers and medical specialists with a primary focus on the senior population under our Care Delivery Organization, or CDO. CDO operates these clinics primarily under the Conviva, Partners in Primary Care or Family Physicians Group, or FPG, brands. Our care delivery subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services. CDO currently operates 156 medical centers and employs or contracts with 662 primary care providers, serving approximately 255,400 members, generally under risk sharing arrangements with Humana and third party health plans.

CDO also operates a Medical Services Organization, or MSO, through Conviva that coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. This MSO provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Conviva's MSO collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions.

In February 2020, Partners in Primary Care entered into a strategic partnership with Welsh, Carson, Anderson & Stowe to open a minimum of 50 additional payor-agnostic, senior-focused primary care centers over the next three years and in 2018 we acquired FPG serving Medicare Advantage and Managed Medicaid HMO patients through its senior focused clinics in Greater Orlando, Florida. Also, during 2018, we acquired the remaining equity interest in Miami, Florida based MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2020, we have enrolled approximately 910,600 members, with complex chronic conditions participating in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. These members may not be unique to each program since members have the ability to enroll in multiple programs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities with our acquisition of a 40% minority interest in Kindred at Home, Inc., or Kindred at Home, and Curo Health Services, or Curo, which combined creates the nation's largest home health and hospice provider with significant overlap with our individual Medicare Advantage business. See Note 4 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions

of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

Wellness

We offer wellness solutions including our Go365 wellness and loyalty rewards program, employee assistance program, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual’s needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange.

We discontinued substantially all off-exchange individual commercial medical plans effective January 1, 2017, and we exited our remaining individual commercial medical business effective January 1, 2018.

Other Businesses

Other Businesses includes those businesses that do not align with the reportable segments previously described, primarily our closed-block long-term care insurance policies, which were sold in 2018. For a detailed discussion of the sale refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2020, by market and product:

	Retail Segment				Group and Specialty Segment					
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	728.3	7.5	169.7	18.1	594.4	135.2	40.1	—	1,693.3	10.1 %
Texas	319.7	247.9	266.9	27.4	—	114.0	33.4	—	1,009.3	6.0 %
Kentucky	107.3	69.2	167.0	7.4	168.6	94.6	136.5	—	750.6	4.5 %
Georgia	196.0	1.9	101.8	11.1	—	113.6	77.9	—	502.3	3.0 %
California	95.1	0.9	383.9	20.7	—	—	—	—	500.6	3.0 %
Illinois	139.1	26.1	153.1	8.0	9.4	26.9	39.3	—	401.9	2.4 %
Ohio	164.0	22.1	109.9	40.5	—	26.9	31.1	—	394.5	2.3 %
Missouri/Kansas	105.9	4.7	166.3	14.2	—	35.5	28.6	—	355.2	2.1 %
North Carolina	188.6	0.4	133.6	6.6	—	—	—	—	329.2	2.0 %
Tennessee	152.4	3.7	97.8	8.3	—	36.5	21.2	—	319.9	1.9 %
Louisiana	183.4	13.5	53.7	3.8	—	43.9	20.1	—	318.4	1.9 %
Virginia	134.4	3.9	118.6	9.1	—	—	—	—	266.0	1.6 %
Indiana	120.0	6.7	102.0	11.6	—	17.5	6.9	—	264.7	1.6 %
Wisconsin	61.1	5.6	87.3	7.5	—	51.0	29.4	—	241.9	1.4 %
Michigan	89.9	20.2	102.9	6.1	—	1.4	—	—	220.5	1.3 %
Alabama	75.4	82.5	55.7	5.0	—	—	—	—	218.6	1.3 %
Arizona	99.5	0.4	78.2	9.0	—	19.1	7.9	—	214.1	1.3 %
New York	75.2	6.4	113.0	8.1	—	—	—	—	202.7	1.1 %
Military services	—	—	—	—	—	—	—	5,998.7	5,998.7	35.6 %
Others	927.4	89.6	1,405.3	113.1	—	61.3	32.5	—	2,629.2	15.6 %
Totals	3,962.7	613.2	3,866.7	335.6	772.4	777.4	504.9	5,998.7	16,831.6	100.0 %

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate for diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge

for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2020, approximately 1,465,700 members, or 8.7% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 1,231,900 individual Medicare Advantage members, or 31.1% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and measure the financial performance of our capitated providers and require guarantees in certain instances. However, we delegated claim processing functions under capitation arrangements covering approximately 230,400 HMO members, including 224,300 individual Medicare Advantage members, or 18.2% of the 1,231,900 individual Medicare Advantage members covered under risk-based contracts at December 31, 2020, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $2.4 billion, or 3.9% of total benefits expense, for the year ended December 31, 2020. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Set, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance (NCQA) to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or The Joint Commission.

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or URAC. Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, and member experience. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2020, we employed approximately 1,400 sales representatives, as well as approximately 1,600 telemarketing representatives who assisted in the marketing of Medicare products, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare Stand-Alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our individual Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2020 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2020 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, cybersecurity, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Human Capital Management

Our associates are essential to our success in delivering on our core strategy, and creating positive healthcare experiences for our members. We are committed to recruiting, developing, and retaining strong, diverse teams, actively promoting a culture of inclusion and diversity. As of December 31, 2020, we had approximately 48,700 associates and approximately 900 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations.

Our Culture

We believe that our members' experience is linked to our associates' experience and that engaged, productive associates are the key to building a healthy company, creating a caring environment that enables our associates to go above and beyond for our members, driving innovation, and allowing for fulfilling experiences that incentivize them to stay with us over the long-term. Each year, we measure our success and opportunities to advance through our annual, third-party administered Associate Experience Survey. Results of the 2020 survey showed that 93% of associates are highly engaged. To continue to build on these results, we provide the survey results to our entire associate population and encourage leaders to use the information to create open, honest action plans with their teams to further deepen our collective engagement.

Inclusion and Diversity

Our associates' vast experiences and perceptions, their unique characteristics, backgrounds and beliefs, drive the groundbreaking, strategic thinking that gives our Company its competitive edge. We are committed to having balanced diversity at all levels of the Company and have developed a pathway for top, diverse talent within our recruiting initiatives. To achieve our recruiting and hiring goals we partner with local and national advocacy groups to provide information about open roles, assistance with resume preparation and application submission.

We have also incorporated balanced interview panels into our interview process, through which we strategically engage a broad spectrum of interviewers that bring greater diversity and perspective. This proven best practice strengthens the candidate experience and hiring of diverse talent, ensuring we get the right talent for any given role, and minimizes the potential for personal blind spots when evaluating candidates.

Pay and Benefits Philosophy, Compensation and Financial Security

Our Company's pay and benefits structure is designed to motivate and reward our associates at all levels of the organization for their skill development, demonstration of our values and performance. While our programs vary by location and business, they may include:

Financial	**Health**	**Life**
Competitive Base Pay	Medical, Dental and Vision Benefits	Paid time off, paid holidays and jury duty pay
Associate Incentive Plan (Annual Bonus)	Supplemental Health Benefits	Paid Parental Leave
Supplemental Pay (Including Overtime)	Long-term Care Insurance	Caregiver Time Off Program
Recognition Pay and Service Awards	Wellness and Rewards Program	Employee Assistance Program
401(k) Retirement Savings Plan with Company Match Program	Health Plan Incentives	Associate Discount Programs and Services
Life insurance	On-site Health and Fitness Centers	Helping Hands Program
Short- and Long-Term Disability Insurance	On-site Health Screenings and Vaccinations	Transit Services

Talent Development and Growth Opportunities

We champion the individual goals and development of our associates, and provide a number of programs to ensure that our associates have the resources and support they need to deliver on their passion. We provide opportunities for our associates to earn professional certifications through continued education programs and to participate in instructor-led and online courses designed to strengthen soft and hard-skills and enhance leadership development. Our Career Cultivation team sponsors workshops and events to promote associate accountability within their personal and professional growth as part of overall career development. Our associates are also encouraged to participate in mentoring programs with people of various backgrounds and cultures. We view mentoring as an essential development tool for sharing skills and knowledge so we can all succeed. Our commitment to mentoring feeds the successful future of our Company. Additionally, we utilize development programs to enhance talent within our organizations through targeted internal initiatives, where we aim to upskill and reskill existing associates for opportunities in new career pathways.

COVID-19

Our response to the pandemic and performance throughout 2020 would not have been possible without the extraordinary, resilient efforts of our associates, who went above and beyond to continually meet the needs of our stakeholders while facing their own daily challenges as a result of COVID-19. To support them, we quickly transitioned nearly all of our workforce to a remote work environment, while ensuring that our frontline care providers, clinicians, and pharmacists who continued to care for our members and patients in our clinics and in the home, and ensure that they had access to their medications, had the equipment and space to safely do so. We also expanded our benefits to assist our associates who faced financial hardship and to address the difficulties that the pandemic presented to daily life. A few of those COVID-19 response initiatives are highlighted below.

- transitioning approximately 94% of the workforce to work-at-home and equipping them with the necessary technology and resources for a successful remote work environment.
- providing funding for emergency relief for elder and child caregiving and financial hardship from family job loss, food insecurity and household essentials.
- adjusting pay and leave policies to provide additional paid time off to manage personal challenges as a result of COVID-19 including school closings and child care.

Additional information related to our human capital can be found by referencing our Definitive Proxy Statement of the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the captions "Human Capital Management" and "Our COVID-19 Response."

Information About Our Executive Officers

Set forth below are names and ages of all of our current executive officers as of February 1, 2021, their positions, and the date first elected as an officer**:**

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	58	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	46	Chief Strategy and Corporate Development Officer	12/18	(2)
Heather M. Carroll Cox	50	Chief Digital Health and Analytics Officer	08/18	(3)
Sam M. Deshpande	56	Chief Technology and Risk Officer	07/17	(4)
Susan M. Diamond	47	Segment President, Home Business	07/19	(5)
William K. Fleming, PharmD	53	Segment President, Clinical and Pharmacy Solutions	03/17	(6)
Christopher H. Hunter	52	Segment President, Group and Military Business	01/14	(7)
Timothy S. Huval	54	Chief Administrative Officer	12/12	(8)
Brian A. Kane	48	Chief Financial Officer	06/14	(9)
William H. Shrank, M.D., MSHS	49	Chief Medical and Corporate Affairs Officer	04/19	(10)
Joseph C. Ventura	44	Chief Legal Officer	02/19	(11)
T. Alan Wheatley	53	Segment President, Retail	03/17	(12)
Cynthia H. Zipperle	58	Senior Vice President, Chief Accounting Officer and Controller	12/14	(13)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal currently serves as Chief Strategy and Corporate Development Officer, having joined the company in December 2018. Prior to joining the company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Ms. Cox currently serves as Chief Digital Health and Analytics Officer, having joined the Company in August 2018. Prior to joining the Company, Ms. Cox served as Chief Technology and Digital Officer at USAA, where she led the teams responsible for designing and building personalized and digitally-enabled end-to-end experiences for USAA members. Prior to USAA, Heather was the CEO of Citi FinTech at Citigroup, Inc., helping the company adapt to a future dominated by mobile technology, and she headed Card Operations, reshaping customer and digital experience for Capital One.

(4) Mr. Deshpande currently serves as Chief Technology and Risk Officer, having been elected to this position in August 2019, from his prior role as Chief Risk Officer. Before joining Humana in July 2017, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(5) Ms. Diamond currently serves as Segment President, Home Business, having been elected to this position in July 2019. Ms. Diamond joined the Company in June 2004 and has spent the majority of her Humana career in various leadership roles in the Medicare business, with a particular passion and emphasis on growth and consumer segmentation strategies for the Company's individual Medicare Advantage and Stand Alone Part D offerings. Ms. Diamond also served for two and a half years as the Enterprise Vice President of Finance, where she was responsible for enterprise planning and forecasting, trend analytics and had responsibility for each of the Company's line of business CFOs and controllers.

(6) Dr. Fleming currently serves as Segment President, Clinical and Pharmacy Solutions, where he is responsible for Humana's Clinical Solutions (strategy, quality, trend, and operations), Pharmacy Solutions (PBM, mail, specialty, retail), and Enterprise Clinical Operating Model, having held this position since December 2019. Prior to that, Dr. Fleming held positions of Segment President, Healthcare Services as well as President of the Company's pharmacy business. Dr. Fleming joined the Company in 1994.

(7) Mr. Hunter currently serves as Segment President, Group and Military Business, having been elected to this position in August 2018 after having previously served as the Company's Chief Strategy Officer since January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(8) Mr. Huval currently serves as Chief Administrative Officer, having been elected to this position in July 2019, from his previous role as Chief Human Resources Officer. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(9) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. He also oversees the operations of Humana's primary care business. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(10) Dr. Shrank currently serves as Chief Medical and Corporate Affairs Officer, having been elected to this position in July 2019, from his previous role as Chief Medical Officer. Before joining Humana in April 2019, Dr. Shrank served as Chief Medical Officer, Insurance Services Division at the University of Pittsburgh Medical Center, from 2016-2019, where he oversaw approximately $9 billion in annual health care expenditures for approximately 3.5 million members in Medicare, Medicaid, behavioral health, Managed Long Term Social Supports and commercial lines of business. He also developed and evaluated population health programs to further advance the medical center's mission as an integrated delivery and financing system. Prior to that, Dr. Shrank served as Senior Vice President, Chief Scientific Officer, and Chief Medical Officer of Provider Innovation at CVS Health from 2013 to 2016. Prior to joining CVS Health, Dr. Shrank served as Director, Research and Rapid-Cycle Evaluation Group, for the Center for Medicare and Medicaid Innovation, part of CMS from 2011 to 2013, where he led the evaluation of all

payment and health system delivery reform programs and developed the rapid-cycle strategy to promote continuous quality improvement. Dr. Shrank began his career as a practicing physician with Brigham and Women's Hospital in Boston and as an Assistant Professor at Harvard Medical School. His research at Harvard focused on improving the quality of prescribing and the use of chronic medications. He has published more than 200 papers on these topics.

(11) Mr. Ventura currently serves as Chief Legal Officer. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(12) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his long-tenured career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(13) Ms. Zipperle currently serves as Senior Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Ms. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. These estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Accordingly, our reserves may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members, including claims payments, capitation payments to providers (predetermined amounts paid to cover services), estimates of future payments to hospitals and others for medical care provided to our members, and various other costs. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit 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 benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, prescription drugs, or new technologies;
- our 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;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our purchase discounts or pharmacy volume rebates received from drug manufacturers and wholesalers, which are generally passed on to clients in the form of steeper price discounts;
- catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as the spread of the novel coronavirus (COVID-19) or severe weather (e.g. hurricanes and earthquakes));
- medical cost inflation; and
- government mandated benefits, member eligibility criteria, or other legislative, judicial, or regulatory changes.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part

on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments, and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have 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 program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors through the Medicare Annual Enrollment Period. In addition, contracts for the sale of group 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 and administrative costs.

The policies and decisions of the federal and state governments regarding the Medicare, military and Medicaid programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as changes to the programs in which we participate, those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

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, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives and our state-based contracts strategy, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products. In addition, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model and our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. The growth of our Medicare products is an important part of our business strategy, and the attendant concentration of revenues intensifies the risks to us inherent in Medicare products. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows.

The achievement of star ratings of 4-star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

If we fail to properly maintain the integrity of our data, to strategically maintain existing or implement new information systems, or to protect our proprietary rights to our systems, our business may 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. These 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. 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 or other legal problems, have difficulty preventing and detecting fraud, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

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. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers and service providers, 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, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows. The misappropriation of our proprietary information and/or third-party infringement claims against any software products we use could hinder our ability to market and sell products and services and may result in a material adverse effect on our results of operations, financial position and cash flows.

There can be no assurance that our information technology, or IT, process will successfully maintain and improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, or improve service levels. Failure to adequately protect and maintain the integrity of our information systems and data may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we

could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, and rely on third party service providers to do the same, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2020, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems, or the security of third party service providers, could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to detect, prevent, eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures or the security measures of third party service providers, and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our associates' or members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment compensation and other labor and employment practice suits, employee benefit claims, stockholder suits and other securities laws claims, intellectual and other property claims, 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; claims relating to our administration of our Medicare Part D offerings; medical malpractice actions brought against our employed providers or affiliated physician-owned professional groups, based on our medical necessity decisions or brought against us on the theory that we are liable for a third-party providers' alleged malpractice; claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients; allegations of anti-competitive and unfair business activities; provider disputes over compensation or non-acceptance or termination of provider contracts; disputes related to ASO business, including actions alleging claim administration errors; qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model; claims related to the failure to disclose some business practices; claims relating to customer audits and contract performance; claims relating to dispensing of drugs associated with our in-house dispensing pharmacies; and professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act 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 our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

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 materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, 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 results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability 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 Medicare, military, and Medicaid programs. These programs accounted for approximately 88% of our total premiums and services revenue for the year ended December 31, 2020. These programs involve various risks, as described further below.

- At December 31, 2020, under our contracts with CMS we provided health insurance coverage to approximately 728,300 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2020. The loss of these and other CMS contracts (which are generally renewed annually) or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2020, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a 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. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If

the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

  CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

  In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. We refer to the process of accounting for errors in FFS claims as the "FFS Adjuster." This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern

differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been finalized. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the “Proposed Rule”) related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

We believe that CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS’s final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an “overpayment” without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net asset of $95 million at December 31, 2020 and net payable of $170 million at December 31, 2019.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys general, CMS, HHS-OIG, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. 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 business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative (including the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19), judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage business profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, create uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health 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, 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 the confidentiality and security of patient data. The 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. These regulations set

standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures.

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened and strengthened the scope of the privacy and security regulations of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other requirements, the HITECH Act and HIPAA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

We are subject to various federal and state healthcare fraud and abuse laws including the federal False Claims Act (the “False Claims Act”), the federal anti-kickback statute (the “Anti-Kickback Statute”), the federal “Stark Law,” and related state laws. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participating in the Medicare and Medicaid programs or other government healthcare programs. The False Claims Act prohibits knowingly submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. The Anti-Kickback Statute prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of business under Medicare or other governmental health program. The Stark Law prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services to any entity with which the physician, or an immediate family member of the physician, has a financial relationship, unless the financial relationship fits within a permissible exception.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made.

In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

In November 2020, the Office of the Inspector General of the Department of Health and Humana Services issued a final rule to eliminate, under the Anti-Kickback Statute's regulatory discount safe harbor, protection for rebates paid by manufacturers to Part D plan sponsors or their PBMs in connection with the sale or purchase of Part D drugs. This regulatory change is currently scheduled to become effective on January 1, 2023. The final rule also introduced a new safe harbor to protect reductions in price from manufacturers on prescription drugs that are payable under Medicare Part D or by Medicaid managed care organizations when such price reduction is offered at the point of sale. The precise interpretation, impact, and legality of the final rule are not clear and are subject to pending litigation.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions, investments, joint ventures or strategic alliances may cause asset write-offs, restructuring costs or other expenses and may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic,

growth or profitability objectives, and we may divest or wind down such businesses. There can be no assurance that we will be able to complete any such divestiture on terms favorable to us, and the divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations.

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

We employ or 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. A key component of our integrated care delivery strategy is to increase the number of providers who 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 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 specialty groups, 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 compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a “capitation” contract. 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 may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

The success of our care delivery businesses depends on our ability, and the ability of our affiliated physician-owned professional groups and management services organizations, to recruit, hire, acquire, contract with, and retain physicians and other medical professionals who are experienced in providing care services to older adults. The market to acquire or manage physician practices, and to employ or contract with individual physicians is, and is expected to remain, highly competitive, and the performance of our care delivery businesses may be adversely impacted if we, and our affiliated physician-owned professional groups and management services organizations, are unable to attract, maintain satisfactory relationships with, and retain physicians and other medical professionals, or if these businesses are unable to retain patients following the departure of a physician. In addition, our care delivery businesses contract with competitors of our health benefits businesses, and these businesses could suffer if they are unable to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

Our pharmacy business is highly competitive and subject us to regulations and supply chain risks in addition to those we face with our core health benefits businesses.

Our in-house dispensing pharmacy business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies.

Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, including manufacturing, distribution or other supply chain disruptions that could impact the availability or cost of supplying of such products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our in-house dispensing pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

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., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and 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 insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, 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. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital

to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. 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.

We believe that certain of our customers place importance on our claims paying ability, financial strength, and debt ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings impact our ability to obtain future borrowings and investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Ongoing volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell or are not required to sell a security in an unrealized loss position, potential credit related impairments are considered using a variety of factors, including the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or credit related impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, including the heightened uncertainty created by the COVID-19 pandemic, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the

possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

The spread of, and response to, COVID-19 underscores certain risks we face, including those discussed above, and the ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19.

COVID-19, which has spread to every state in the United States and been declared a pandemic by the World Health Organization, underscores certain risks we face, including those discussed above. To the extent that the spread of COVID-19 is not contained, the premiums we charge may prove to be insufficient to cover the cost of health care services delivered to our members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs. We may also experience increased costs or decreased revenues if, as a result of our members being unable or unwilling to see their providers due to actions taken to mitigate the spread of COVID-19, we are unable to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles. In addition, we are offering, and have been mandated by legislative and regulatory action (including the Families First Act and CARES Act) to provide, certain expanded benefit coverage to our members, such as waiving out of pocket costs for COVID-19 testing and treatment. We are also taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps taken by us, or governmental action, to continue to respond to and to address the ongoing impact of COVID-19 (including further expansion or modification of the services delivered to our members, the adoption or modification of regulatory requirements associated with those services and the costs and challenges associated with ensuring timely compliance with such requirements) to provide further relief for the health care provider community, or in connection with the relaxation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity, including the potential for widespread testing and therapeutic treatments and the distribution and administration of COVID-19 vaccines, could adversely impact our profitability.

The spread and impact of COVID-19, or actions taken to mitigate this spread, could have material and adverse effects on our ability to operate effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in public and private infrastructure, including communications, availability of in-person sales and marketing channels, financial services and supply chains, could materially and adversely disrupt our normal business operations. We have transitioned a significant subset of our employee population to a remote work environment in an effort to mitigate the spread of COVID-19, as have a number of our third-party service providers, which may exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties. The outbreak of COVID-19 has severely impacted global economic activity, including the businesses of some of our commercial customers, and caused significant volatility and negative pressure in the financial markets. In addition to disrupting our operations, these developments may adversely affect the timing of commercial customer premium collections and corresponding claim payments, the value of our investment portfolio, or future liquidity needs.

The ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19. We are continuing to monitor the spread of COVID-19, changes to our benefit coverages, and the ongoing costs and business impacts of dealing with COVID-19, including the potential costs and impacts associated with lifting, or reimposing, restrictions on movement and economic activity, the timing and degree in resumption of demand for deferred healthcare services, the pace of administration of COVID-19 vaccines and the effectiveness of those vaccines, and related risks. The magnitude and duration of the pandemic and its ultimate impact on our business, results of operations, financial position, and cash flows is uncertain, but such impacts could be material to our business, results of operations, financial position and cash flows.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

We owned or leased numerous medical centers and administrative offices at December 31, 2020. The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of these medical centers, approximately 195 of these facilities are leased or subleased to our contracted providers to operate.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, qui tam litigation brought by individuals seeking to sue on behalf of the government, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see “Legal Proceedings and Certain Regulatory Matters” in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2021, there were 1,943 holders of record of our common stock and 297,870 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2019 and 2020, under our Board approved quarterly cash dividend policy:

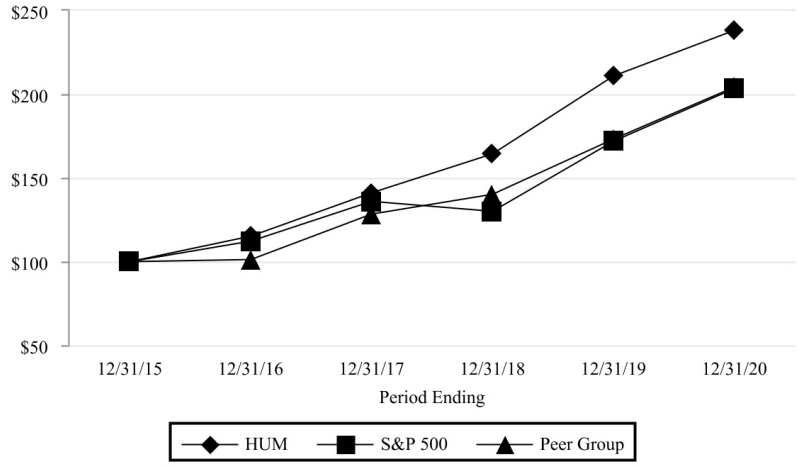
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2019 payments			
12/31/2018	1/25/2019	$0.500	$68
3/29/2019	4/26/2019	$0.550	$74
6/28/2019	7/26/2019	$0.550	$74
9/30/2019	10/25/2019	$0.550	$73
2020 payments			
12/31/2019	1/31/2020	$0.550	$73
3/31/2020	4/24/2020	$0.625	$83
6/30/2020	7/31/2020	$0.625	$83
9/30/2020	10/30/2020	$0.625	$83

On November 1, 2020, the Board declared a cash dividend of $0.625 per share that was paid on January 29, 2021 to stockholders of record on December 31, 2020, for an aggregate amount of $81 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2021, the Board declared a cash dividend of $0.70 per share payable on April 30, 2021 to stockholders of record on March 31, 2021.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2020. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2015, and that dividends were reinvested when paid.



	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020
HUM	$ 100	$ 115	$ 141	$ 164	$ 211	$ 238
S&P 500	$ 100	$ 112	$ 136	$ 130	$ 172	$ 203
Peer Group	$ 100	$ 101	$ 128	$ 140	$ 173	$ 204

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2020 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2) (3)
October 2020	—	$ —	—	$ 2,000,000,000
November 2020	—	—	—	2,000,000,000
December 2020	3,829,420	388.44	3,829,420	250,000,000
Total	3,829,420	$ 388.44	3,829,420	

(1) On December 22, 2020, we entered into separate accelerated stock repurchase agreements, ("the December 2020 ASR Agreements"), with Citibank, N.A., or Citi, and JPMorgan Chase Bank, or JPM, to repurchase $1.75 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On December 23, 2020, in accordance with the December 2020 ASR Agreements, we made a payment of $1.75 billion ($875 million to Citi and $875 million to JPM) and received an initial delivery of 3.8 million shares of our common stock (1.9 million shares each from Citi and JPM). We recorded the payments to Citi and JPM as a reduction to stockholders' equity, consisting of an $1.5 billion increase in treasury stock, which reflects the value of the initial 3.8 million shares received upon initial settlement, and a $262.5 million decrease in capital in excess of par value, which reflects the value of stock held back by Citi and JPM pending final settlement of the December 2020 ASR Agreements. The final number of shares that we may receive, or be required to remit, under the December 2020 ASR Agreements, will be determined based on the daily volume-weighted average share price of our common stock over the term of the December 2020 ASR Agreements, less a discount and subject to adjustments pursuant to the terms and conditions of the December 2020 ASR Agreements. We expect final settlement under the December 2020 Agreements to occur during the second quarter of 2021. The December 2020 Agreements contain provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the agreement may be accelerated, extended, or terminated early by Citi, JPM or Humana as well as various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Citi and JPM or we may be required to make a payment. If we are obligated to make a payment, we may elect to satisfy such obligation in cash or shares of our common stock.

(2) Excludes 0.2 million shares repurchased in connection with employee stock plans.

(3) On February 18, 2021, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $250 million remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring as of February 18, 2024.

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

For discussion of 2018 items and year-over-year comparisons between 2019 and 2018 that are not included in this 2020 Form 10-K, refer to "Item 7. – Management Discussion and Analysis of Financial Condition and Results of Operations" found in our Form 10-K for the year ended December 31, 2019, that was filed with the Securities and Exchange Commission on February 20, 2020.

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding Merger termination fee and related costs, net, and depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

COVID-19

During 2020 we took actions to protect, inform, and care for our members, providers, employees, and other stakeholders associated with the outbreak of the novel coronavirus, or COVID-19. Specifically, we highlight the following actions to support our members:

- waiving all cost sharing for COVID-19 treatment and testing, including inpatient hospital admissions as well as in-network primary care, outpatient behavioral health, and telehealth visits, to reduce financial barriers to members seeking care and to re-engage with their physician, while continuing to encourage the use of telehealth;
- delivering meals to our senior members in need;
- making it easier for members to be tested for COVID-19 by offering at-home testing, as well as offering in-home preventive screening and diabetes testing kits to encourage members to seek preventive care that may have been delayed during the pandemic.
- proactively delivering safety kits, including face masks, to members and employee homes to facilitate access to care and support visits to providers safely;
- extending grace periods for premium payments for our fully-insured commercial group members, to ensure continuity of coverage during times of financial stress; and
- establishing a clinical outreach team to proactively engage with our most vulnerable members.

In addition, we took steps to support our provider partners and boost system viability by:

- increasing provider funding, simplifying and expanding claims processing and releasing advanced funding to providers, to get reimbursement payments to providers as quickly as possible and ease financial concerns so that members are able to continue to access the care and information they need; and

• expanding modifications to certain utilization management processes, to ease administrative stress and make sure providers are able to most efficiently care for their patients.

We also supported our workforce keeping them safe and addressing other needs during this time, highlighting the following:

• transitioning nearly 94% of the workforce to work-at-home and equipping them with the necessary technology and resources for a successful remote work environment.

• providing funding for emergency relief for elder and child caregiving and financial hardship from family job loss, food insecurity and household essentials.

• adjusting pay and leave policies to provide additional paid time off to manage personal challenges as a result of COVID-19 including school closings and child care.

Finally, we continued to support the communities we serve by donating $200 million to the Humana Foundation to address social determinants of health in an effort to promote more health days and encourage greater health equity.

The emergence and spread of COVID-19 has impacted our business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020, and continued to rebound throughout the third quarter and early in the fourth quarter of 2020, reaching approximately 95% of historic baseline levels as of the end of October 2020. Then, in the latter half of November and accelerating throughout the month of December, we experienced a significant increase in COVID-19 admissions in nearly all of the markets in which we operate across our Medicare Advantage, Medicaid, and group commercial insurance business lines, resulting in higher COVID-19 treatment and testing costs. During this period, we also experienced a corresponding decline in non-COVID utilization in all service categories to well below the near baseline levels of non-COVID utilization witnessed as late as the end of October 2020 (with non-COVID utilization in our Medicare Advantage business running approximately 15% below normal levels at the close of the fourth quarter of 2020). The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during this period. Our 2020 results were also impacted by our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model.

We currently anticipate that the higher levels of COVID-19 admissions experienced late in 2020, and the corresponding decrease in non-COVID utilization, will continue for at least the first few months of 2021. Over the course of 2021, we then expect COVID utilization to decline as more of our members are vaccinated, and that non-COVID utilization will trend back to more normal levels. The significant disruption in utilization during 2020, and in particular the unanticipated decline in non-COVID utilization in November and December, also impacted our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles. We currently expect this may impact our 2021 revenues under the risk adjustment payment model for Medicare Advantage plans, but that these trends will also normalize in 2022 as non-COVID utilization trends back to more normal levels throughout 2021. However, the course and magnitude of these trends and their associated impact remains highly uncertain and subject to a significant number of variables and uncertainties including, among others, the severity and duration of the pandemic, continued actions taken to mitigate the spread of COVID-19 (including new COVID-19 variants) and in turn, relax those restrictions, the timing and degree in resumption of demand for deferred health care services, the pace of administration of COVID-19 vaccines and the effectiveness of those vaccines, and level and cost of treatment and testing, all of which are difficult to predict. As such, our response to this global health crisis and the subsequent recovery will continue to evolve over the coming months.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our non-consolidating minority investment in Kindred at Home and the strategic partnership with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers.

The results of each segment are measured by income before income taxes and equity in net earnings from equity method investments, or segment earnings. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

COVID-19 disrupted the pattern of our quarterly earnings and operating cash flows in 2020 largely due to the temporary deferral of non-essential care which resulted in significant reductions in hospital admissions and lower overall healthcare system utilization during higher levels of COVID-19 hospital admissions. Similar impacts and seasonal disruptions from either higher or lower utilization are expected to persist as we respond to and recover from the COVID-19 global health crisis.

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member’s cumulative out-of-pocket costs pass through successive stages of a member’s plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less

in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare marketing season.

Our Group and Specialty segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group and Specialty segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses.

Recent Transactions

In the first quarter of 2020, we purchased privately held Enclara Healthcare, or Enclara, one of the nation's largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received.

Also, in the first quarter of 2020, we entered into a strategic partnership with WCAS to accelerate the expansion of our primary care model. The WCAS partnership opened 20 payor-agnostic, senior-focused primary care centers during 2020, and is expected to open an additional 30 over the next 2 years.

These transactions are more fully discussed in Note 3 to the consolidated financial statements.

Highlights

- Our 2020 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2020, approximately 2,650,100 members, or 67%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 2,407,000 members, or 67%, at December 31, 2019. Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 910,600 at December 31, 2020, an increase of 4.8% from 868,800 at December 31, 2019. These members may not be unique to each program since members have the ability to enroll in multiple programs. The increase is driven by our improved process for identifying and enrolling members in the appropriate program at the right time, coupled with growth in Special Needs Plans, or SNP, membership.

- On January 15, 2021, Centers for Medicare & Medicaid Services, or CMS, published its Announcement of Calendar Year 2022 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies, or the Final Rate Notice. We expect the Final Rate Notice to result in a 3.7% rate increase for non end stage renal disease, or ESRD, Medicare Advantage business, excluding the impact of Employer Group Waiver Plan, or EGWP, funding changes. Our 3.7% rate increase compares to CMS's estimate for the sector of 4.08% on a comparable basis, with the variance primarily driven by county rebasing and our geographic footprint. CMS also establishes separate rates of payment for ESRD beneficiaries enrolled in Medicare Advantage plans. We expect the Final Rate Notice to result in a 5.0% rate increase in 2021 for ESRD beneficiaries. Our estimate of 5.0% is equivalent to CMS's estimate.

The 2022 benchmark increase of 3.7% includes roughly 0.8% for the projected cost of COVID-19 vaccines.

- Net income was $3.4 billion for 2020 compared to $2.7 billion in 2019 and earnings per diluted common share increased $5.21 from $20.10 earnings per diluted common share in 2019 to $25.31 earnings per diluted common share in 2020. These comparisons were significantly impacted by the change in the fair value of publicly-traded equity securities, the net receipt of commercial risk corridor receivables previously written off, and the put/call valuation adjustments associated with certain equity method investments. The change in the fair value of our publicly-traded equity securities relates primarily to our common stock holdings, including both the gain resulting from the initial conversion of our prior ownership interest in certain privately held companies, primarily in Oak Street Health, Inc., or OSH, into common stock upon such companies' initial public offering, or IPO, during the third quarter of 2020, and the subsequent changes in the market value of such securities from their IPO through the end of 2020. In 2020 we received $578 million, net of related fees and expenses pursuant to the U.S. Supreme Court ruling that the government is obligated to pay the losses under the risk corridor program. The receipt of the risk corridor payments was associated with losses incurred under the Health Care Reform business in 2014 to 2016. The receipt of these risk corridor payments accounted for less than half of our accumulated losses before income taxes from this business during that time period. The impact of these adjustments to our consolidated income before income taxes and equity in net earnings and diluted earnings per common share was as follows for 2020.

	2020	2019
Consolidated income before income taxes and equity in net earnings:		
Change in the fair value of publicly-traded equity securities	$ 745	$ —
Receipt of commercial risk corridor receivables previously written-off	578	—
Put/call valuation adjustments	(103)	506
	$ 1,220	$ 506

	2020	2019
Diluted earnings per common share:		
Change in the fair value of publicly-traded equity securities	$ 4.32	$ —
Receipt of commercial risk corridor receivables previously written-off	3.35	—
Put/call valuation adjustments	(0.60)	2.89
	$ 7.07	$ 2.89

- Excluding these adjustments, our results of operations reflect the impact of the ongoing COVID-19 pandemic. Comparisons were impacted by cost reductions due to lower non-COVID utilization patterns from stay-at-home and physical distancing orders and other restrictions on movement offset by cost increases due to COVID-19 treatment and testing costs and our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model. These changes were also favorably impacted by a lower number of shares used to compute dilutive earnings per common share, primarily reflecting share repurchases completed during 2019, partially offset by a higher tax rate resulting from the return of the non-deductible health insurance industry fee in 2020.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

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 year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers and are described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2020 Form 10-K.

Comparison of Results of Operations for 2020 and 2019

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2020 and 2019:

Consolidated

			Change	
	2020	2019	Dollars	Percentage
		(dollars in millions, except per common share results)		
Revenues:				
Premiums:				
Retail	$ 67,124	$ 56,254	$ 10,870	19.3 %
Group and Specialty	6,460	6,694	(234)	(3.5)%
Corporate	602	—	602	100.0 %
Total premiums	74,186	62,948	11,238	17.9 %
Services:				
Retail	19	17	2	11.8 %
Group and Specialty	780	790	(10)	(1.3)%
Healthcare Services	1,016	632	384	60.8 %
Total services	1,815	1,439	376	26.1 %
Investment income	1,154	501	653	130.3 %
Total revenues	77,155	64,888	12,267	18.9 %
Operating expenses:				
Benefits	61,628	53,857	7,771	14.4 %
Operating costs	10,052	7,381	2,671	36.2 %
Depreciation and amortization	489	458	31	6.8 %
Total operating expenses	72,169	61,696	10,473	17.0 %
Income from operations	4,986	3,192	1,794	56.2 %
Interest expense	283	242	41	16.9 %
Other expense (income), net	103	(506)	609	(120.4)%
Income before income taxes and equity in net earnings	4,600	3,456	1,144	33.1 %
Provision for income taxes	1,307	763	544	71.3 %
Equity in net earnings	74	14	60	428.6 %
Net income	$ 3,367	$ 2,707	$ 660	24.4 %
Diluted earnings per common share	$ 25.31	$ 20.10	$ 5.21	25.9 %
Benefit ratio (a)	83.1 %	85.6 %		(2.5)%
Operating cost ratio (b)	13.2 %	11.5 %		1.7 %
Effective tax rate	28.0 %	22.0 %		6.0 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Premiums Revenue

Consolidated premiums increased $11.2 billion, or 17.9%, from $62.9 billion for 2019 to $74.2 billion for 2020 primarily due to higher premium revenues from Medicare Advantage and state-based contracts membership growth, higher per member Medicare Advantage premiums, and the receipt of commercial risk corridor receivables previously written off, partially offset by the impact of declining stand-alone PDP and fully-insured group commercial medical membership as more fully described in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue increased $376 million, or 26.1%, from $1.4 billion for 2019 to $1.8 billion for 2020, primarily due to an increase in services revenue in the Healthcare Services segment associated with higher external pharmacy revenues resulting from the Enclara acquisition in the first quarter of 2020.

Investment Income

Investment income was $1.2 billion for 2020, increasing $653 million, or 130.3%, from 2019, primarily due to the $745 million change in fair value of publicly-traded equity securities during 2020.

Benefits Expense

Consolidated benefits expense was $61.6 billion for 2020, an increase of $7.8 billion, or 14.4%, from 2019. The consolidated benefit ratio for 2020 was 83.1%, a decrease of 250 basis points from 2019 primarily reflecting significantly depressed non-COVID utilization in the first half of 2020 as well as the last two months of the fourth quarter, the reinstatement of the non-deductible health insurance industry fee in 2020 that was contemplated in the pricing and benefit design of our products, along with the receipt of the commercial risk corridor receivables previously written off. These decreases were partially offset by the meaningful COVID-19 treatment and testing costs along with our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model, as well as lower prior-period medical claims reserve development.

We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020 and $336 million in 2019. The favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 40 basis points in 2020 and 50 basis points in 2019.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs increased $2.7 billion, or 36.2%, from 2019 to $10.1 billion in 2020 reflecting an increase in operating costs in the Retail and the Group and Specialty segments as discussed in the detailed segment results discussion that follows.

The consolidated operating cost ratio for 2020 was 13.2%, increasing 170 basis points from 11.5% in 2019 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2020, COVID-19 related administrative costs, including those associated with purchasing personal protective equipment for our clinicians and the build-out of infrastructure necessary to support employees working remotely. Higher marketing spend associated with the Medicare Annual Election Period, or AEP, strategic investments in our integrated care delivery model and continued support for our constituents, including a $200 million contribution to the Humana Foundation to support the communities served by us, particularly those with social and health disparities, also contributed to the increase. These increases were partially offset by scale efficiencies associated with growth in our Medicare Advantage membership, significant operating cost efficiencies in 2020 driven by previously disclosed productivity initiatives, and the net impact of the receipt of the commercial risk corridor receivables previously written off. The nondeductible health insurance industry fee impacted the operating cost ratio by 160 basis points in 2020.

Depreciation and Amortization

Depreciation and amortization in 2020 totaled $489 million compared to $458 million in 2019, an increase of 6.8%, primarily due to capital expenditures.

Interest Expense

Interest expense was $283 million for 2020 compared to $242 million for 2019, an increase of $41 million, or 16.9%. This increase primarily was due to the higher average borrowings outstanding.

Income Taxes

Our effective tax rate during 2020 was 28.0% compared to the effective tax rate of 22.0% in 2019. This change primarily was due to the reinstatement of the non-deductible health insurance industry fee in 2020. See Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2020	2019	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	3,962,700	3,587,200	375,500	10.5 %
Group Medicare Advantage	613,200	525,300	87,900	16.7 %
Medicare stand-alone PDP	3,866,700	4,365,200	(498,500)	(11.4)%
Total Retail Medicare	8,442,600	8,477,700	(35,100)	(0.4)%
State-based Medicaid	772,400	469,000	303,400	64.7 %
Medicare Supplement	335,600	298,400	37,200	12.5 %
Total Retail medical members	9,550,600	9,245,100	305,500	3.3 %

			Change	
	2020	2019	Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 51,697	$ 43,128	$ 8,569	19.9 %
Group Medicare Advantage	7,774	6,475	1,299	20.1 %
Medicare stand-alone PDP	2,742	3,165	(423)	(13.4)%
Total Retail Medicare	62,213	52,768	9,445	17.9 %
State-based Medicaid	4,223	2,898	1,325	45.7 %
Medicare Supplement	688	588	100	17.0 %
Total premiums	67,124	56,254	10,870	19.3 %
Services	19	17	2	11.8 %
Total premiums and services revenue	$ 67,143	$ 56,271	$ 10,872	19.3 %
Segment earnings	$ 3,017	$ 2,235	$ 782	35.0 %
Benefit ratio	84.2 %	86.4 %		(2.2)%
Operating cost ratio	11.0 %	9.4 %		1.6 %

Segment Earnings

- Retail segment earnings were $3.0 billion in 2020, an increase of $782 million, or 35.0%, compared to $2.2 billion in 2019 primarily resulting from the net favorable impact of a lower benefit ratio, partially offset by a higher operating cost ratio as more fully described below.

Enrollment

- Individual Medicare Advantage membership increased 375,500 members, or 10.5%, from 3,587,200 members as of December 31, 2019 to 3,962,700 members as of December 31, 2020, primarily due to membership additions associated with the 2020 Annual Election Period, or AEP, continued enrollment due to special elections, age-ins, and and Dual Eligible Special Need Plans, or D-SNP, members as well as the 2020 Open Election Period, or OEP, for Medicare beneficiaries. The 2020 OEP sales period, which ran from January 1 to March 31, 2020, added approximately 30,000 members. individual Medicare Advantage membership includes 406,100 D-SNP members as of December 31, 2020, a net increase of 117,900, or 40.9%, from 288,200 December 31, 2019. For the full year 2021, we anticipate a net membership increase in our individual Medicare Advantage offerings of 425,000 members to 475,000 members.

- Group Medicare Advantage membership increased 87,900 members, or 16.7%, from 525,300 members as of December 31, 2019 to 613,200 members as of December 31, 2020, primarily due to the addition of a large account in January 2020, along with net membership additions associated with the 2020 selling season. For the full year 2021, we anticipate a net membership decline in our Group Medicare Advantage offerings of approximately 50,000 members.

- Medicare stand-alone PDP membership decreased 498,500 members, or 11.4%, from 4,365,200 members as of December 31, 2019 to 3,866,700 members as of December 31, 2020, primarily resulting from terminations driven by premium and benefit adjustments experienced by members that were previously enrolled in our 2019 Humana Walmart Rx plan and the 2019 Humana Enhanced plan, which were consolidated into the Premier Rx plan in 2020. The PDP losses were partially offset by growth in the new low-price Humana Walmart Value Rx plan, driven by both new sales and plan to plan changes. For the full year 2021, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of approximately 300,000 members.

- State-based Medicaid membership increased 303,400 members, or 64.7%, from 469,000 members as of December 31, 2019 to 772,400 members as of December 31, 2020, primarily reflecting the impact of discontinuing the reinsurance agreement with CareSource and the assumption of full financial risk for the existing Kentucky Medicaid contract as of January 1, 2020, as well as additional enrollment resulting from the current economic downturn due to the COVID-19 pandemic.

Premiums revenue

- Retail segment premiums increased $10.9 billion, or 19.3%, from 2019 to 2020 primarily due to higher premiums as a result of Medicare Advantage and state-based contracts membership growth and higher per member Medicare Advantage premiums. These favorable items were partially offset by the decline in membership in our stand-alone PDP offerings.

Benefits expense

- The Retail segment benefit ratio of 84.2% for 2020 decreased 220 basis points from 86.4% in 2019 primarily reflecting significantly depressed non-COVID utilization in the first half of 2020 as well as in the last two months of 2020 and the reinstatement of the non-deductible health insurance industry fee in 2020 which was contemplated in the pricing and benefit design of our products. These were partially offset by meaningful COVID-19 treatment costs and testing, our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model, the impact from a shift in Medicare membership mix, and lower favorable prior-period medical claims reserve development.

- The Retail segment's benefits expense for 2020 included the beneficial effect of $266 million in favorable prior-year medical claims reserve development versus $386 million in 2019. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 40 basis points in 2020 versus approximately 70 basis points in 2019.

Operating costs

- The Retail segment operating cost ratio of 11.0% for 2020 increased 160 basis points from 9.4% in 2019 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2020, COVID-19 related administrative costs as previously discussed, continued support for our constituents and strategic investments in our integrated care delivery model, and increased spending associated with Medicare AEP. These were partially offset by scale efficiencies associated with growth in our Medicare Advantage membership and significant operating cost efficiencies driven by previously disclosed productivity initiatives.
- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2020.

Group and Specialty Segment

			Change	
	2020	2019	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	777,400	908,600	(131,200)	(14.4)%
ASO	504,900	529,200	(24,300)	(4.6)%
Military services	5,998,700	5,984,300	14,400	0.2 %
Total group medical members	7,281,000	7,422,100	(141,100)	(1.9)%
Specialty membership (a)	5,310,300	5,425,900	(115,600)	(2.1)%

(a) Specialty products include dental, vision, and life insurance benefits. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

			Change	
	2020	2019	Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 4,761	$ 5,123	$ (362)	(7.1)%
Specialty	1,699	1,571	128	8.1 %
Total premiums	6,460	6,694	(234)	(3.5)%
Services	780	790	(10)	(1.3)%
Total premiums and services revenue	$ 7,240	$ 7,484	$ (244)	(3.3)%
Segment (loss) earnings	$ (143)	$ 28	$ (171)	(610.7)%
Benefit ratio	85.6 %	86.0 %		(0.4)%
Operating cost ratio	25.0 %	22.0 %		3.0 %

Segment Earnings

- Group and Specialty segment loss was $143 million in 2020, a decrease of $171 million, or 610.7%, from $28 million of segment earnings in 2019 primarily due to the net negative impact of a higher operating cost ratio, partially offset by a slightly lower benefit ratio as more fully described below.

Enrollment

- Fully-insured commercial group medical membership decreased 131,200 members, or 14.4% from 908,600 members as of December 31, 2019 primarily reflecting lower membership in small group accounts due in part to more small group accounts selecting level-funded ASO products, as well as the loss of certain large group accounts due to disciplined pricing in the competitive environment. Additionally, the declines in membership were impacted by the current economic downturn driven by the COVID-19 pandemic resulting in higher unemployment rates and loss of coverage for fully-insured commercial group members. The portion of group fully-insured commercial medical membership in small group accounts was approximately 54% at December 31, 2020 and 59% at December 31, 2019.

- Group ASO commercial medical membership decreased 24,300 members, or 4.6%, from 529,200 members as of December 31, 2019 to 504,900 members as of December 31, 2020 primarily reflecting the loss of certain large group accounts due to continued discipline in pricing of services for self-funded accounts amid a highly competitive environment and the impact of the current economic downturn driven by the COVID-19 pandemic as previously discussed, partially offset by more small group accounts selecting level-funded ASO products. Small group membership comprised 45% of group ASO medical membership at December 31, 2020 versus 40% at December 31, 2019.

- Military services membership increased 14,400 members, or 0.2%, from 5,984,300 members as of December 31, 2019 to 5,998,700 members as of December 31, 2020. Membership includes military service members, retirees, and their families to whom we are providing healthcare services under the current TRICARE East Region contract.

- Specialty membership decreased 115,600 members, or 2.1%, from 5,425,900 as of December 31, 2019 to 5,310,300 members as of December 31, 2020 primarily due to the loss of certain group accounts offering stand-alone dental and vision products, as well as the impact of the current economic downturn driven by the COVID-19 pandemic as previously discussed.

Premiums revenue

- Group and Specialty segment premiums decreased $234 million, or 3.5%, from $6.7 billion in 2019 to $6.5 billion in 2020, primarily due to the decline in our fully-insured group commercial membership, partially offset by higher stop-loss premiums related to our level-funded ASO accounts resulting from membership growth in this product and higher per member premiums across the fully-insured commercial business.

Services revenue

- Group and Specialty segment services revenue decreased $10 million, or 1.3%, from 2019 to 2020 primarily due to lower ASO membership described previously.

Benefits expense

- The Group and Specialty segment benefit ratio decreased 40 basis points from 86.0% in 2019 to 85.6% in 2020 primarily due to significantly depressed non-COVID utilization in the first half of 2020 and again in the last two months of 2020, the reinstatement of the non-deductible health insurance industry fee in 2020 which was contemplated in the pricing and benefit design of our products, and higher favorable prior-period medical claims reserve development. These items were partially offset by meaningful COVID-19 treatment costs and testing and our ongoing pandemic relief efforts and strategic investments as previously described.

- The Group and Specialty segment's benefits expense included the favorable effect of $47 million in prior-period medical claims reserve development in 2020 versus the unfavorable effect of $50 million in favorable prior-period medical claims reserve development in 2019. This favorable prior-period medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2020 while the unfavorable prior-period medical claims reserve development increased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2019.

Operating costs

- The Group and Specialty segment operating cost ratio of 25.0% for 2020 increased 300 basis points from 22.0% for 2019, primarily due to COVID-19 related administrative costs as previously discussed, continued support for our constituents and strategic investments in the segment to position the business for long-term success, and the reinstatement of the non-deductible health insurance industry fee in 2020. These increases were partially offset by significant operating cost efficiencies driven by previously disclosed productivity initiatives.

- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 130 basis points in 2020.

Healthcare Services Segment

			Change	
	2020	2019	Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Clinical care services	$ 107	$ 140	$ (33)	(23.6)%
Pharmacy solutions	581	186	395	212.4 %
Provider services	328	306	22	7.2 %
Total services revenues	1,016	632	384	60.8 %
Intersegment revenues:				
Pharmacy solutions	24,587	22,189	2,398	10.8 %
Provider services	2,266	2,344	(78)	(3.3)%
Clinical care services	566	616	(50)	(8.1)%
Total intersegment revenues	27,419	25,149	2,270	9.0 %
Total services and intersegment revenues	$ 28,435	25,781	$ 2,654	10.3 %
Segment earnings	$ 944	$ 789	$ 155	19.6 %
Operating cost ratio	96.3 %	96.4 %		(0.1)%

Segment Earnings

- Healthcare Services segment earnings were $944 million in 2020, an increase of $155 million, or 19.6%, from 2019 reflecting the same factors that resulted in a lower operating cost ratio as more fully described below, as well as higher earnings from equity method investments in 2020.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 478 million in 2020, up 4.8% versus scripts of approximately 456 million in 2019. The increase primarily was driven by higher Medicare Advantage and state-based contracts membership, partially offset by the decline in stand-alone PDP membership.

Services revenue

- Services revenue increased $384 million, or 60.8%, from 2019 to $1.0 billion for 2020 primarily due to the additional pharmacy revenues associated with the acquisition of Enclara in 2020.

Intersegment revenues

- Intersegment revenues increased $2.3 billion, or 9.0%, from 2019 to $27.4 billion for 2020 primarily due to strong Medicare Advantage membership growth and a slight shift by members to 90-day mail supply, partially offset by the loss of intersegment revenues associated with the decline in stand-alone PDP membership.

Operating costs

- The Healthcare Services segment operating cost ratio of 96.3% for 2020 decreased 10 basis points from 96.4% in 2019 due to operational improvements and reduced utilization resulting from COVID-19 in our provider services business, as well as significant operating cost efficiencies in 2020 driven by previously disclosed productivity initiatives. These decreases were partially offset by COVID-19 administrative related costs, including expenses associated with additional safety measures taken for our pharmacy, provider, and clinical teams who have continued to provide services to members during the COVID-19 pandemic. The increase further reflects higher costs incurred in the pharmacy business to ensure timely delivery of prescriptions amid the COVID-19 pandemic and additional investments in the segment's provider business related to marketing and AEP initiatives.

Liquidity

Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, and borrowings. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2020 Form 10-K.

Cash and cash equivalents increased to $4.7 billion at December 31, 2020 from $4.1 billion at December 31, 2019. The change in cash and cash equivalents for the years ended December 31, 2020, 2019 and 2018 is summarized as follows:

	2020	2019	2018
		(in millions)	
Net cash provided by operating activities	$ 5,639	$ 5,284	$ 2,173
Net cash used in investing activities	(3,065)	(1,278)	(3,087)
Net cash used in financing activities	(1,955)	(2,295)	(785)
Increase (decrease) in cash and cash equivalents	$ 619	$ 1,711	$ (1,699)

Cash Flow from Operating Activities

The increase in operating cash flows in 2020 was primarily due to the impact of higher earnings and the timing of working capital items, in particular; the impact of Medicare Advantage membership growth on IBNR, described below, as claim payments related to new members lag the related premium collected.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2020, 2019 and 2018:

	2020	2019	2018	Change 2020
		(in millions)		
IBNR (1)	$ 5,290	$ 4,150	$ 3,361	$ 1,140
Reported claims in process (2)	816	628	617	188
Other benefits payable (3)	2,037	1,226	884	811
Total benefits payable	$ 8,143	$ 6,004	$ 4,862	2,139

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. 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 and processed (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, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.

(3) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable in 2020 was primarily due to an increase in IBNR, mainly as a result of Medicare Advantage membership growth. In addition, 2020 was impacted by an increase in the amounts owed to providers under capitated and risk sharing arrangements, primarily related to Medicare Advantage membership growth in risk sharing arrangements and higher provider surplus amounts driven by lower utilization due to COVID-19.

The detail of total net receivables was as follows at December 31, 2020, 2019 and 2018:

	2020	2019	2018	Change 2020
		(in millions)		
Medicare	$ 928	$ 835	$ 836	$ 93
Commercial and other	122	162	135	(40)
Military services	160	128	123	32
Allowance for doubtful accounts	(72)	(69)	(79)	(3)
Total net receivables	$ 1,138	$ 1,056	$ 1,015	82
Reconciliation to cash flow statement:				
Change in receivables disposed from sale of business				3
Change in receivables per cash flow statement resulting in cash used by operations				$ 85

Medicare receivables are impacted by changes in revenue associated with individual and group Medicare membership changes as well as the timing of accruals and related collections associated with the CMS risk-adjustment model.

Military services receivables at December 31, 2020, 2019, and 2018 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE contracts.

Many provisions of the Health Care Reform Law became effective in 2014, including the non-deductible health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. We paid the federal government annual health insurance industry fees of $1.18 billion in 2020.

Cash Flow from Investing Activities

In the first quarter of 2020, we acquired privately held Enclara for cash consideration of approximately $709 million, net of cash received as discussed in Note 3 to the consolidated financial statements included in Item 8 - Financial Statements and Supplementary Data.

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $964 million in 2020, $736 million in 2019, and $612 million in 2018. The increase in capital expenditures year over year was primarily due to information technology expenditures supporting our integrated care delivery model.

In 2018, we completed the sale of our wholly-owned subsidiary KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. Total cash and cash equivalents, including parent company funding, disposed at the time of sale, was $805 million. See Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

During 2018 we paid cash consideration of approximately $1.1 billion to acquire a 40% minority interest in Kindred at Home, $169 million to acquire the remaining interest in MCCI Holdings, LLC, or MCCI, and $185 million to acquire all of Family Physicians Group, or FPG, as discussed in Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income debt securities, totaling $1.4 billion, $542 million, and $221 million, during 2020, 2019 and 2018, respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claim payments were higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk by $938 million, $560 million and $653 million in the 2020, 2019 and 2018 periods, respectively. Our net receivable from CMS for subsidies and brand name prescription drug discounts was $1.2 billion at December 31, 2020 compared to a net receivable of $229 million at December 31, 2019.

Under our administrative services only TRICARE contract, health care costs payments for which we do not assume risk exceeded reimbursements from the federal government by $1 million and $63 million in the 2020 and 2019 periods, respectively, and reimbursements from the federal government exceeded health care costs payments for which we do not assume risk by $38 million in the 2018 period.

Claim payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $25 million in the 2018 period.

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $1,088 million.

In March 2020, we drew $1 billion on our existing term loan commitment and repaid the $1 billion outstanding amount in November 2020.

In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029 and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on its maturity date of October 1, 2019.

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. We repaid $350 million of the outstanding amount in 2018. For a detailed discussion of our debt please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We repurchased common shares for $1.82 billion, $1.07 billion and $1.09 billion in 2020, 2019 and 2018 under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans.

We paid dividends to stockholders of $323 million in 2020, $291 million in 2019, and $265 million in 2018.

We entered into a commercial paper program in October 2014. Net proceeds from issuance of commercial paper were $295 million in 2020 and the maximum principal amount outstanding at any one time during 2020 was $600 million. Net repayments from the issuance of commercial paper were $360 million in 2019 and the maximum principal amount outstanding at any one time during 2019 was $801 million. Net proceeds from issuance of commercial paper were $485 million in 2018 and the maximum principal amount outstanding at any one time during 2018 was $923 million.

The remainder of the cash used in or provided by financing activities in 2020, 2019, and 2018 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Stock Repurchases

For a detailed discussion of stock repurchases, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Debt

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid, were approximately $1,088 million as of December 31, 2020. We used the net proceeds for general corporate purposes.

In February 2020, we entered into a new $1 billion term loan commitment with a bank that matures 1 year after the first draw, subject to a 1 year extension. In March 2020, we made a draw on the entire term loan commitment of $1 billion. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. The note was prepayable without penalty. We repaid the $1 billion outstanding balance in November 2020.

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Acquisitions and Divestiture

During 2020, we completed the acquisition of privately held Enclara, one of the nation’s largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received. For a detailed discussion of our acquisitions and divestitures, please refer to Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2020 was BBB+ according to Standard & Poor’s Rating Services, or S&P, and Baa3 according to Moody’s Investors Services, Inc., or Moody’s. A downgrade by S&P to BB+ or by Moody’s to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis

points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $772 million at December 31, 2020 from $1.4 billion at December 31, 2019. This decrease primarily reflects common stock repurchases, insurance subsidiaries' capital contributions, repayment of debt and capital expenditures partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated insurance subsidiaries paid dividends to our parent company of $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018. Subsidiary capital requirements from significant premium growth has impacted the amount of regulated subsidiary dividends over the last two years. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to our parent, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Off-Balance Sheet Arrangements

As of December 31, 2020, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2020	Percentage of Total	December 31, 2019	Percentage of Total
	(dollars in millions)			
IBNR	$ 5,290	65.0 %	$ 4,150	69.1 %
Reported claims in process	816	10.0 %	628	10.5 %
Other benefits payable	2,037	25.0 %	1,226	20.4 %
Total benefits payable	$ 8,143	100.0 %	$ 6,004	100.0 %

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. For further discussion of our reserving methodology, including our use of completion and claims per member per month trend factors to estimate IBNR, refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2020 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
(dollars in millions)			
0.70%	$(348)	3.00%	$(332)
0.60%	$(298)	2.75%	$(304)
0.50%	$(249)	2.50%	$(276)
0.40%	$(199)	2.25%	$(249)
0.30%	$(149)	2.00%	$(221)
0.20%	$(99)	1.75%	$(194)
0.10%	$(50)	1.50%	$(166)

(a) Reflects estimated potential changes in benefits payable at December 31, 2020 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2020 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group and Specialty segment tables including information about incurred and paid claims development as of December 31, 2020, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2020	2019	2018
	(in millions)		
Balances at January 1	$ 6,004	$ 4,862	$ 4,668
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,936	4,767	4,598
Incurred related to:			
Current year	61,941	54,193	46,385
Prior years	(313)	(336)	(503)
Total incurred	61,628	53,857	45,882
Paid related to:			
Current year	(54,003)	(48,421)	(41,736)
Prior years	(5,418)	(4,267)	(3,977)
Total paid	(59,421)	(52,688)	(45,713)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 8,143	$ 6,004	$ 4,862

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2020		2019		2018	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (167)	(1.9)%	$ (233)	(3.1)%	$ (229)	(3.3)%
Completion factors	(146)	(0.3)%	(103)	(0.3)%	(274)	(0.8)%
Total	$ (313)		$ (336)		$ (503)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020, $336 million in 2019, and $503 million in 2018. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2020, 2019, and 2018.

	(Favorable) Unfavorable Medical Claims Reserve Development			Change	
	2020	2019	2018	2020	2019
	(in millions)				
Retail Segment	$ (266)	$ (386)	$ (398)	$ 120	$ 12
Group and Specialty Segment	(47)	50	(46)	(97)	96
Individual Commercial Segment	—	—	(57)	—	57
Other Businesses	—	—	(2)	—	2
Total	$ (313)	$ (336)	$ (503)	$ 23	$ 167

The favorable medical claims reserve development for 2020, 2019, and 2018 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2020 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and certain contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premiums from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the small group and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses

data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare," and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $13.8 billion, or 39% of total assets at December 31, 2020, and $11.4 billion, or 39% of total assets at December 31, 2019. The investment portfolio was primarily comprised of debt securities, detailed below, at December 31, 2020 and entirely at December 31, 2019. The fair value of investment securities were as follows at December 31, 2020 and 2019:

	12/31/2020	Percentage of Total	12/31/2019	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 616	4.5 %	$ 354	3.1 %
Mortgage-backed securities	3,254	23.6 %	3,710	32.6 %
Tax-exempt municipal securities	1,447	10.5 %	1,463	12.9 %
Mortgage-backed securities:				
Residential	17	0.1 %	—	— %
Commercial	1,318	9.6 %	804	7.1 %
Asset-backed securities	1,372	10.0 %	1,093	9.6 %
Corporate debt securities	4,927	35.8 %	3,947	34.7 %
Total debt securities	12,951	94.1 %	11,371	99.9 %
Common stock	815	5.9 %	7	0.1 %
Total investment securities	$ 13,766	100.0 %	$ 11,378	100.0 %

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2020. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2020:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 225	$ (1)	$ —	$ —	$ 225	$ (1)
Mortgage-backed securities	199	(1)	—	—	199	(1)
Tax-exempt municipal securities	16	—	19	—	35	—
Mortgage-backed securities:						
Residential	17	—	—	—	17	—
Commercial	193	(1)	43	—	236	(1)
Asset-backed securities	65	—	498	(2)	563	(2)
Corporate debt securities	342	(1)	16	—	358	(1)
Total debt securities	$ 1,057	$ (4)	$ 576	$ (2)	$ 1,633	$ (6)

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019 or 2018. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an

investment is related to a credit event requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or expected credit loss impairments may be recorded in future periods.

All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2020. There were no material other-than-temporary impairments in 2019 or 2018.

Goodwill and Long-lived Assets

At December 31, 2020, goodwill and other long-lived assets represented 20% of total assets and 52% of total stockholders' equity, compared to 21% and 50%, respectively, at December 31, 2019.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in government reimbursement rates, the estimates underlying our goodwill impairment tests could be adversely affected. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our clinical and provider reporting units, which accounted for $524 million and $761 million, respectively. Impairment tests completed for 2020, 2019, and 2018 did not result in an impairment loss.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates

or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. If drawn upon, the revolving credit would revert to using the alternative base rate once LIBOR is discontinued.There were no borrowings outstanding under our credit agreement at December 31, 2020 or December 31, 2019.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA- at December 31, 2020. Our net unrealized position increased $303 million from a net unrealized gain position of $211 million at December 31, 2019 to a net unrealized gain position of $514 million at December 31, 2020. At December 31, 2020, we had gross unrealized losses of $6 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. We did not record any material credit allowances for debt securities that were in an unrealized loss position during 2020. There were no material other-than-temporary impairments during 2019. While we believe that these impairments will be recovered and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 3.0 years as of December 31, 2020 and 2.5 years as of December 31, 2019. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $541 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2020 and 2019. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 10 year US treasury rates during the year have not exceeded 300 basis points, have changed between 200 and 300 basis points once, have changed between 100 and 200 basis points twice, and have changed by less than 100 basis points seven times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2020						
Investment income (a)	$ (44)	$ (33)	$ (21)	$ 91	$ 180	$ 270
Interest expense (b)	2	2	2	(6)	(12)	(18)
Pretax	$ (42)	$ (31)	$ (19)	$ 85	$ 168	$ 252
As of December 31, 2019						
Investment income (a)	$ (150)	$ (133)	$ (79)	$ 78	$ 157	$ 235
Interest expense (b)	10	9	4	(4)	(9)	(13)
Pretax	$ (140)	$ (124)	$ (75)	$ 74	$ 148	$ 222

(a) As of December 31, 2020 and 2019, some of our investments had interest rates below 1% and 2%, respectively, so the assumed hypothetical change in pretax earnings does not reflect the full 1% and 2%, respectively, point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2020 or December 31, 2019. There was $600 million and $300 million outstanding under our commercial paper program at December 31, 2020 and 2019, respectively. As of December 31, 2020 and 2019, our interest rate under our commercial paper program was less than 1% so the assumed hypothetical change in pretax earnings does not reflect the full 1% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2020	2019
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,673	$ 4,054
Investment securities	12,554	10,972
Receivables, less allowance for doubtful accounts of $72 in 2020 and $69 in 2019	1,138	1,056
Other current assets	5,276	3,806
Total current assets	23,641	19,888
Property and equipment, net	2,371	1,955
Long-term investment securities	1,212	406
Goodwill	4,447	3,928
Equity method investments	1,170	1,063
Other long-term assets	2,128	1,834
Total assets	$ 34,969	$ 29,074
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 8,143	$ 6,004
Trade accounts payable and accrued expenses	4,013	3,754
Book overdraft	320	225
Unearned revenues	318	247
Short-term debt	600	699
Total current liabilities	13,394	10,929
Long-term debt	6,060	4,967
Other long-term liabilities	1,787	1,141
Total liabilities	21,241	17,037
Commitments and contingencies (Note 17)		
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; 198,648,742 shares issued at December 31, 2020 and 198,629,992 shares issued at December 31, 2019	33	33
Capital in excess of par value	2,705	2,820
Retained earnings	20,517	17,483
Accumulated other comprehensive income (loss)	391	156
Treasury stock, at cost, 69,787,614 shares at December 31, 2020 and 66,524,771 shares at December 31, 2019	(9,918)	(8,455)
Total stockholders' equity	13,728	12,037
Total liabilities and stockholders' equity	$ 34,969	$ 29,074

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions, except per share results)		
Revenues:			
Premiums	$ 74,186	$ 62,948	$ 54,941
Services	1,815	1,439	1,457
Investment income	1,154	501	514
Total revenues	77,155	64,888	56,912
Operating expenses:			
Benefits	61,628	53,857	45,882
Operating costs	10,052	7,381	7,525
Depreciation and amortization	489	458	405
Total operating expenses	72,169	61,696	53,812
Income from operations	4,986	3,192	3,100
Loss on sale of business	—	—	786
Interest expense	283	242	218
Other expense (income), net	103	(506)	33
Income before income taxes and equity in net earnings	4,600	3,456	2,063
Provision for income taxes	1,307	763	391
Equity in net earnings	74	14	11
Net income	$ 3,367	$ 2,707	$ 1,683
Basic earnings per common share	$ 25.47	$ 20.20	$ 12.24
Diluted earnings per common share	$ 25.31	$ 20.10	$ 12.16

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions)		
Net income	$ 3,367	$ 2,707	$ 1,683
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	393	450	(189)
Effect of income taxes	(89)	(105)	51
Total change in unrealized investment gains/losses, net of tax	304	345	(138)
Reclassification adjustment for net realized gains included in investment income	(90)	(34)	(53)
Effect of income taxes	20	8	17
Total reclassification adjustment, net of tax	(70)	(26)	(36)
Other comprehensive income (loss), net of tax	234	319	(174)
Comprehensive income (loss) attributable to equity method investments	1	(4)	(4)
Comprehensive income	$ 3,602	$ 3,022	$ 1,505

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2018	198,572	$ 33	$ 2,445	$ 13,670	$ 19	$ (6,325)	$ 9,842
Net income				1,683			1,683
Other comprehensive income				(4)	(178)		(182)
Common stock repurchases	—		50			(1,140)	(1,090)
Dividends and dividend equivalents			—	(277)			(277)
Stock-based compensation			137				137
Restricted stock unit vesting	—	—	(145)			145	—
Stock option exercises	23	—	48			—	48
Balances, December 31, 2018	198,595	33	2,535	15,072	(159)	(7,320)	10,161
Net income				2,707			2,707
Other comprehensive loss				—	315		315
Common stock repurchases	—		150			(1,220)	(1,070)
Dividends and dividend equivalents			—	(296)			(296)
Stock-based compensation			163				163
Restricted stock unit vesting	32	—	(48)			48	—
Stock option exercises	3	—	20			37	57
Balances, December 31, 2019	198,630	33	2,820	17,483	156	(8,455)	12,037
Net income				3,367			3,367
Impact of adopting accounting standard				(2)			(2)
Other comprehensive income				—	235		235
Common stock repurchases	—		(263)			(1,557)	(1,820)
Dividends and dividend equivalents			—	(331)			(331)
Stock-based compensation			181				181
Restricted stock unit vesting	19	—	(59)			59	—
Stock option exercises	—	—	26			35	61
Balances, December 31, 2020	198,649	$ 33	$ 2,705	$ 20,517	$ 391	$ (9,918)	$ 13,728

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2020	**2019**	**2018**
		(in millions)	
Cash flows from operating activities			
Net income	$ 3,367	$ 2,707	$ 1,683
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on sale of business	—	—	786
Gains on investment securities, net	(838)	(62)	(90)
Equity in net earnings	(74)	(14)	(11)
Stock compensation	181	163	137
Depreciation	528	505	444
Amortization	88	70	90
Provision for deferred income taxes	195	162	194
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(85)	(32)	(164)
Other assets	(581)	118	(484)
Benefits payable	2,139	1,142	252
Other liabilities	599	471	(676)
Unearned revenues	71	(36)	(95)
Other	49	90	107
Net cash provided by operating activities	5,639	5,284	2,173
Cash flows from investing activities			
Acquisitions, net of cash acquired	(709)	—	(354)
Purchase of equity method investment in Kindred at Home	—	—	(1,095)
Cash transferred in sale of business	—	—	(805)
Purchases of property and equipment	(964)	(736)	(612)
Purchases of investment securities	(9,125)	(6,361)	(4,687)
Maturities of investment securities	4,986	1,733	972
Proceeds from sales of investment securities	2,747	4,086	3,494
Net cash used in investing activities	(3,065)	(1,278)	(3,087)
Cash flows from financing activities			
Withdrawals from contract deposits, net	(939)	(623)	(640)
Proceeds from issuance of senior notes, net	1,088	987	—
Repayment of senior notes	(400)	(400)	—
Proceeds (repayments) from issuance of commercial paper, net	295	(360)	485
Proceeds from term loan	1,000	—	1,000
Repayment of term loan	(1,000)	(650)	(350)
Common stock repurchases	(1,820)	(1,070)	(1,090)
Dividends paid	(323)	(291)	(265)
Change in book overdraft	95	54	30
Proceeds from stock option exercises & other	49	58	45
Net cash used in financing activities	(1,955)	(2,295)	(785)
Increase (decrease) in cash and cash equivalents	619	1,711	(1,699)
Cash and cash equivalents at beginning of period	4,054	2,343	4,042
Cash and cash equivalents at end of period	$ 4,673	$ 4,054	$ 2,343

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2020	2019	2018
Supplemental cash flow disclosures:		(in millions)	
Interest payments	$ 258	$ 212	$ 195
Income tax payments, net	$ 1,132	$ 518	$ 631
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 819	$ 28	$ 392
Less: Fair value of liabilities assumed	(110)	(28)	(38)
Cash paid for acquired businesses, net of cash acquired	$ 709	$ —	$ 354

The accompanying notes are an integral part of the consolidated financial statements.

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 83% of our total premiums and services revenue from contracts with the federal government in 2020, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidate the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance 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 consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

COVID-19

The emergence and spread of COVID-19 has impacted our business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020, and continued to rebound throughout the third quarter and early in the fourth quarter of 2020, reaching approximately 95% of historic baseline levels as of the end of October 2020. Then, in the latter half of November and accelerating throughout the month of December, we experienced a significant increase in COVID-19 admissions in nearly all of the markets in which we operate across our Medicare Advantage, Medicaid, and group commercial insurance business lines, resulting in higher COVID-19 treatment and testing costs. During this period, we also experienced a corresponding decline in non-COVID utilization in all service categories to well below the near baseline levels of non-COVID utilization witnessed as late as the end of October 2020 (with non-COVID utilization in our Medicare Advantage business running approximately 15%

below normal levels at the close of the fourth quarter of 2020). The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during this period. Our 2020 results were also impacted by our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model.

Workforce Optimization

We initiated an involuntary workforce reduction program during 2019. This program impacted approximately 1,000 associates. As a result, we recorded charges of $47 million in 2019. Payments under this program were made upon termination during the severance pay period. The remaining 2019 workforce optimization obligation was $45 million as of December 31, 2019 and was fully settled as of December 31, 2020.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee resumed in calendar year 2020. The Further Consolidated Appropriations Act, 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee beginning in calendar year 2021.

The annual premium-based fee on health insurers is not deductible for tax purposes. We estimate a liability for the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurance industry fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurance industry fee in September or October of each year. We paid the federal government $1.18 billion and $1.04 billion for the annual health insurance industry fee attributed to calendar years 2020 and 2018, respectively.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform, for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, we received a $609 million payment from the U.S Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $609 million payment received from the U.S Government and approximately $31 million in related fees and expenses are reflected in Premiums revenue and Operating costs, respectively, in our consolidated statements of income for the year ended December 31, 2020 and reported in the Corporate segment.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist of debt and equity securities, are stated at fair value. Our debt securities have been categorized as available for sale. Debt securities available for current operations are classified as current assets and debt securities available to fund our professional and other self-insurance liability requirements, as well as restricted statutory deposits and equity securities, are classified as long-term assets. For the purpose of determining realized gross gains and losses for debt securities sold, which are included as a component of investment income in

the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses for debt securities, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or an expected credit loss is recognized. For the purpose of determining gross gains and losses for equity securities, changes in fair value at the reporting date are included as a component of investment income in the consolidated statements of income.

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019 or 2018. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and certain contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder

rebates by projecting calendar year minimum benefit ratios for the small group and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by Health and Human Services, or HHS, separately by state and legal entity. Medicare Advantage and Medicaid products are also subject to minimum benefit ratio requirements. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2020, subsidy and discount payments of $13.3 billion exceeded reimbursements of $12.4 billion by $0.9 billion. For 2019, subsidy and discount payments of $11.8 billion exceeded reimbursements of $11.2 billion by $0.6 billion. For 2018, subsidy and discount payments of $10.3 billion exceeded reimbursements of $9.6 billion by $0.7 billion. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to customer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectability of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our TRICARE contracts with the Department of Defense (DoD) we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under our contracts net of estimated health care costs similar to an administrative services fee only agreement. Our contracts include fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2020, health care cost reimbursements and payments were each approximately $6.3 billion with payments exceeding reimbursements by $1 million. For 2019, health care cost payments of approximately $6.5 billion exceeded reimbursements of approximately $6.4 billion by $63 million. For 2018, health care cost reimbursements and payments were each approximately $5.6 billion with reimbursements exceeding payments by $38 million for the year.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

At December 31, 2020 and 2019, accounts receivable related to services were $161 million and $141 million, respectively. For the year ended December 31, 2020, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2020 and 2019.

For the year ended December 31, 2020, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.4 billion and $1.3 billion at December 31, 2020 and 2019, respectively.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and definite-lived intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee's financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

See Note 4 for further information.

Goodwill and Definite-Lived Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting units that are expected to benefit from the specific synergies of the business combination.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our clinical and provider reporting units, which accounted for $524 million and $761 million of goodwill, respectively. Impairment tests completed for 2020, 2019, and 2018 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, public health emergencies, epidemics and pandemics (such as the spread of COVID-19) also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies primarily related to certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status, and are included in our consolidated balance sheet with other long-term liabilities. Prior period future policy benefits payable previously included as a separate line item has been reclassified to conform to the 2020 presentation. Most of these policies are subject to reinsurance as detailed in Note 19.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only

for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

Additional detail regarding our stock-based compensation plans is included in Note 14.

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 restricted shares, or units, using the treasury stock method.

Additional detail regarding earnings per common share is included in Note 15.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt and equity securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment adviser. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance was effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available for sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists primarily of available for sale debt securities. We adopted the new standard effective January 1, 2020. Due to the high concentration of our financial assets measured at amortized cost being with the federal government resulting in zero nonpayment risk as well as our available for sale debt securities primarily being in an unrealized gain position, the adoption of the new standard did not have a material impact on our results of operations, financial condition, or cash flows.

Accounting Pronouncements Effective in Future Periods

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers and reinsurers. The new guidance is effective for us beginning with annual and interim periods in 2023, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We are currently evaluating the impact on our results of operations, financial position and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

In the first quarter of 2020, we acquired privately held Enclara Healthcare, or Enclara, one of the nation’s largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received. This resulted in a purchase price allocation to goodwill of $517 million, other intangible assets of $240 million, and net tangible liabilities assumed of $13 million. The goodwill was assigned to the Healthcare Services segment. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 11 years. Enclara's goodwill is not amortizable as deductible expense for tax purposes.

Also in the first quarter of 2020, our Partners in Primary Care wholly-owned subsidiary entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. The WCAS partnership opened 20 payor-agnostic, senior-focused primary care centers during 2020, and is expected to open an additional 30 over the next 2 years. Partners in Primary Care committed to the acquisition of a non-controlling interest in the approximately $600 million entity. In addition, the agreement includes a series of put

and call options through which WCAS may require us to purchase their interest in the entity and, through which we may acquire WCAS's interest over the next 5 to 10 years.

In the first quarter of 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million. This resulted in a purchase price allocation to goodwill of $483 million, other intangible assets of $80 million, and net tangible assets of $24 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 8 years. Goodwill is amortizable as deductible expense for tax purposes.

In the second quarter of 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. This resulted in a purchase price allocation to goodwill of $133 million, other intangible assets of $38 million and net tangible assets of $14 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 5 years. The purchase price allocations for Enclara, MCCI and FPG are final.

During 2020 and 2019, we acquired other health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2020, 2019 and 2018 were not material to our results of operations. For asset acquisitions the goodwill acquired is partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

Sale of Closed Block of Commercial Long-Term Care Insurance Business

On August 9, 2018, we completed the sale of KMG to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, included our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit.

Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

KMG revenues and net income for the 2018 period prior to the date of sale were $182 million and $47 million, respectively.

4. EQUITY METHOD INVESTMENT

In the third quarter of 2018, we, along with TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS (together, the "Sponsors"), completed the acquisitions of Kindred Healthcare, Inc., or Kindred, and privately-held Curo Health Services, or Curo, respectively, merging Curo with the hospice business of the Kindred at Home Division, or Kindred at Home. As part of these transactions, we acquired a 40% minority interest in Kindred at Home, a leading home health and hospice company, for total cash consideration of approximately $1.1 billion.

We account for our 40% investment in Kindred at Home using the equity method of accounting. This investment is reflected in Equity method investments in our consolidated balance sheets, with our share of income or loss reported as Equity in net earnings in our consolidated statements of income.

We entered into a shareholders agreement with the Sponsors that provides for certain rights and obligations of each party. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture beginning on July 2, 2021 and ending on July 1, 2022. Likewise, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning on July 2, 2022 and ending on July 1, 2023. The put and call options, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The simulation relies on assumptions around Kindred at Home's equity value, risk free interest rates, volatility, and the details specific to the put and call options. The fair values of the put option and call option were $45 million and $503 million, respectively, at December 31, 2020 and were $28 million and $557 million, respectively, at December 31, 2019.

The put option is included within other long-term liabilities and the call option is included within other long-term assets. The change in fair value of the put and call options for the years ended December 31, 2020 and 2019 of $71 million and $(506) million, respectively, are reported as Other expense (income), net in our consolidated statements of income.

The summarized balance sheets and statements of income at December 31, 2020 and 2019 of Kindred at Home were as follows:

Balance sheets	**December 31, 2020**	**December 31, 2019**
	(in millions)	
Current assets	$ 844	$ 563
Non-current assets	4,858	4,967
Current liabilities	556	405
Non-current liabilities	2,445	2,637
Shareholders' equity	2,700	2,488

Statements of income	**For the year ended December 31, 2020**	**For the year ended December 31, 2019**
	(in millions)	
Revenues	$ 2,972	$ 3,100
Expenses	2,552	2,835
Net income	207	54

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2020 and 2019, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2020				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 616	$ 1	$ (1)	$ 616
Mortgage-backed securities	3,115	140	(1)	3,254
Tax-exempt municipal securities	1,393	54	—	1,447
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	1,260	59	(1)	1,318
Asset-backed securities	1,364	10	(2)	1,372
Corporate debt securities	4,672	256	(1)	4,927
Total debt securities	$ 12,437	$ 520	$ (6)	12,951
Common stock				815
Total investment securities				$ 13,766
December 31, 2019				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 353	$ 1	$ —	$ 354
Mortgage-backed securities	3,628	85	(3)	3,710
Tax-exempt municipal securities	1,433	30	—	1,463
Commercial mortgage-backed securities	786	18	—	804
Asset-backed securities	1,093	3	(3)	1,093
Corporate debt securities	3,867	82	(2)	3,947
Total debt securities	$ 11,160	$ 219	$ (8)	11,371
Common stock				7
Total investment securities				$ 11,378

Gross unrealized losses and fair values aggregated by investment category and length of time that individual debt securities have been in a continuous unrealized loss position were as follows at December 31, 2020 and 2019, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2020						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 225	$ (1)	$ —	$ —	$ 225	$ (1)
Mortgage-backed securities	199	(1)	—	—	199	(1)
Tax-exempt municipal securities	16	—	19	—	35	—
Mortgage-backed securities:						
Residential	17	—	—	—	17	—
Commercial	193	(1)	43	—	236	(1)
Asset-backed securities	65	—	498	(2)	563	(2)
Corporate debt securities	342	(1)	16	—	358	(1)
Total debt securities	$ 1,057	$ (4)	$ 576	$ (2)	$ 1,633	$ (6)
December 31, 2019						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 48	$ —	$ 23	$ —	$ 71	$ —
Mortgage-backed securities	315	(1)	204	(2)	519	(3)
Tax-exempt municipal securities	58	—	75	—	133	—
Commercial mortgage-backed securities	118	—	36	—	154	—
Asset-backed securities	20	—	607	(3)	627	(3)
Corporate debt securities	589	(2)	155	—	744	(2)
Total debt securities	$ 1,148	$ (3)	$ 1,100	$ (5)	$ 2,248	$ (8)

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2020. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all debt securities was generated from approximately 150 positions out of a total of approximately 1,520 positions at December 31, 2020. All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized

cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2020.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2020, 2019, and 2018:

	2020	2019	2018
	(in millions)		
Gross gains on investment securities	$ 947	$ 129	$ 106
Gross losses on investment securities	(109)	(67)	(16)
Net realized gains on investment securities	$ 838	$ 62	$ 90

Gross gains and gross losses on investment securities include both the gain resulting from the initial conversion of our prior ownership interest in certain privately held companies into common stock upon such companies' initial public offering, or IPO, and subsequent changes in the market value of such securities from the IPO through December 31, 2020, which combined to total $837 million and $91 million, respectively.

All purchases of and proceeds from investment securities for the years ended December 31, 2020 and 2019 relate to debt securities.

There were no material other-than-temporary impairments in 2019 or 2018.

The contractual maturities of debt securities available for sale at December 31, 2020, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 802	$ 805
Due after one year through five years	2,145	2,236
Due after five years through ten years	2,247	2,396
Due after ten years	1,487	1,553
Mortgage and asset-backed securities	5,756	5,961
Total debt securities	$ 12,437	$ 12,951

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2020 and 2019, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2020				
Cash equivalents	$ 4,548	$ 4,548	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	616	—	616	—
Mortgage-backed securities	3,254	—	3,254	—
Tax-exempt municipal securities	1,447	—	1,447	—
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	1,318	—	1,318	—
Asset-backed securities	1,372	—	1,372	—
Corporate debt securities	4,927	—	4,927	—
Total debt securities	12,951	—	12,951	—
Common stock	815	815	—	—
Total invested assets	$ 18,314	$ 5,363	$ 12,951	$ —
December 31, 2019				
Cash equivalents	$ 3,660	$ 3,660	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	354	—	354	—
Mortgage-backed securities	3,710	—	3,710	—
Tax-exempt municipal securities	1,463	—	1,463	—
Mortgage-backed securities:				
Commercial	804	—	804	—
Asset-backed securities	1,093	—	1,093	—
Corporate debt securities	3,947	—	3,947	—
Total debt securities	11,371	—	11,371	—
Common stock	7	7	—	—
Total invested assets	$ 15,038	$ 3,667	$ 11,371	$ —

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $6,060 million at December 31, 2020 and $5,366 million at December 31, 2019. The fair value of our senior note debt was $7,352 million at December 31, 2020 and $5,916 million at December 31, 2019. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for commercial paper borrowings. The commercial paper borrowings were $600 million and $300 million at December 31, 2020 and December 31, 2019, respectively.

Put and Call Options Measured at Fair Value

The put and call options associated with our investment in Kindred at Home, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The put and call options fair values, derived from the Monte Carlo simulation, were $45 million and $503 million, respectively, at December 31, 2020 and $28 million and $557 million, respectively, at December 31, 2019.

The significant unobservable inputs utilized in these Level 3 fair value measurements (and selected values) include the enterprise value of Kindred at Home, annualized volatility and secured credit rate. Enterprise value was derived from a discounted cash flow model, which utilized significant unobservable inputs for long-term net operating profit after tax margin, or NOPAT, to measure underlying cash flows, weighted average cost of capital and long term growth rate. The table below presents the assumptions used for each reporting period.

	December 31, 2020	December 31, 2019
Annualized volatility	29.9 %	19.8 %
Secured credit rate	0.4 %	2.2 %
NOPAT	12.0 %	12.0 %
Weighted average cost of capital	9.5 %	10.0 %
Long term growth rate	3.0 %	3.0 %

The calculation of NOPAT utilized net income plus after tax interest expense. We regularly evaluate each of the assumptions used in establishing these assets and liabilities. Significant changes in assumptions for weighted average cost of capital, long term growth rates, NOPAT, volatility, credit spreads, risk free rate, and underlying cash flow estimates, could result in significantly lower or higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we acquired Enclara, MCCI, FPG, and other health and wellness related businesses during 2020, 2019, and 2018. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected future cash flows and discount rates used in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2020, 2019, or 2018.

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 216	$ 1,420	$ 5	$ 585
Trade accounts payable and accrued expenses	(39)	(253)	(120)	(356)
Net current asset (liability)	177	1,167	(115)	229
Other long-term assets	8	—	6	—
Other long-term liabilities	(90)	—	(61)	—
Net long-term liability	(82)	—	(55)	—
Total net asset (liability)	$ 95	$ 1,167	$ (170)	$ 229

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2020 and 2019.

	2020	2019
	(in millions)	
Land	$ 19	$ 20
Buildings and leasehold improvements	952	874
Equipment	1,009	922
Computer software	3,514	2,799
	5,494	4,615
Accumulated depreciation	(3,123)	(2,660)
Property and equipment, net	$ 2,371	$ 1,955

Depreciation expense was $528 million in 2020, $505 million in 2019, and $444 million in 2018, including amortization expense for capitalized internally developed and purchased software of $351 million in 2020, $343 million in 2019, and $298 million in 2018.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2020 and 2019 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2019	$ 1,535	$ 261	$ 2,101	$ 3,897
Acquisitions	—	—	31	31
Balance at December 31, 2019	1,535	261	2,132	3,928
Acquisitions	—	—	519	519
Balance at December 31, 2020	$ 1,535	$ 261	$ 2,651	$ 4,447

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2020 and 2019.

	Weighted Average Life	2020			2019		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.5 years	$ 849	$ 572	$ 277	$ 646	$ 496	$ 150
Trade names and technology	7.0 years	122	89	33	84	84	—
Provider contracts	11.8 years	69	50	19	70	44	26
Noncompetes and other	7.3 years	29	29	—	29	28	1
Total other intangible assets	9.3 years	$ 1,069	$ 740	$ 329	$ 829	$ 652	$ 177

Amortization expense for other intangible assets was approximately $88 million in 2020, $70 million in 2019, and $90 million in 2018. Amortization expense for 2018 included $12 million associated with the write-off of a trade name value reflecting the re-branding of certain provider assets.

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2021	$ 56
2022	53
2023	40
2024	33
2025	33

10. LEASES

We determine if a contract contains a lease by evaluating the nature and substance of the agreement. We lease facilities, computer hardware, and other furniture and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet; we recognize lease expense for these leases on a straight-line basis over the lease term. For new lease agreements, we combine lease and nonlease components for all of our asset classes.

When portions of the lease payments are not fixed or depend on an index or rate, we consider those payments to be variable in nature. Our variable lease payments include, but are not limited to, common area maintenance, taxes and insurance which are not dependent upon an index or rate. Variable lease payments are recorded in the period in which the obligation for the payment is incurred. Most leases include options to renew, with renewal terms that can extend the lease term. The exercise of lease renewal options is at our sole discretion. Certain leases also include options to purchase the leased property. The depreciable life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Right-of-use assets included within other long-term assets in our consolidated balance sheets were $437 million and $410 million at December 31, 2020 and 2019, respectively. Operating lease liabilities included within trade accounts payable and accrued expenses were $129 million and $116 million at December 31, 2020 and December 31, 2019, respectively. Additionally, operating lease liabilities included within other long-term liabilities were $355 million and $332 million at December 31, 2020 and December 31, 2019, respectively. The classification of our operating lease liabilities is based on the remaining lease term.

For the years ended December 31, 2020 and December 31, 2019, total fixed operating lease costs, excluding short-term lease costs, were $141 million and $154 million, respectively, and are included within operating costs in our consolidated statements of income. Short-term lease costs were not material for the years ended December 31, 2020 and December 31, 2019. In addition, for the years ended December 31, 2020 and December 31, 2019, total variable operating lease costs were $92 million and $82 million, respectively, and are included within operating costs in our consolidated statements of income.

We sublease facilities or partial facilities to third party tenants for space not used in our operations. For the years ended December 31, 2020 and December 31, 2019, sublease rental income was $36 million and $45 million, respectively, and is included within operating costs in our consolidated statements of income.

The weighted average remaining lease term is 5.2 years and 4.9 years with a weighted average discount rate of 3.7% and 4.1% at December 31, 2020 and December 31, 2019, respectively. For the year-ended December 31, 2020 and December 31, 2019, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $146 million and $151 million, respectively.

Maturity of Lease Liabilities	December 31, 2020 (in millions)
2021	$ 146
2022	129
2023	82
2024	59
2025	41
After 2025	87
Total lease payments	544
Less: Interest	60
Present value of lease liabilities	$ 484

As most of our leases do not provide an implicit rate, we use our incremental borrowing rate, as adjusted for collateralized borrowings, based on the information available at date of adoption or commencement date in determining the present value of lease payments.

For the year ended 2018, under prior lease disclosure requirements

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancellable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the year ended December 31, 2018:

	2018
	(in millions)
Rent expense	$ 167
Sublease rental income	(32)
Net rent expense	$ 135

11. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 6,004	$ 4,862	$ 4,668
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,936	4,767	4,598
Incurred related to:			
Current year	61,941	54,193	46,385
Prior years	(313)	(336)	(503)
Total incurred	61,628	53,857	45,882
Paid related to:			
Current year	(54,003)	(48,421)	(41,736)
Prior years	(5,418)	(4,267)	(3,977)
Total paid	(59,421)	(52,688)	(45,713)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 8,143	$ 6,004	$ 4,862

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020, $336 million in 2019, and $503 million in 2018. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2020, 2019, and 2018.

	(Favorable) Unfavorable Medical Claims Reserve Development		
	2020	2019	2018
Retail Segment	$ (266)	$ (386)	$ (398)
Group and Specialty Segment	(47)	50	(46)
Individual Commercial Segment	—	—	(57)
Other Businesses	—	—	(2)
Total	$ (313)	$ (336)	$ (503)

The medical claims reserve development for 2020, 2019, and 2018 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development is primarily attributed to our Medicare Advantage medical business.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2020, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2019 and 2018 is presented as supplementary information.

Claims frequency is measured as medical fee-for-service claims for each service encounter with a unique provider identification number. Our claims frequency measure includes claims covered by deductibles as well as claims under capitated arrangements. Claim counts may vary based on product mix and the percentage of delegated capitation arrangements.

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 5,363	$ 4,338	$ 3,963
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,295	4,243	3,893
Incurred related to:			
Current year	56,821	48,983	41,323
Prior years	(266)	(386)	(398)
Total incurred	56,555	48,597	40,925
Paid related to:			
Current year	(49,586)	(43,831)	(37,189)
Prior years	(4,836)	(3,714)	(3,386)
Total paid	(54,422)	(47,545)	(40,575)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 7,428	$ 5,363	$ 4,338

At December 31, 2020, benefits payable for our Retail segment included IBNR of approximately $4.7 billion, primarily associated with claims incurred in 2020. The cumulative number of reported claims as of December 31, 2020 was approximately 133.0 million for claims incurred in 2020, 128.8 million for claims incurred in 2019, and 109.9 million for claims incurred in 2018.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2020, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
		(in millions)	
2018	$ 41,323	$ 40,984	$ 40,946
2019		48,983	48,820
2020			56,821
Total			$ 146,587

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
		(in millions)	
2018	$ 37,189	$ 40,841	$ 40,946
2019		43,831	48,627
2020			49,586
Total			139,159
All outstanding benefit liabilities before 2018, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 7,428

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 641	$ 517	$ 568
Incurred related to:			
Current year	5,576	5,708	5,466
Prior years	(47)	50	(46)
Total incurred	5,529	5,758	5,420
Paid related to:			
Current year	(4,873)	(5,081)	(4,957)
Prior years	(582)	(553)	(514)
Total paid	(5,455)	(5,634)	(5,471)
Balances at December 31	$ 715	$ 641	$ 517

At December 31, 2020, benefits payable for our Group and Specialty segment included IBNR of approximately $594 million, primarily associated with claims incurred in 2020. The cumulative number of reported claims as of December 31, 2020 was approximately 8.6 million for claims incurred in 2020, 10.0 million for claims incurred in 2019, and 10.9 million for claims incurred in 2018.

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2020, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
	(in millions)		
2018	$ 5,466	$ 5,501	$ 5,505
2019		5,708	5,657
2020			5,576
Total			$ 16,738

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
	(in millions)		
2018	$ 4,957	$ 5,487	$ 5,505
2019		5,081	5,645
2020			4,873
Total			16,023
All outstanding benefit liabilities before 2018, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 715

Reconciliation to Consolidated

The reconciliation of the net incurred and paid claims development tables to benefits payable in the consolidated statement of financial position is as follows:

	December 31, 2020
Net outstanding liabilities	
Retail	$ 7,428
Group and Specialty	715
Benefits payable, net of reinsurance	8,143
Reinsurance recoverable on unpaid claims	
Retail	—
Total benefits payable, gross	$ 8,143

12. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Current provision:			
Federal	$ 1,019	$ 560	$ 139
States and Puerto Rico	93	41	58
Total current provision	1,112	601	197
Deferred expense	195	162	194
Provision for income taxes	$ 1,307	$ 763	$ 391

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2020, 2019 and 2018 due to the following:

	2020	2019	2018
		(in millions)	
Income tax provision at federal statutory rate	$ 982	$ 729	$ 436
States, net of federal benefit, and Puerto Rico	63	49	42
Tax exempt investment income	(5)	(6)	(11)
Health insurance industry fee	268	—	243
Nondeductible executive compensation	19	25	17
Tax reform	—	—	(39)
KMG sale	—	—	(272)
Other, net	(20)	(34)	(25)
Provision for income taxes	$ 1,307	$ 763	$ 391

The tax reform law enacted on December 22, 2017, or Tax Reform Law, reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. Revisions to our prior estimate for the income tax effects of the Tax Reform Law decreased our 2018 tax provision by approximately $39 million.

Due to a higher tax basis in KMG than book basis the incremental tax benefit on the sale of KMG of $272 million resulted from a tax loss higher than the loss recorded in the statement of income for the year ended December 31, 2018. In addition, the amount reflects our ability to carryback the capital loss to tax years 2015, 2016 and 2017 at the historical tax rate of 35 percent instead of the current tax rate of 21 percent.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

Principal components of our net deferred tax balances at December 31, 2020 and 2019 were as follows:

	Assets (Liabilities)	
	2020	2019
	(in millions)	
Compensation and other accrued expense	$ 171	$ 111
Benefits payable	87	89
Net operating loss carryforward	32	42
Deferred acquisition costs	26	22
Unearned revenues	12	8
Other	11	8
Capital loss carryforward	—	1
Total deferred income tax assets	339	281
Valuation allowance	(37)	(45)
Total deferred income tax assets, net of valuation allowance	302	236
Depreciable property and intangible assets	(449)	(329)
Investment securities	(418)	(181)
Prepaid expenses	(91)	(64)
Future policy benefits payable	(3)	(3)
Total deferred income tax liabilities	(961)	(577)
Total net deferred income tax liabilities	$ (659)	$ (341)

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2020 and 2019.

At December 31, 2020, we had approximately $86 million of net operating losses to carry forward. These loss carryforwards, if not used to offset future taxable income, will expire from 2024 through 2031. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $37 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2017 and prior years. Our 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2020 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2017. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

13. DEBT

The carrying value of debt outstanding was as follows at December 31, 2020 and 2019:

	2020	2019
	(in millions)	
Short-term debt:		
Commercial paper	$ 600	$ 300
Senior notes:		
$400 million, 2.50% due December 15, 2020	—	399
Total short-term debt	$ 600	$ 699
Long-term debt:		
Senior notes:		
$600 million, 3.15% due December 1, 2022	$ 598	$ 598
$400 million, 2.90% due December 15, 2022	398	397
$600 million, 3.85% due October 1, 2024	598	597
$600 million, 4.50% due April 1, 2025	595	—
$600 million, 3.95% due March 15, 2027	596	595
$500 million, 3.125% due August 15, 2029	495	495
$500 million, 4.875% due April 1, 2030	494	—
$250 million, 8.15% due June 15, 2038	262	262
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	396
$500 million, 3.95% due August 15, 2049	493	492
Total long-term debt	$ 6,060	$ 4,967

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2021	$ 600
2022	1,000
2023	—
2024	600
2025	600
Thereafter	3,900

Senior Notes

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid, were approximately $1,088 million as of December 31, 2020. We used the net proceeds for general corporate purposes.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances.

Credit Agreement

Our 5-year, $2.0 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. If drawn upon, the revolving credit would revert to using the alternative base rate once LIBOR is discontinued. The LIBOR spread, currently 110.0 basis points, varies depending on our credit ratings ranging from 91.0 to 150.0 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, may fluctuate between 9.0 and 25.0 basis points, depending upon our credit ratings. 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 based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 50% as well as customary events of default. We are in compliance with this financial covenant, with an actual debt to capitalization of 33% as measured in accordance with the credit agreement as of December 31, 2020. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2020, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2020, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2020 was $600 million, with $600 million outstanding at December 31, 2020 compared to $300 million outstanding at December 31, 2019. The outstanding commercial paper at December 31, 2020 had a weighted average annual interest rate of 0.34%.

Term Note

In February 2020, we entered into a new $1 billion term loan commitment with a bank that matures 1 year after the first draw, subject to a 1 year extension. In March 2020, we made a draw on the entire term loan commitment of $1 billion. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. The note was prepayable without penalty. We repaid the $1 billion outstanding balance in November 2020.

14. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $236 million in 2020, $221 million in 2019, and $197 million in 2018. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $410.27 on December 31, 2020, approximately 10% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.5 million shares, representing approximately 1.2% of the shares outstanding as of December 31, 2020. At December 31, 2020, approximately 1.3 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2020, 2019, and 2018:

	2020	2019	2018
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 171	$ 152	$ 124
Stock options	10	11	13
Total stock-based compensation expense	181	163	137
Tax benefit recognized	(29)	(35)	(21)
Stock-based compensation expense, net of tax	$ 152	$ 128	$ 116

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $32 million in 2020, $25 million in 2019, and $49 million in 2018. There was no capitalized stock-based compensation expense during these years.

At December 31, 2020, there were 11.7 million shares reserved for stock award plans under the Humana Inc. 2011 Stock Incentive Plan, or 2011 Plan, and 15.9 million shares reserved for stock award plans under the Humana Inc. 2019 Stock Incentive Plan, or 2019 Plan. These reserved shares included giving effect to, under the 2011 Plan, 3.9 million shares of common stock available for future grants assuming all stock options were granted or 1.7 million shares available for future grants assuming all restricted stock were granted. These reserved shares included giving effect to, under the 2019 Plan, 14.4 million shares of common stock available for future grants assuming all stock options were granted or 4.3 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $354.66 in 2020, $302.09 in 2019, and $276.62 in 2018. Activity for our restricted stock was as follows for the year ended December 31, 2020:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2019	976	$ 245.21
Granted	471	354.66
Vested	(486)	274.80
Forfeited	(50)	303.74
Nonvested restricted stock at December 31, 2020	911	$ 282.81

Approximately 33% of the nonvested restricted stock at December 31, 2020 included performance-based conditions.

The fair value of shares vested was $191 million during 2020, $141 million during 2019, and $298 million during 2018. Total compensation expense not yet recognized related to nonvested restricted stock was $175 million at December 31, 2020. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2020, 2019, and 2018 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2020	2019	2018
Weighted-average fair value at grant date	$ 69.73	$ 68.53	$ 63.67
Expected option life (years)	4.0 years	4.1 years	4.1 years
Expected volatility	24.9 %	25.5 %	26.1 %
Risk-free interest rate at grant date	1.2 %	2.4 %	2.5 %
Dividend yield	0.7 %	0.7 %	0.7 %

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2020:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2019	493	$ 250.46
Granted	111	350.79
Exercised	(276)	221.15
Forfeited	(5)	307.96
Options outstanding at December 31, 2020	323	$ 309.04
Options exercisable at December 31, 2020	100	$ 277.51

As of December 31, 2020, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $32 million, and a weighted-average remaining contractual term of 4.9 years. As of December 31, 2020, exercisable stock options had an aggregate intrinsic value of $13 million, and a weighted-average remaining contractual term of 3.8 years. The total intrinsic value of stock options exercised during 2020 was $51 million, compared with $43 million during 2019 and $43 million during 2018. Cash received from stock option exercises totaled $61 million in 2020, $58 million in 2019, and $50 million in 2018.

Total compensation expense not yet recognized related to nonvested options was $9 million at December 31, 2020. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

15. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(dollars in millions, except per common share results, number of shares/options in thousands)	
Net income available for common stockholders	$ 3,367	$ 2,707	$ 1,683
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	132,199	134,055	137,486
Dilutive effect of:			
Employee stock options	92	107	194
Restricted stock	721	565	723
Shares used to compute diluted earnings per common share	133,012	134,727	138,403
Basic earnings per common share	$ 25.47	$ 20.20	$ 12.24
Diluted earnings per common share	$ 25.31	$ 20.10	$ 12.16
Number of antidilutive stock options and restricted stock awards excluded from computation	238	478	223

16. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2018, 2019, and 2020 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2018	$1.90	$262
2019	$2.15	$289
2020	$2.43	$322

In November 2020, the Board declared a cash dividend of $0.625 per share that was paid on January 29, 2021 to stockholders of record on December 31, 2020, for an aggregate amount of $81 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2021, the Board declared a cash dividend of $0.70 per share payable on April 30, 2021 to stockholders of record on March 31, 2021.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Upon settlement of the ASR on March 26, 2018, we received an additional 0.46 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement, less a discount, of $267.55, bringing the total shares received under this program to 3.74 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by BofA from capital in excess of par value to treasury stock.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflected the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Upon final settlement of the November 2018 ASR on February 28, 2019, we received an additional 0.6 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $295.15, bringing the total shares received under this program to 2.54 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

On July 30, 2019, the Board of Directors replaced a previous share repurchase authorization of up to $3 billion (of which approximately $1.03 billion remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on June 30, 2022.

On July 31, 2019, we entered into an accelerated stock repurchase agreement, the July 2019 ASR, with Citibank, N.A., or Citi, to repurchase $1 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On August 2, 2019, we made a payment of $1 billion to Citi and received an initial delivery of 2.7 million shares of our common stock. We recorded the payment to Citi as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 2.7 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by Citi pending final settlement of the July 2019 ASR. Upon final settlement of the July 2019 ASR on December 26, 2019, we received an additional 0.7 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $296.19, bringing the total shares received under the July 2019 ASR to 3.4 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by Citi from capital in excess of par value to treasury stock.

On December 22, 2020, we entered into separate accelerated stock repurchase agreements, ("the December 2020 ASR Agreements"), with Citibank, N.A., or Citi, and JPMorgan Chase Bank, or JPM, to repurchase $1.75 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On December 23, 2020, in accordance with the December 2020 ASR Agreements, we made a payment of $1.75 billion ($875 million to Citi and $875 million to JPM) and received an initial delivery of 3.8 million shares of our common stock (1.9 million shares each from Citi and JPM). We recorded the payments to Citi and JPM as a reduction to stockholders' equity, consisting of an $1.5 billion increase in treasury stock, which reflects the value of the initial 3.8 million shares received upon initial settlement, and a $262.5 million decrease in

capital in excess of par value, which reflects the value of stock held back by Citi and JPM pending final settlement of the December 2020 ASR Agreements. The final number of shares that we may receive, or be required to remit, under the December 2020 ASR Agreements, will be determined based on the daily volume-weighted average share price of our common stock over the term of the December 2020 ASR Agreements, less a discount and subject to adjustments pursuant to the terms and conditions of the December 2020 ASR Agreements. We expect final settlement under the December 2020 Agreements to occur during the second quarter of 2021. The December 2020 Agreements contain provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the agreement may be accelerated, extended, or terminated early by Citi, JPM or Humana as well as various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Citi and JPM or we may be required to make a payment. If we are obligated to make a payment, we may elect to satisfy such obligation in cash or shares of our common stock.

On February 18, 2021, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $250 million remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring as of February 18, 2024.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2020, 2019 and 2018.

		2020		2019		2018	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
				(in millions)			
December 2017	3,000	—	$ —	—	$ —	3.07	$ 1,024
July 2019	3,000	3.80	1,750	3.40	1,000	—	—
Total repurchases		3.80	$ 1,750	3.40	$ 1,000	3.07	$ 1,024

In connection with employee stock plans, we acquired 0.2 million common shares for $70 million in 2020, 0.2 million common shares for $70 million in 2019, and 0.4 million common shares for $116 million in 2018.

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, and 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, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.4 billion and $8.0 billion as of December 31, 2020 and 2019, respectively, which exceeded aggregate minimum regulatory requirements of $7.0 billion and $5.9 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual

dividends that were paid to our parent company were approximately $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

17. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $291 million in 2021, $250 million in 2022, $138 million in 2023, $77 million in 2024, and $51 million in 2025. Purchase obligations exclude agreements that are cancellable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2020, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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 certain of our non-regulated subsidiaries and funding to maintain required statutory capital levels of certain regulated subsidiaries.

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.

Government Contracts

Our Medicare products, which accounted for approximately 82% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2021, and all of our product offerings filed with CMS for 2021 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the

risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. We refer to the process of accounting for errors in FFS claims as the "FFS Adjuster." This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been finalized. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our

results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

We believe that CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS's final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2020, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately 6% of our total premiums and services revenue for the year ended December 31, 2020. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, or increases in member benefits or member eligibility criteria without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned United States of America *ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. We take seriously our obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. We have substantially completed discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expect the Court to consider our motion for summary judgment.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, disputes arising from competitive procurement process, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of nonperformance of contractual obligations to providers, members, and others, including

failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extra contractual damages, care delivery malpractice, and claims 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.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

18. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our non-consolidating minority investment in Kindred at Home and the strategic partnership with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis, including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non-risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non-risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $16.5 billion in 2020, $14.9 billion in 2019, and $13.4 billion in 2018. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $127 million in 2020, $117 million in 2019, and $129 million in 2018.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, were approximately 83% for 2020, 82% for 2019 and 81% for 2018.

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2020					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 51,697	$ —	$ —	$ —	$ 51,697
Group Medicare Advantage	7,774	—	—	—	7,774
Medicare stand-alone PDP	2,742	—	—	—	2,742
Total Medicare	62,213	—	—	—	62,213
Fully-insured	688	4,761	—	602	6,051
Specialty	—	1,699	—	—	1,699
Medicaid and other	4,223	—	—	—	4,223
Total premiums	67,124	6,460	—	602	74,186
Services revenue:					
Provider	—	—	435	—	435
ASO and other	19	780	—	—	799
Pharmacy	—	—	581	—	581
Total services revenue	19	780	1,016	—	1,815
Total external revenues	67,143	7,240	1,016	602	76,001
Intersegment revenues					
Services	—	29	19,491	(19,520)	—
Products	—	—	7,928	(7,928)	—
Total intersegment revenues	—	29	27,419	(27,448)	—
Investment income	155	16	13	970	1,154
Total revenues	67,298	7,285	28,448	(25,876)	77,155
Operating expenses:					
Benefits	56,537	5,529	—	(438)	61,628
Operating costs	7,402	1,818	27,395	(26,563)	10,052
Depreciation and amortization	342	81	183	(117)	489
Total operating expenses	64,281	7,428	27,578	(27,118)	72,169
Income (loss) from operations	3,017	(143)	870	1,242	4,986
Interest expense	—	—	—	283	283
Other expense, net	—	—	—	103	103
Income (loss) before income taxes and equity in net earnings	3,017	(143)	870	856	4,600
Equity in net earnings	—	—	74	—	74
Segment earnings (loss)	$ 3,017	$ (143)	$ 944	$ 856	$ 4,674

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2019					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 43,128	$ —	$ —	$ —	$ 43,128
Group Medicare Advantage	6,475	—	—	—	6,475
Medicare stand-alone PDP	3,165	—	—	—	3,165
Total Medicare	52,768	—	—	—	52,768
Fully-insured	588	5,123	—	—	5,711
Specialty	—	1,571	—	—	1,571
Medicaid and other	2,898	—	—	—	2,898
Total premiums	56,254	6,694	—	—	62,948
Services revenue:					
Provider	—	—	446	—	446
ASO and other	17	790	—	—	807
Pharmacy	—	—	186	—	186
Total services revenue	17	790	632	—	1,439
Total external revenues	56,271	7,484	632	—	64,387
Intersegment revenues					
Services	—	18	18,255	(18,273)	—
Products	—	—	6,894	(6,894)	—
Total intersegment revenues	—	18	25,149	(25,167)	—
Investment income	195	23	2	281	501
Total revenues	56,466	7,525	25,783	(24,886)	64,888
Operating expenses:					
Benefits	48,602	5,758	—	(503)	53,857
Operating costs	5,306	1,651	24,852	(24,428)	7,381
Depreciation and amortization	323	88	156	(109)	458
Total operating expenses	54,231	7,497	25,008	(25,040)	61,696
Income from operations	2,235	28	775	154	3,192
Interest expense	—	—	—	242	242
Other income, net	—	—	—	(506)	(506)
Income before income taxes and equity in net earnings	2,235	28	775	418	3,456
Equity in net earnings	—	—	14	—	14
Segment earnings	$ 2,235	$ 28	$ 789	$ 418	$ 3,470

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2018							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 35,656	$ —	$ —	$ —	$ —	$ —	$ 35,656
Group Medicare Advantage	6,103	—	—	—	—	—	6,103
Medicare stand-alone PDP	3,584	—	—	—	—	—	3,584
Total Medicare	45,343	—	—	—	—	—	45,343
Fully-insured	510	5,444	—	8	—	—	5,962
Specialty	—	1,359	—	—	—	—	1,359
Medicaid and other	2,255	—	—	—	22	—	2,277
Total premiums	48,108	6,803	—	8	22	—	54,941
Services revenue:							
Provider	—	—	404	—	—	—	404
ASO and other	11	835	—	—	4	—	850
Pharmacy	—	—	203	—	—	—	203
Total services revenue	11	835	607	—	4	—	1,457
Total external revenues	48,119	7,638	607	8	26	—	56,398
Intersegment revenues							
Services	—	18	16,840	—	—	(16,858)	—
Products	—	—	6,330	—	—	(6,330)	—
Total intersegment revenues	—	18	23,170	—	—	(23,188)	—
Investment income	136	23	34	—	110	211	514
Total revenues	48,255	7,679	23,811	8	136	(22,977)	56,912
Operating expenses:							
Benefits	40,925	5,420	—	(70)	77	(470)	45,882
Operating costs	5,327	1,810	22,905	4	6	(22,527)	7,525
Depreciation and amortization	270	88	163	—	—	(116)	405
Total operating expenses	46,522	7,318	23,068	(66)	83	(23,113)	53,812
Income from operations	1,733	361	743	74	53	136	3,100
Loss on sale of business	—	—	—	—	—	786	786
Interest expense	—	—	—	—	—	218	218
Other expense, net	—	—	—	—	—	33	33
Income (loss) before income taxes and equity in net earnings	1,733	361	743	74	53	(901)	2,063
Equity in net earnings	—	—	11	—	—	—	11
Segment earnings (loss)	$ 1,733	$ 361	$ 754	$ 74	$ 53	$ (901)	$ 2,074

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Reinsurance recoverables, included in other current and long-term assets, were $194 million at December 31, 2020 and $267 million at December 31, 2019. The amount of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately $193 million at December 31, 2020 and approximately $267 million at December 31, 2019. Premiums ceded were $29 million in 2020, $1 billion in 2019 and $976 million in 2018. Benefits ceded were $7 million in 2020, $881 million in 2019, and $980 million in 2018. Historical ceded premium and benefits reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer. The reinsurance agreement ceding all risk under the Medicaid contract was terminated effective January 1, 2020.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $171 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ at December 31, 2020. The remaining reinsurance recoverables of $22 million are divided between 10 other reinsurers, with $3 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2020 and 2019, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flow for each of the three years in the period ended December 31, 2020, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed 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. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail,

accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Incurred but not yet Reported Benefits Payable

As described in Notes 2 and 11 to the consolidated financial statements, the Company's incurred but not yet reported benefits payable (IBNR) was $5.3 billion as of December 31, 2020. Management develops its estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. As described by management, for the periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, IBNR is estimated primarily from a trend analysis based upon per member per month claims trends developed from historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix and workday seasonality.

The principal considerations for our determination that performing procedures relating to the valuation of IBNR is a critical audit matter are the significant judgment by management when developing the estimate of IBNR, which in turn led to a high degree of auditor judgment, subjectivity and effort in performing procedures to evaluate the actuarial methodologies and significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in evaluating the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of IBNR, including controls over the actuarial methodologies and development of significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. These procedures also included, among others, the involvement of professionals with specialized skill and knowledge to assist in developing an independent estimate of IBNR. This independent estimate includes a range of reasonable outcomes, including outcomes under moderately adverse conditions, which are compared to management's estimate of IBNR. Developing the independent estimate involved developing independent completion factors and per member per month claims trends assumptions using management's data,

testing the completeness and accuracy of data provided by management, and evaluating the reasonableness of management's assumptions.

Goodwill Impairment Assessment - Provider and Clinical Reporting Units

As described in Notes 2 and 9 to the consolidated financial statements, the Company's consolidated goodwill balance was $4.4 billion as of December 31, 2020, and the goodwill associated with the Provider and Clinical Reporting Units was $761 million and $524 million, respectively. Management conducts an impairment test in the fourth quarter of each year and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. Management relies on a discounted cash flow analysis to determine fair value and uses discount rates that correspond to a market-based weighted-average cost of capital, and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in management's cash flow projections, including revenue growth rates, medical and operating cost trends, and projected operating income, are supported with management's long-range business plan and annual planning process.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessment of the Provider and Clinical Reporting Units is a critical audit matter are the significant judgment by management when developing the fair value estimate of the reporting units, which in turn led to a high degree of auditor judgment, subjectivity, and audit effort in performing procedures to evaluate management's cash flow projections, including significant assumptions related to the revenue and terminal growth rates, projected operating income, and the discount rate. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in evaluating the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's goodwill impairment assessment, including controls over the significant assumptions used in the valuation of the Provider and Clinical Reporting Units. These procedures also included, among others, testing management's process for developing the fair value estimate of the reporting units; evaluating the appropriateness of the discounted cash flow analysis; testing the completeness and accuracy of underlying data used in the analysis; and evaluating the reasonableness of the significant assumptions used by management related to the revenue and terminal growth rates and projected operating income, by considering the past performance of the reporting units and considering whether these assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the appropriateness of the Company's discounted cash flow analysis and the reasonableness of the significant assumptions related to the terminal growth rates and the discount rate impacting the reporting units' future cash flows.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 18, 2021

We have served as the Company's auditor since 1968.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2020, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed 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. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2020. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2020, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2020 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on pages 121-123.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2020 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Proposal One: Election of Directors" in such Definitive Proxy Statement.

Executive Officers of the Registrant

A list of our executive officers and biographical information appears in Part I, Item 1 of this Form 10-K.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day (the "Code"). All employees and directors are required to annually affirm in writing their acceptance of the Code. The Code was adopted by our Board of Directors in June 2014, replacing a previous iteration, known as the Humana Inc. Principles of Business Ethics, as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Code is available on the Investor Relations section of our web site at www.humana.com, and any waiver of the application of the Code with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on the Investor Relations section of our Internet web site at www.humana.com is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors, pursuant to our Corporate Governance Guidelines;
- the pre-approval process of non-audit services provided by our independent accountants;
- our By-laws and Certificate of Incorporation;
- our Majority Vote policy, pursuant to our By-laws;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;

- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Corporate Governance – Audit Committee" of such Definitive Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Definitive Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, and key employees. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2020 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	323,009	$ 309.044	$ 18,281,908	(2)(3)(4)
Equity compensation plans not approved by security holders	—	—	—	
Total	323,009	$ 309.044	$ 18,281,908	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 14.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) The Humana Inc. Amended and Restated Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 18, 2019. On May 1, 2019, 16 million shares were registered with the Securities and Exchange Commission on Form S-8.
(4) Of the number listed above, 5,996,605 (1,704,458 from the 2011 Plan and 4,292,148 from the Amended and Restated Plan) can be issued as restricted stock at December 31, 2020 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan and 3.35 stock options in the Amended and Restated Plan).

The information under the captions “Stock Ownership Information - Security Ownership of Certain Beneficial Owners of Company Common Stock” and “Stock Ownership Information - Security Ownership of Directors and Executive Officers” in our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the captions “Certain Transactions with Management and Others” and “Corporate Governance – Director Independence” of such Definitive Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption “Audit Committee Report” of such Definitive Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2020 and 2019 and for the years ended December 31, 2020, 2019 and 2018
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2020, 2019 and 2018

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(c) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(d) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 13 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(e) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(f) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(g) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(h)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(i)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(j)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(k)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017).
(l)	Fourteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(m)	Fifteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(n)	Sixteenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(o)	Seventeenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(p)	Description of Securities (incorporated herein by reference to Exhibit 4(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*†	Humana Inc. Executive Incentive Compensation Plan, as amended and restated January 1, 2020.
(c)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(d)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
(e)*	Humana Inc. Executive Severance Policy, effective as of March 1, 2019 (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(f)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).
(g)*	Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).

(h)*	Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).
(i)*	Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).
(j)*	Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).
(k)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.
(l)	Five-Year $2 Billion Amended and Restated Credit Agreement, dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).
(m)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(n)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(o)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(p)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(q)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(r)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(t)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(u)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(v)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).

(w)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(x)*	Humana Inc. Change in Control Policy, effective March 1, 2019 (incorporated herein by reference to Exhibit 10(aa) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(y)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(z)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(aa)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(bb)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
(cc)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(ff) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(dd)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(gg) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ee)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(hh) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ff)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(ii) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(gg)*	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019 (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(hh)*	Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 18, 2019).
(ii)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(jj)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).

(kk)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(ll)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(mm)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(nn)*†	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options).
(oo)*†	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(pp)*†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(qq)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions).
(rr)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions).
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.

101 The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2020 and 2019; (ii) the Consolidated Statements of Income for the years ended December 31, 2020, 2019 and 2018; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019 and 2018; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2020, 2019, and 2018; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019 and 2018; and (vi) Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.

104 Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

*Exhibits 10(a) through and including 10(k), and Exhibits 10(t) through and including 10(x), as well as Exhibits 10(z) through and including Exhibit 10(rr) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2020	2019
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 436	$ 1,006
Investment securities	336	355
Receivable from operating subsidiaries	1,187	1,248
Other current assets	763	778
Total current assets	2,722	3,387
Property and equipment, net	1,774	1,403
Investments in subsidiaries	17,005	14,763
Equity method investment in Kindred at Home	1,147	1,063
Long-term investment securities	836	32
Other long-term assets	686	746
Total assets	$ 24,170	$ 21,394
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 1,342	$ 1,975
Current portion of notes payable to operating subsidiaries	36	36
Book overdraft	120	40
Short-term debt	600	699
Other current liabilities	1,438	1,128
Total current liabilities	3,536	3,878
Long-term debt	6,060	4,967
Other long-term liabilities	846	512
Total liabilities	10,442	9,357
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; 198,648,742 shares issued at December 31, 2020 and 198,629,992 shares issued at December 31, 2019	33	33
Capital in excess of par value	2,705	2,820
Retained earnings	20,517	17,483
Accumulated other comprehensive income (loss)	391	156
Treasury stock, at cost, 69,787,614 shares at December 31, 2020 and 66,524,771 shares at December 31, 2019	(9,918)	(8,455)
Total stockholders' equity	13,728	12,037
Total liabilities and stockholders' equity	$ 24,170	$ 21,394

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 2,216	$ 1,789	$ 1,666
Investment and other income, net	763	28	30
	2,979	1,817	1,696
Expenses:			
Operating costs	2,204	1,577	1,468
Depreciation	397	387	342
Interest	283	242	218
	2,884	2,206	2,028
Other expense (income), net	60	(506)	33
Loss on sale of business	—	—	782
Income (loss) before income taxes and equity in net earnings of subsidiaries	35	117	(1,147)
Provision (benefit) for income taxes	18	27	(542)
Income (loss) before equity in net earnings of subsidiaries	17	90	(605)
Equity in net earnings of subsidiaries	3,269	2,603	2,277
Equity in net earnings of Kindred at Home	81	14	11
Net income	$ 3,367	$ 2,707	$ 1,683

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2020	2019	2018
		(in millions)	
Net income	$ 3,367	$ 2,707	$ 1,683
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	393	450	(189)
Effect of income taxes	(89)	(105)	51
Total change in unrealized investment gains/losses, net of tax	304	345	(138)
Reclassification adjustment for net realized gains included in investment income	(90)	(34)	(53)
Effect of income taxes	20	8	17
Total reclassification adjustment, net of tax	(70)	(26)	(36)
Other comprehensive income (loss), net of tax	234	319	(174)
Comprehensive income (loss) attributable to our equity method investment in Kindred at Home	1	(4)	(4)
Comprehensive income	$ 3,602	$ 3,022	$ 1,505

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2020	2019	2018
		(in millions)	
Net cash provided by operating activities	$ 2,531	$ 3,529	$ 2,719
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(709)	—	(354)
Acquisitions, equity method investment in Kindred at Home	—	—	(1,095)
Capital contributions to operating subsidiaries	(538)	(423)	(697)
Purchases of investment securities	(460)	(204)	(145)
Proceeds from sale of investment securities	13	15	35
Maturities of investment securities	411	134	59
Purchases of property and equipment, net	(785)	(585)	(465)
Net cash used in investing activities	(2,068)	(1,063)	(2,662)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	1,088	987	—
Repayment of senior notes	(400)	(400)	—
Proceeds (repayments) from issuance of commercial paper, net	295	(360)	485
Proceeds from term loan	1,000	—	1,000
Repayment of term loan	(1,000)	(650)	(350)
Change in book overdraft	80	2	(3)
Common stock repurchases	(1,820)	(1,070)	(1,090)
Dividends paid	(323)	(291)	(265)
Proceeds from stock option exercises and other	47	57	48
Net cash used in financing activities	(1,033)	(1,725)	(175)
(Decrease) increase in cash and cash equivalents	(570)	741	(118)
Cash and cash equivalents at beginning of year	1,006	265	383
Cash and cash equivalents at end of year	$ 436	$ 1,006	$ 265

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by 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 has also guaranteed the obligations of our military services subsidiaries and funding to maintain required statutory capital levels of certain other regulated subsidiaries.

3. 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, and 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, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.4 billion and $8.0 billion as of December 31, 2020 and 2019, respectively, which exceeded aggregate minimum regulatory requirements of $7.0 billion and $5.9 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Notes 3 and 4 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. During 2020, 2019 and 2018, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 13 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDERS' EQUITY

Refer to Note 16 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders’ equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2020, 2019, and 2018
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2020	$ 69	$ —	$ 36	$ (1)	$ (32)	$ 72
2019	79	—	(1)	—	(9)	69
2018	96	—	36	(29)	(24)	79
Deferred tax asset valuation allowance:						
2020	(45)	—	8	—	—	(37)
2019	(54)	—	9	—	—	(45)
2018	(49)	—	(5)	—	—	(54)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE
Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

Date: February 18, 2021

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 18, 2021
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 18, 2021
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 18, 2021
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 18, 2021
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 18, 2021
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 18, 2021
/s/ RAQUEL C. BONO, M.D. **Raquel C. Bono, M.D.**	Director	February 18, 2021
/s/ WAYNE A. I. FREDERICK, M.D. **Wayne A. I. Frederick, M.D.**	Director	February 18, 2021
/s/ JOHN W. GARRATT **John W. Garratt**	Director	February 18, 2021
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 18, 2021
/s/ KAREN W. KATZ **Karen W. Katz**	Director	February 18, 2021
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 18, 2021
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 18, 2021
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 18, 2021

HUMANA INC.
EXECUTIVE INCENTIVE COMPENSATION PLAN
As Amended and Restated January 1, 2020

I. OBJECTIVES.

The objectives of the Humana Inc. Executive Incentive Compensation Plan, as amended and restated (the "Plan") are to (i) link the compensation of selected executives to certain key performance targets; and (ii) reward them, when appropriate, for their efforts in achieving the performance targets of Humana Inc. (the "Company"), consistent with appropriate balance of risk and reward and appropriate governance and risk management practices aligned to the Company's short-term and long-term strategic plan.

II. ELIGIBILITY AND AWARDS.

A. Executives eligible to participate in this Plan ("Participants") will be limited to Section 16 officers of Humana Inc., as determined pursuant to Section 16 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Participation in the Plan will be approved by the Organization & Compensation Committee of the Board of Directors of the Company (the "Committee"). Each Participant shall be notified of his/her selection as a Participant.

B. Incentive compensation will be computed by measuring the Company's achievement of predetermined goals ("Performance Targets") established by the Committee in accordance with Internal Revenue Service regulations promulgated under Section 162(m) of the Internal Revenue Code as amended (the "Code"), to the extent applicable. Performance Targets may be expressed in terms of (i) earnings per share, (ii) share price, (iii) consolidated net income, (iv) pre-tax profits, (v) earnings or net earnings, (vi) return on equity or assets, (vii) sales, (viii) cash flow from operating activities, (ix) return on invested capital, (x) membership, (xi) other performance objectives as determined by the Committee, to the extent permitted under Section 162(m) of the Code (if applicable), or (xii) any combination of the foregoing. Performance Targets may be in respect of the performance of the Company, any of its Subsidiaries, any of its divisions or any combination thereof. Performance Targets may be absolute or relative (to prior performance of the Company or to the performance of one or more other entities or external indices) and may be expressed in terms of a progression within a specified range.

C. Incentive compensation for a fiscal year or other relevant period determined by the Committee ("Performance Period") shall be based on the Participant's base salary paid or accrued during such fiscal year exclusive of any bonus, equity compensation, or fringe benefits paid or accrued during such fiscal year ("Salary"). The Committee shall determine, subject to the limits in the Plan, the potential percentage of Salary which any Participant shall be eligible to receive as incentive compensation, which need not be the same for each Participant. The precise percentage earned shall be based upon a schedule of achievement of Performance Targets. Notwithstanding anything herein to the contrary, the maximum incentive compensation paid for any fiscal year to the CEO may not exceed Six Million Dollars ($6,000,000), or Three Million Dollars ($3,000,000) for any other Participant.

D. The Company's achievement of any relevant Performance Targets will be determined in accordance with generally accepted accounting principles. Any incentive compensation generated pursuant to incentive plans of the Company, including this Plan, shall be accrued and deducted as an expense in the appropriate fiscal year in determining the achievement of any Performance Targets.

E. Each Participant may receive an award ("Award") if the Performance Target(s) established by the Committee are attained in the applicable Performance Period. The applicable Performance Period and Performance Target(s) shall be determined by the Committee consistent with the terms of the Plan and, to the extent applicable, Section 162(m) of the Code. Notwithstanding the

fact that the Performance Target(s) have been attained, the Committee may pay an Award of less than the amount determined by the formula or standard established by the Committee or may pay no Award at all.

F. The specific Performance Target(s) must be established by the Committee in advance of the deadlines applicable under Section 162(m) of the Code, to the extent applicable, and while the performance relating to the Performance Target(s) remains substantially uncertain within the meaning of Section 162(m) of the Code. The Performance Target(s) with respect to any Performance Period may be established on a cumulative basis or in the alternative, and may be established on a stand-alone basis with respect to the Company or on a relative basis with respect to any peer companies or index selected by the Committee. At the time the Performance Target(s) are selected, the Committee shall provide, in terms of an objective formula or standard for each Participant, the method of computing the specific amount of Award payable to the Participant if the Performance Target(s) are attained. The objective formula or standard shall preclude the use of discretion to increase the amount of any Award earned pursuant to the terms of the Award.

G. If services as a Participant commence after the adoption of the Plan and the Performance Target(s) are established for a Performance Period, the Committee may grant an Award that is proportionately adjusted based on the period of actual service, and the amount of any Award paid to such Participant shall not exceed that proportionate amount of the applicable maximum individual Award allowable under the Plan.

H. Notwithstanding anything to the contrary set forth herein, the Performance Target(s) shall be adjusted to reflect the following events, subject to such event resulting in a change to the applicable Performance Target in excess of the aggregate threshold amount established by the Committee at the time of the granting of the applicable Award;: (A) the acquisition or disposition of a business, a merger, or a similar transaction, and the related integration costs including external costs such as legal, accounting and consulting fees and internal costs such as severance and benefits, contract cancellation costs, lease abandonment costs, overhead costs of integration including allocated wages and benefits and administrative costs in connection therewith; (B) the impact of securities issuances or repurchases in connection with an acquisition or disposition of a business, a merger, or a similar transaction, and related expenses including both direct and incremental costs incurred in connection therewith; (C) changes in accounting principles, tax laws, or other laws, provisions or regulations; (D) any litigation or regulatory investigations not in the ordinary course of business; (E) restructuring activity, including, but not limited to, reductions in force not in the ordinary course of business; (F) impact of exit or disposal activities, such as the close of blocks of business, market or product exits, asset sales or abandonments, contracts placed in run-off, related premium deficiency reserves or capital charges; and (G) any extraordinary, natural disaster, unusual and/or infrequent event, including, but not limited to those defined by SEC Regulation S-K Item 10(e), as appropriate for reporting as non-GAAP financial measures. For the avoidance of doubt, the Committee shall in all events retain the discretion to reduce (but not increase) any Award, regardless of the result of any adjustments described above.

I. To preserve the intended incentives and benefits of an Award based on a Performance Target, the Committee may determine at the time Performance Targets are established that certain adjustments shall apply to the objective formula or standard with respect to the applicable Performance Target to take into account, in whole or in part, in any manner specified by the Committee, any one or more of the following with respect to the Performance Period: (i) the gain, loss, income or expense resulting from changes in accounting principles that become effective during the Performance Period; (ii) the gain, loss, income or expense reported publicly by the Company with respect to the Performance Period that are extraordinary or unusual in nature or infrequent in occurrence; (iii) the gains or losses resulting from, and the direct expenses incurred in connection with the disposition of a business, or the sale of investments or non-core assets; (iv) the gain or loss from all or certain claims and/or litigation and all or certain insurance

recoveries relating to claims or litigation; (v) the impact of impairment of tangible or intangible assets; including goodwill; (vi) the impact of restructuring or business recharacterization activities, including but not limited to reductions in force, that are reported publicly by the Company; or (vii) the impact of investments or acquisitions made during the year or, to the extent provided by the Committee, any prior year. Each of the adjustments described in this Section may relate to the Company as a whole or any part of the Company's business operations. The adjustments are to be determined in accordance with generally accepted accounting principles and standards, unless another objective method of measurement is designated by the Committee. In addition to the foregoing, the Committee shall adjust any Performance Targets or other features of an Award that relate to or are wholly or partially based on the number of, or the value of, any stock of the Company, to reflect any stock dividend or split, recapitalization, combination or exchange of shares or other similar changes in such stock.

J. The Committee has the sole discretion to determine the standard or formula pursuant to which each Participant's Award shall be calculated and whether all or any portion of the amount so calculated will be paid, subject in all cases to the terms, conditions and limits of the Plan. To this same extent, the Committee may at any time establish (and, once established, rescind, waive or amend) additional conditions and terms of payment of Awards (including but not limited to the achievement of other financial, strategic or individual goals, which may be objective or subjective) as it may deem desirable in carrying out the purposes of the Plan and may take into account such other factors as it deems appropriate in administering any aspect of the Plan. The Committee may not, however, increase the maximum amount permitted to be paid to any individual under the Plan or pay Awards under this Plan if applicable Performance Target(s) have not been satisfied.

K. Incentive compensation shall be paid to Participants on or before March 15th of the year following the fiscal year with respect to which it was earned or such earlier date as may be required in order that such amount be deductible under the Code for the fiscal year with respect to which it was earned.

III. ADMINISTRATION OF THIS PLAN.

The Committee has sole authority (except as specified otherwise herein) to determine all questions of interpretation and application of the Plan, or of the terms and conditions pursuant to which Awards are granted under the Plan and in general, to make all determinations advisable for the administration of the Plan to achieve its purpose. The Committee determinations under the Plan (including without limitation, determinations of the persons to receive Awards, the form, amount and timing of such Awards, the terms and provisions of such Awards and any agreements evidencing such Awards) need not be uniform and may be made by the Committee selectively among persons who receive or are eligible to receive Awards under the Plan, whether or not such persons are similarly situated. Such determinations shall be final and not subject to further appeal.

IV. TERMINATION OF EMPLOYMENT.

Subject to the discretion of the Committee, a Participant must be actively employed or on short-term disability (as determined pursuant to the applicable Company policy) on the last day of the applicable Performance Period to be eligible for a payout, unless the Participant's employment was terminated due to: (i) the Participant's death or [Disability (as defined in the Amended and Restated Humana Inc. Stock Incentive Plan)]; (ii) the Participant's Retirement; or (iii) the Participant's termination of employment due to a (A) Workforce Reduction, (B) Position Elimination, (C) Divestiture or (D) position reassignment to a Strategic Joint Venture (as each term is defined in the Amended and Restated Humana Inc. Stock Incentive Plan). To the extent that a Participant is not actively employed on the last day of the applicable Performance Period due to death, Disability, Retirement, Workforce Reduction, Position Elimination, Divestiture or position reassignment to a Strategic Joint Venture, the Participant will be eligible to receive a pro-rated Award based on the period that the Participant was actively employed during the Performance Period, with the amount of the pro-rated Award to be based on actual

performance and paid at the same time as Awards are paid to employees who remain actively employed through the end of the applicable Performance Period.

V. AMENDMENT OF PLAN.

Subject to any restrictions imposed under Section 162(m) of the Code, to the extent applicable, the Committee may at any time and from time to time alter, amend, suspend or terminate the Plan in whole or in part, provided that no such amendment that would require the consent of the Board and/or stockholders of the Company pursuant to Section 162(m) of the Code, to the extent applicable, or the Exchange Act, any New York Stock Exchange (or other relevant stock exchange) rule or regulation, or any other applicable law, rule or regulation, shall be effective without such consent.

VI. GENERAL PROVISIONS.

A. No person has any claim or right to be included in this Plan or to be granted incentive compensation under this Plan until such individual has been declared a Participant and received official notice thereof in accordance with the procedures as set forth in this Plan. In addition, all of the requirements and applicable rules and regulations of this Plan must have been met including, but not limited to the availability of funds for incentive compensation awards and the determination by the Committee of the extent to which Performance Targets have been met.

B. The designation of an individual as a Participant under this Plan does not in any way alter the nature of the Participant's employment relationship. Participation in this Plan shall not constitute a contract of employment between the Company or any subsidiary and any person and shall not be deemed to be consideration for, or a condition of, continued employment of any person.

C. No benefit provided under the Plan shall be subject to alienation or assignment by a Participant (or by any person entitled to such benefit pursuant to the terms of this Plan), nor shall it be subject to attachment or other legal process except (i) to the extent specifically mandated and directed by applicable state or federal statute; and (ii) as requested by the Participant and approved by the Committee to members of the Participant's family, or a trust established by the Participant for the benefit of family members.

D. The Company or a subsidiary may withhold any applicable federal, state or local taxes at such time and upon such terms and conditions as required by law or determined by the Company or subsidiary.

E. Each member of the Committee (and each person to whom the Committee or any member thereof has delegated any of its authority or power under this Plan) shall be fully justified in relying or acting in good faith upon any report made by the independent public accountants of the Company and its subsidiaries and upon any other information furnished the Committee in connection with the Plan. In no event shall any person who is or shall have been a member of the Committee be liable for any determination made or other action taken or any omission to act in reliance upon any such report or information, or for any action taken or failure to act if in good faith.

F. In the event the Company becomes a party to a merger, consolidation, sale of substantially all of its assets or any other corporate reorganization in which the Company will not be the surviving corporation or in which the holders of the common stock of the Company will receive securities of another corporation (in any such case, the "New Company"), then the New Company shall assume the rights and obligations of the Company under this Plan. All matters relating to the Plan or to G. Awards granted hereunder shall be governed by the laws of the State of Delaware, without regard to the principles of conflict of laws.

G. The expenses of administering the Plan shall be borne by the Company and its subsidiaries.

H. The titles and headings of the sections in the Plan are for convenience of reference only, and in the event of any conflict, the text of the Plan, rather than such titles or headings, shall control.

VII. STOCKHOLDER APPROVAL.

This Plan has been previously approved by the Company's stockholders at the April 24, 2008 annual meeting of stockholders.

VIII. INTERNAL REVENUE CODE SECTION 162(m).

Transactions under this Plan are intended to comply with all applicable conditions of Section 162(m) of the Internal Revenue Code, as amended, or its successor. To the extent any provision of the Plan or action by the Committee fails to so comply (to the extent applicable), it shall be deemed null and void, to the extent permitted by law and deemed advisable by the Committee.

VIII. INTERNAL REVENUE CODE SECTION 409A.

All Awards granted under the Plan are intended to be exempt from Section 409A of the Code. Notwithstanding this or any other provision of the Plan to the contrary, the Committee may amend the Plan or any Award granted hereunder in any manner, or take any other action that it determines, in its sole discretion, is necessary, appropriate or advisable (including replacing any Award) to cause the Plan or any Award granted hereunder to not be subject to Section 409A of the Code. Any such action, once taken, shall be deemed to be effective from the earliest date necessary to avoid a violation of Section 409A of the Code and shall be final, binding and conclusive on all Participants and other individuals having or claiming any right or interest under the Plan.

Adopted: August 21, 2019

HUMANA INC.
STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the **"Date of Grant"**) by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, a Non-Qualified Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date>.

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby.

D. Effect of Termination of Employment on Option. If the employment of Optionee by the Company is terminated for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately. If the employment of Optionee is terminated for any reason other than for Cause, the Option shall vest and remain exercisable in accordance with Sections 12 and 13 of the Plan.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows: (a) In full in cash upon the exercise of the Option; (b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; (c) A combination of I(E)(2)(a) and I(E)(2)(b) above; or (d) Through the cashless exercise provisions of the designated broker-dealer as described in the procedures communicated to Optionee by the Company.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Optionee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Optionee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Optionee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Optionee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Optionee worked, had business contact, or about which Optionee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4)

provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Options, the prohibitions on Optionee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Options, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Options that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Options, assuming target performance has been achieved (or by the number of Shares underlying the Options that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by the Company other than with Cause prior to vesting herein of the Options, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Options, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Optionee shall forfeit all or a portion of any vested or unvested Options held by Optionee without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of any exercised Options.

1. If Optionee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Optionee shall immediately forfeit as of the date that the violation first occurs all unexercised Options described above in Section I(A) (whether vested or unvested) without payment. This provision does not alter the circumstances for forfeiture of unexercised Options as described in Section I(D) of this Agreement.

2. If Optionee has exercised any of the Options prior to the Forfeiture Event, then for any Option that has been exercised during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Optionee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to the amount described below.

To the extent that (i) any Shares related to exercised Options have been sold or transferred, the amount shall be the aggregate gross proceeds realized by Optionee from such sale or transfer of the net Shares acquired after payment of the exercise price and any applicable taxes (the "**Net Shares**") (or, in the case of any disposition or transfer of the Net Shares for less than the Fair Market Value of such Net Shares,

Optionee will repay or reimburse to the Company an amount equal to the Fair Market Value of such Net Shares) or (ii) if the Net Shares have not been sold at the time Company demand is made, the amount shall be the aggregate Fair Market Value of the Net Shares on the date the Options were exercised.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Optionee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Optionee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Options. By receiving the Options, Optionee agrees upon Optionee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Optionee following the Last Day any amounts Optionee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Optionee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Optionee realizes any amounts in excess of what he or she should have received under the terms of any Options for any reason due to mistake in calculations or other administrative error, then Optionee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to Kentucky's conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Optionee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Optionee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Optionee's unfair competition or

wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Optionee agrees that, during the Restricted Period, Optionee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Optionee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Optionee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Optionee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Optionee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Optionee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **Jurisdiction; Service of Process**. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. **No Employment Agreement**. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. **Assignment.** The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. **Defined Terms.**

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this

Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) **"Change in Control Termination"** means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Optionee is terminated within two (2) years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Optionee with Good Reason.

(ii) **"Competitive Product or Service"** means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Optionee's Last Day (as defined below).

(iii) **"Competitor"** means Optionee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) **"Last Day"** means Optionee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Optionee's separation.

(v) **"Protected Relationship"** means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, state Medicaid agencies, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (*e.g.*, through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(vi) **"Restricted Geographic Area"** means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) c ity(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) **"Restricted Period"** means the period of Optionee's employment with the Company, its subsidiaries', and/or its affiliates' and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) **"Solicit"** means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Optionee or indirectly through another individual.

I. Execution. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

HUMANA INC.
INCENTIVE STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, an Incentive Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company ("**Common Stock**") at the purchase price of $<award_price> per share (the "**Option**") exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the **"Expiration Date"**).

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby.

D. Effect of Termination of Employment on Option. If the employment of Optionee by the Company is terminated for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately. If the employment of Optionee is terminated for any reason other than for Cause, the Option shall vest and remain exercisable in accordance with Sections 12 and 13 of the Plan, but in no event beyond the Expiration Date.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows: (i) In full in cash upon the exercise of the Option; (ii) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; or (iii) A combination of I(E)(2)(i) and I(E)(2)(ii) above.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Optionee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Optionee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Optionee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Optionee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings

represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Optionee worked, had business contact, or about which Optionee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Options, the prohibitions on Optionee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Options, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Options that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Options, assuming target performance has been achieved (or by the number of Shares underlying the Options that become vested as a result of the acceleration of vesting,

if any), by the per Share Fair Market Value on the Last Day, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by the Company other than with Cause prior to vesting herein of the Options, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Options, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Optionee shall forfeit all or a portion of any vested or unvested Options held by Optionee without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of any exercised Options.

1. If Optionee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Optionee shall immediately forfeit as of the date that the violation first occurs all unexercised Options described above in Section I(A) (whether vested or unvested) without payment. This provision does not alter the circumstances for forfeiture of unexercised Options as described in Section I(D) of this Agreement.

2. If Optionee has exercised any of the Options prior to the Forfeiture Event, then for any Option that has been exercised during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Optionee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to the amount described below.

To the extent that (i) any Shares related to exercised Options have been sold or transferred, the amount shall be the aggregate gross proceeds realized by Optionee from such sale or transfer of the net Shares acquired after payment of the exercise price and any applicable taxes (the "**Net Shares**") (or, in the case of any disposition or transfer of the Net Shares for less than the Fair Market Value of such Net Shares, Optionee will repay or reimburse to the Company an amount equal

to the Fair Market Value of such Net Shares) or (ii) if the Net Shares have not been sold at the time Company demand is made, the amount shall be the aggregate Fair Market Value of the Net Shares on the date the Options were exercised.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Optionee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Optionee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Options. By receiving the Options, Optionee agrees upon Optionee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Optionee following the Last Day any amounts Optionee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Optionee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Optionee realizes any amounts in excess of what he or she should have received under the terms of any Options for any reason due to mistake in calculations or other administrative error, then Optionee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. **Injunctive Relief; Invalidity of Any Provision.** Optionee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Optionee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Optionee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether

as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Optionee agrees that, during the Restricted Period, Optionee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Optionee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Optionee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Optionee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Optionee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Optionee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed

amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Optionee is terminated within two (2) years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Optionee's Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Optionee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Optionee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, state Medicaid agencies, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (*e.g.*, through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Optionee's employment with the Company, its subsidiaries', and/or its affiliates' and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Optionee or indirectly through another individual.

I. Execution. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Humana Inc. ("Humana") has granted you the number of shares of restricted stock of Humana set forth below in this Restricted Stock Grant Agreement ("Restricted Stock Grant" or "Grant") under the Amended and Restated Stock Incentive Plan. **The award is subject to the provisions of the Plan and the Terms and Conditions below**.

YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

If you are not willing to agree to all of the Grant terms and conditions, do not click the ACCEPT button for the Restricted Stock Grant Acknowledgement and Agreement. If you do not accept the Grant, you will not receive the benefits of the Grant.

If you do click the ACCEPT button, you are accepting and agreeing to all of the terms and conditions of this Restricted Stock Grant, which include, among other things, certain restrictive covenants that may include non-competition and/or non-solicitation provisions.

Please be aware that the Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality places restrictions on your transactions in Humana securities and requires certain Humana employees to obtain advance permission from the Equity Compliance Team before executing transactions in Humana securities.

If you have any questions about your award, please contact EquityCompliance@humana.com.

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT WITH PERFORMANCE VESTING
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Performance-Based Restricted Stock Units (the "Restricted Stock Units") (which represents the target amount of shares available as set out on Appendix A). Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I(E). In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("DERs"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I(E). hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I(B) through I(E), inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I(D) hereof, the related DER shall also be forfeited.

B. **Restrictions and Non-Transferability.** The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I(D).

C. **Vesting of Shares.** Subject to the terms set forth below, if as of the third anniversary of the Date of Grant (the "Vesting Date"), Grantee and the Company have achieved the performance goals to be set forth in Appendix A, the Restricted Stock Units and related DERs shall vest to the extent such performance goals have been achieved. Effective on the Vesting Date, any portion of the Restricted Stock Units and the related DERs for which the performance goals set forth in Appendix A have not been satisfied shall be immediately forfeited. However, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest in accordance with Sections 12 and 13 of the Plan.

D. **Forfeiture.** Except as set forth in Sections 12 and 13 of the Plan, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. **Distributions**. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I(C) hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I(C) hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. **Taxes**. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances"

shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. <u>Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit</u>.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not

related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company any gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts

to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. **Tolling.** In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. **Binding Effect & Adjustment.** This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. **Amendment**. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **No Employment Agreement**. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. **Defined Terms.**

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any

disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "**Competitor**" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, state Medicaid agencies, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Grantee or indirectly through another individual.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

Humana Inc. ("Humana") has granted you the number of shares of restricted stock of Humana set forth below in this Restricted Stock Grant Agreement ("Restricted Stock Grant" or "Grant") under the Amended and Restated Stock Incentive Plan. The award is subject to the provisions of the Plan and the Terms and Conditions below.

YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

If you are not willing to agree to all of the Grant terms and conditions, do not click the ACCEPT button for the Restricted Stock Grant Acknowledgement and Agreement. If you do not accept the Grant, you will not receive the benefits of the Grant.

If you do click the ACCEPT button, you are accepting and agreeing to all of the terms and conditions of this Restricted Stock Grant, which include, among other things, certain restrictive covenants that may include non-competition and/or non-solicitation provisions.

Please be aware that the Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality places restrictions on your transactions in Humana securities and requires certain Humana employees to obtain advance permission from the Equity Compliance Team before executing transactions in Humana securities.

If you have any questions about your award, please contact EquityCompliance@humana.com.

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT ("Agreement") made as of <award_date> (the "Date of Grant") by and between HUMANA INC., a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the "Company"), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as "Grantee").

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the "Plan") was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("DERs"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Restricted Stock Units. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on the Anniversary Date of the Grant, and the next two

installments vesting on each year of the next two anniversaries of the Date of Grant (each such date, a "Vesting Date") subject to Grantee's continued employment with the Company through each such Vesting Date, except as set forth in Sections 12 and 13 of the Plan, or as set forth below:

1. Section 13(c)(ii) of the Plan and any references to "Retirement" in any other section of the Plan will not apply to the Restricted Stock Units.

2. Notwithstanding Section 13(e)(ii)(B) of the Plan, in the event that Grantee's employment with the Company terminates due to a Divestiture of the business to which Grantee provides services, if the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s).

3. Notwithstanding Section 13(g)(ii) of the Plan, in the event that Grantee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s).

D. Forfeiture. Except as set forth in Sections 12 and 13 of the Plan (as modified by Section C above), upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the

contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("Withholding Taxes") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in

violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other

amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II.C shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units without payment.. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes the Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to Kentucky's conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. **Notice of Agreement.** Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. **Tolling.** In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. **Binding Effect & Adjustment.** This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. **Amendment**. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **No Employment Agreement**. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the

Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "Change in Control Termination" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "Competitive Product or Service" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "Competitor" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "Last Day" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "Protected Relationship" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, state Medicaid agencies, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "Restricted Geographic Area" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "Restricted Period" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "Solicit" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Grantee or indirectly through another individual.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

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Humana Inc. ("Humana") has granted you the number of shares of restricted stock of Humana set forth below in this Restricted Stock Grant Agreement ("Restricted Stock Grant" or "Grant") under the Amended and Restated Stock Incentive Plan. **The award is subject to the provisions of the Plan and the Terms and Conditions below**.

YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

If you are not willing to agree to all of the Grant terms and conditions, do not click the ACCEPT button for the Restricted Stock Grant Acknowledgement and Agreement. If you do not accept the Grant, you will not receive the benefits of the Grant.

If you do click the ACCEPT button, you are accepting and agreeing to all of the terms and conditions of this Restricted Stock Grant, which include, among other things, certain restrictive covenants that may include non-competition and/or non-solicitation provisions.

Please be aware that the Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality places restrictions on your transactions in Humana securities and requires certain Humana employees to obtain advance permission from the Equity Compliance Team before executing transactions in Humana securities.

If you have any questions about your award, please contact EquityCompliance@humana.com.

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive one (1) Share on the date of distribution provided for in Section I(E). In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I(E) hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I(B) through I(E), inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I(D) hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I(D).

C. Vesting of Shares. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on December 15 of the year in which the Date of Grant occurs, and the next two installments vesting on December 15 of each of the next two years (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**") subject to Grantee's continued employment with the Company through each such Vesting Date; However, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest in accordance with Sections 12 and 13 of the Plan.

D. Forfeiture. Except as set forth in Sections 12 and 13 of the Plan, upon the Last Day, but prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I(C) hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I(C) hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or

Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed

to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II.C shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units without payment.. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares

of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes the Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. **Injunctive Relief; Invalidity of Any Provision.** Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents

necessary to evidence such amendment.

I. Notice of Agreement. Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "**Competitor**" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, state Medicaid agencies, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Grantee or indirectly through another individual.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary,

Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

HUMANA INC.

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARKANSAS

1. Humana Regional Health Plan, Inc.

CALIFORNIA

1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.

DELAWARE

1. Atlantis Physician Group, LLC
2. CDO 1, LLC
3. CDO 2, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. Conviva Care Solutions, LLC
7. Conviva Care Solutions II, LLC
8. Conviva Group Holdings, LLC
9. Conviva Health Management, LLC
10.. Conviva Health MSO of Texas, Inc.
11. Conviva Medical Center Management, LLC
12. Eagle NY Rx, LLC
13. Eagle Rx Holdco, Inc.
14. Eagle Rx, Inc.
15. Edge Health MSO, Inc.
16. Emphesys, Inc.
17. Enclara Pharmacia, Inc.
18. FPG Acquisition Corp.
19. FPG Acquisition Holdings Corp.
20. FPG Holding Company, LLC
21. Go365, LLC
22. Health Value Management, Inc.
23. HUM Provider Holdings, LLC
24. Humana at Home, Inc.
25. Humana Digital Health and Analytics Platform Services, Inc.
26. Humana Direct Contracting Entity, Inc.
27. Humana Government Business, Inc.
28. Humana Inc.
29. Humana Innovation Enterprises, Inc.
30. Humana Pharmacy, Inc.
31. Humana WellWorks LLC
32. HumanaDental, Inc.
33. North Region Providers, LLC
34. PBM Holding Company
35. PBM Plus Mail Service Pharmacy, LLC
36. Primary Care Holdings II, LLC
37. Primary Care Management, Inc.
38. Transcend Population Health Management II, LLC

FLORIDA

1. 154th Street Medical Plaza, Inc.
2. 54th Street Medical Plaza, Inc.
3. CAC Medical Center Holdings, Inc.
4. CAC-Florida Medical Centers, LLC
5. Care Partners Home Care, LLC
6. CarePlus Health Plans, Inc.
7. CompBenefits Company
8. Complex Clinical Management, Inc.
9. Continucare Corporation
10. Conviva Specialty, LLC
11. Family Physicians of Winter Park, Inc.
12. FPG Senior Services, LLC
13. HUM-e-FL, Inc.
14. Humana At Home 1, Inc.
15. Humana Dental Company
16. Humana Health Insurance Company of Florida, Inc.
17. Humana Medical Plan, Inc.
18. METCARE of Florida, Inc.
19. Metropolitan Health Networks, Inc.
20. Naples Health Care Specialists, LLC
21. Nursing Solutions, LLC
22. RMA Island Doctors Orlando MSO, LLC
23. RMA Medical Center of Orlando, LLC
24. RMA Medical Center of South Orlando, LLC
25. SeniorBridge Family Companies (FL), Inc.
26. SeniorBridge-Florida, LLC

GEORGIA

1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS

1. CompBenefits Dental, Inc.
2. Dental Care Plus Management, Corp.
3. Humana Benefit Plan of Illinois, Inc.
4. Humana Healthcare Research, Inc.

INDIANA

1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY

1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. Humana Active Outlook, Inc.
4. Humana Health Plan, Inc.

5 Humana Insurance Company of Kentucky

6. Humana MarketPOINT, Inc.
7. Humana Pharmacy Solutions, Inc.

8. Humana Real Estate Company
9. Humco, Inc.
10. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

NEW YORK
1. Alexander Infusion, LLC
2. Harris, Rothenberg International Inc.
3. Humana Health Company of New York, Inc.
4. Humana Insurance Company of New York
5. SeniorBridge Family Companies (NY), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

South Carolina
1. Humana Benefit Plan of South Carolina, Inc.

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Benefit Plan of Texas, Inc.
9. Humana Health Plan of Texas, Inc.
10. Medical Care Consortium Incorporated of Texas
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH

1. Humana Medical Plan of Utah, Inc.

VERMONT

1. Managed Care Indemnity, Inc.

WASHINGTON

1. Arcadian Health Plan, Inc.

WISCONSIN

1. CareNetwork, Inc.
2. GuidantRx, Inc.
3. Humana Insurance Company
4. Humana Wisconsin Health Organization Insurance Corporation
5. HumanaDental Insurance Company
6. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and S-3 (No. 333-223554) of Humana Inc. of our report dated February 18, 2021 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 18, 2021

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual 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 report;

3. Based on my knowledge, the financial statements, and other financial information included in this 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 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 an 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: February 18, 2021

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual 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 report;

3. Based on my knowledge, the financial statements, and other financial information included in this 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 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 an 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: February 18, 2021

Signature: /s/ BRIAN A. KANE

Brian A. Kane
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 Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2020 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) or 15(d) of the Securities Exchange Act of 1934; and

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

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 18, 2021

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 18, 2021

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.