Table of Contents

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, 2011

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 of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(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	Name of exchange on which registered
Common stock, $0.16 2/3 par value	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 and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). Yes ☑ No ☐

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

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

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

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, 2011 was $13,491,060,746 calculated using the average price on such date of $81.39.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2012 was 164,050,846.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held April 26, 2012.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2011

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 care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. As of December 31, 2011, we had approximately 11.2 million members in our medical benefit plans, as well as approximately 7.3 million members in our specialty products. During 2011, 76% of our premiums and services revenue were derived from contracts with the federal government, including 16% related to our Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, and 10% related to our military services contracts. Under our Medicare Advantage CMS contracts in Florida, we provide health insurance coverage to approximately 381,300 members as of December 31, 2011.

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 2011 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2011 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Health Insurance Reform

In March 2010, the President signed into law 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 Insurance Reform Legislation) which enact significant reforms to various aspects of the U.S. health insurance industry. There are many significant provisions of the legislation that will require additional guidance and clarification in the form of regulations and interpretations in order to fully understand the impacts of the legislation on our overall business, which we expect to occur over the next several years.

Certain significant provisions of the Health Insurance Reform Legislation include, among others, mandated coverage requirements, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare

Advantage premiums, the establishment of state-based exchanges coupled with programs designed to spread risk among insurers, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. Implementation dates of the Health Insurance Reform Legislation vary from September 30, 2010 to as late as 2018. The Health Insurance Reform Legislation is discussed more fully in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Insurance Reform."

2011 Business Segment Realignment

During the first quarter of 2011, we realigned our business segments to reflect our evolving business model. As a result, we reassessed and changed our operating and reportable segments in the first quarter of 2011 to reflect management's view of the business and to align our external financial reporting with our new operating and internal financial reporting model. Historical segment information has been retrospectively adjusted to reflect the effect of this change. Our new reportable segments and the basis for determining those segments are discussed below.

Business Segments

We currently manage our business with three reportable segments: Retail, Employer Group, and Health and Well-Being Services. In addition, we include businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles in an Other Businesses category. These 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 to assess performance and allocate resources.

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, as well as administrative services only products marketed to employer groups. The Health and Well-Being Services segment includes services offered to our health plan members as well as to third parties that promote health and wellness, including primary care, pharmacy, integrated wellness, and home care services. The Other Businesses category consists of our Military services, primarily our TRICARE South Region contract, Medicaid, and closed-block long-term care businesses as well as our contract with CMS to administer the Limited Income Newly Eligible Transition program, or the LI-NET program.

The results of each segment are measured by income before income taxes. Transactions between reportable segments consist of sales of services rendered by our Health and Well-Being Services segment, primarily pharmacy and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize 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 the corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations.

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, generally require a referral from the member's primary care physician before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. 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, primary care, integrated wellness, and home care services. 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, 2011:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 18,100	49.6 %
Individual Medicare stand-alone PDP	2,317	6.4 %
Total individual Medicare	20,417	56.0 %
Individual commercial	861	2.4 %
Individual specialty	124	0.3 %
Total premiums	21,402	58.7 %
Services	16	0.0 %
Total premiums and services revenue	$ 21,418	58.7 %

Individual Medicare

We have participated in the Medicare program for private health plans for over 25 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 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 original Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as original Medicare. As an alternative to original Medicare, 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 original Medicare. Our Medicare Advantage 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, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, 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 original Medicare, 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, disease 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 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, 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 most 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.

Our Medicare PFFS plans generally 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 original Medicare payment rates. On January 1, 2011, most of our members enrolled in PFFS plans transitioned to networked-based PPO type products 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.

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 and Improvement 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.

At December 31, 2011, we provided health insurance coverage under CMS contracts to approximately 1,640,300 individual Medicare Advantage members. Under our individual Medicare Advantage contracts with CMS in Florida, we provided health insurance coverage to approximately 362,100 members. These Florida

contracts accounted for premiums revenue of approximately $5.6 billion, which represented approximately 31% of our individual Medicare Advantage premiums revenue, or 15% of our consolidated premiums and services revenue for the year ended December 31, 2011.

Our HMO, PPO, and PFFS 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 August 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 2012, and all of our product offerings filed with CMS for 2012 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on 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. In October 2010, we announced the lowest premium national stand-alone Medicare Part D prescription drug plan co-branded with Wal-Mart Stores, Inc., the Humana Walmart-Preferred Rx Plan. This plan was first offered for the 2011 plan year. Our revenues from CMS and the beneficiary are determined from our bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." 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 August 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 2012, and all of our product offerings filed with CMS for 2012 have been approved.

Medicare and Medicaid Dual Eligible

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. There were approximately 9 million dual eligible enrollees in 2011. These dual eligibles may enroll in a privately-offered Medicare Advantage product, but may also receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. As of December 31, 2011, we served approximately 242,000 dual eligible members in our Medicare Advantage plans and approximately 482,000 dual eligible members in our stand-alone prescription drug plans.

Individual Commercial Coverage

Our individual health plans, marketed under the HumanaOne ® brand include offerings designed to promote wellness and engage consumers. HumanaOne plans are designed specifically for self-employed entrepreneurs, small-business employees, part-time workers, students, and early retirees and include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices, as well as HumanaVitality ®, our wellness and loyalty rewards program.

Our HumanaOne plans primarily are offered as PPO plans in select markets where we can generally underwrite risk and utilize our existing networks and distribution channels. This individual product includes provisions mandated by law to guarantee renewal of coverage for as long as the individual chooses.

The HumanaOne plans can be further customized with optional benefits such as dental, vision, life, and a broad portfolio of financial protection products.

Our Employer Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Employer Group segment by product for the year ended December 31, 2011:

	Employer Group Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Fully-insured commercial group	$ 4,782	13.1 %
Group Medicare Advantage	3,152	8.6 %
Group Medicare stand-alone PDP	8	0.0 %
Total group Medicare	3,160	8.6 %
Group specialty	935	2.6 %
Total premiums	8,877	24.3 %
Services	356	1.0 %
Total premiums and services revenue	$ 9,233	25.3 %

Employer 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. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include HumanaVitality's wellness offerings.

Our administrative services only, or ASO, products are offered to 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 retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

As with individual commercial policies, employers can customize their offerings with optional benefits such as dental, vision, life, and a broad portfolio of financial protection products.

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 offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

Our Health and Well-Being Services Segment Products

This segment is comprised of stand-alone businesses that promote health and well-being. These services are sold primarily to other Humana businesses, as well as external health plan members and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Health and Well-Being Services segment by line of business for the year ended December 31, 2011:

	Health and Well-Being Services Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 9,886	n/a
Primary care services	185	n/a
Integrated wellness services	175	n/a
Home care services	84	n/a
Total intersegment revenue	$ 10,330	
External services revenue:		
Primary care services	$ 880	2.5 %
Integrated wellness services	12	0.0 %
Pharmacy solutions	11	0.0 %
Total external services revenue	$ 903	2.5 %

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 and generic drugs, specialty drugs and diabetic supplies through RightSourceRx®, as well as research services.

Primary care services

Our subsidiary, Concentra Inc.®, acquired in December 2010, delivers occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities.

In addition to Concentra, our primary care services also include our CAC Medical Centers, or CAC, in South Florida. CAC operates full-service, multi-specialty medical centers staffed by primary care physicians and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

Integrated wellness services

Corphealth, Inc. (d/b/a LifeSynch®), a Humana subsidiary, offers disease management services through an innovative suite of integrated products, integrating behavioral health services with wellness programs, and employee assistance programs and work-life services. LifeSynch's integrated wellness services include Hummingbird Coaching®, a wellness coaching company that offers a comprehensive turn-key coaching program, an enhancement to a medically based coaching protocol and a platform that makes coaching programs more efficient.

HumanaVitality, LLC, a joint venture with Discovery Holdings Ltd., 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. HumanaVitality ® became available to certain of our members in mid-2011. A key element of the program includes a sophisticated health-behavior-change model supported by an actuarially sound incentive program.

Home care services

Humana Cares® provides 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.

Other Businesses

Products and services offered by our Other Businesses are described in the discussion that follows. The following table presents our premiums and services revenue for our Other Businesses for the year ended December 31, 2011:

	Other Businesses Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Military services	$ 3,616	9.9%
Medicaid	919	2.5%
LI-NET	253	0.7%
Closed-block long-term care	39	0.1%
Total premiums	4,827	13.2%
Services	85	0.3%
Total premiums and services revenue	$ 4,912	13.5%

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide health insurance coverage to the dependents of active duty military personnel and to retired military personnel and their dependents. Currently, three health benefit options are available to TRICARE beneficiaries. In addition to a traditional indemnity option, participants may enroll in a HMO-like plan with a point-of-service option or take advantage of reduced copayments by using a network of preferred providers, similar to a PPO.

We have participated in the TRICARE program since 1996 under contracts with the Department of Defense. Our current TRICARE South Region contract, which we were awarded in 2003, covers approximately 3.0 million eligible beneficiaries as of December 31, 2011 in Florida, Georgia, South Carolina, Mississippi, Alabama, Tennessee, Louisiana, Arkansas, Texas, and Oklahoma. The South Region is one of the three regions in the United States as defined by the Department of Defense. Of these eligible beneficiaries, 1.3 million were TRICARE ASO members representing active duty beneficiaries and seniors over the age of 65 for which the Department of Defense retains all of the risk of financing the cost of their health benefit. We have subcontracted with third parties to provide selected administration and specialty services under the contract. The original 5-year South Region contract expired on March 31, 2009 and was extended through March 31, 2012. On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the new TRICARE South Region contract to us, which we expect to take effect on April 1, 2012. The new 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option.

Under the current TRICARE South Region contract, any variance from the negotiated target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to enroll due to the federal government's decision to increase or decrease U.S. military deployments.

The TRICARE South Region contract represents approximately 97% of total military services premiums and services revenue.

Medicaid

Medicaid is a federal program that is state-operated to facilitate the delivery of health care services primarily to low-income residents. Each electing state develops, through a state-specific regulatory agency, a Medicaid managed care initiative that must be approved by CMS. CMS requires that Medicaid managed care plans meet federal standards and cost no more than the amount that would have been spent on a comparable fee-for-service basis. States currently either use a formal proposal process in which they review many bidders before selecting one or award individual contracts to qualified bidders who apply for entry to the program. In either case, the contractual relationship with a state generally is for a one-year period. Under these contracts, we receive a fixed monthly payment from a government agency for which we are required to provide health insurance coverage to enrolled members. Due to the increased emphasis on state health care reform and budgetary constraints, more states are utilizing a managed care product in their Medicaid programs.

Our Medicaid business consists of contracts in Puerto Rico and Florida, with the vast majority in Puerto Rico.

LI-NET

In 2010, we began to administer CMS's LI-NET program. 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 program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Closed Block of Long-Term Care Insurance

We acquired a closed block of approximately 35,000 long-term care policies in connection with our acquisition of KMG America Corporation in 2007. Long-term care policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

Membership

The following table summarizes our total medical membership at December 31, 2011, by market and product:

	Retail Segment			Employer Group Segment					
	(in thousands)								
	Individual Medicare Advantage	Individual Medicare stand-alone PDP	Individual Commercial	Fully-insured commercial Group	Group Medicare Advantage and stand-alone PDP	ASO	Other Businesses	Total	Percent of Total
Florida	362.1	169.9	80.5	149.7	19.2	70.1	0	851.5	7.6%
Texas	118.6	204.1	74.7	266.8	5.1	108.7	0	778.0	7.0%
Kentucky	43.1	46.0	21.4	99.0	29.4	513.1	0	752.0	6.7%
Illinois	64.5	82.7	37.8	170.7	5.6	118.9 (a)	0	480.2	4.3%
Ohio	51.0	83.7	6.3	52.0	122.4	152.8	0	468.2	4.2%
Wisconsin	44.4	48.8	15.4	82.8	12.3	142.9	0	346.6	3.1%
Georgia	53.7	53.4	41.6	82.3	6.6	44.6	0	282.2	2.5%
Missouri/Kansas	69.9	134.0	14.1	43.6	6.0	8.9	0	276.5	2.5%
Tennessee	87.8	70.1	17.5	36.6	2.7	31.8	0	246.5	2.2%
California	17.2	215.9	3.1	0.2	0	0	0	236.4	2.1%
Louisiana	91.3	32.7	14.0	43.6	7.2	24.1	0	212.9	1.9%
Indiana	42.1	67.9	5.9	20.3	3.5	47.9	0	187.6	1.7%
North Carolina	62.1	91.4	6.4	0.2	1.9	0	0	162.0	1.5%
Michigan	35.1	80.9	12.5	15.4	6.2	9.3	0	159.4	1.4%
Virginia	57.8	72.9	3.7	0	2.5	0	0	136.9	1.2%
Arizona	36.2	39.8	16.3	24.5	3.5	6.7	0	127.0	1.1%
Colorado	21.8	35.4	34.1	19.2	5.1	0.4	0	116.0	1.0%
Military services	0	0	0	0	0	0	1,722.9	1,722.9	15.4%
Military services ASO	0	0	0	0	0	0	1,305.2	1,305.2	11.7%
Medicaid and other	0	0	0	0	0	0	614.2	614.2	5.5%
LI-NET	0	0	0	0	0	0	73.5	73.5	0.7%
Others	381.6	1,010.8	87.9	73.3	55.6	39.7	0	1,648.9	14.7%
Totals	1,640.3	2,540.4	493.2	1,180.2	294.8	1,319.9	3,715.8	11,184.6	100.0%

(a) Includes 27,600 Medicare Advantage ASO members.

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care physicians, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include 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 and enrolling members into various disease management programs. The focal point for health care services in many of our HMO networks is the primary care physician 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. Our hospitalist programs use specially-trained physicians to effectively manage the entire range of an HMO member's medical care during a hospital admission and to effectively coordinate the member's discharge and post-discharge care. We have available a variety of disease management programs related to specific medical conditions such as congestive heart failure, coronary artery disease, 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 or 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 or other nationally recognized inflation indexes. 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 Budget Control Act of 2011 established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. At this time it is unclear how this automatic reduction may be applied to various Medicare healthcare programs or the timing when such reductions may begin. We expect that if such reductions were to occur, there would be a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the timing or application of any such reductions, there can be no assurances that we could completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.

Capitation

For approximately 1.0% of our medical membership, including 3.3% of our total Medicare Advantage membership, at December 31, 2011, we contract with hospitals and physicians to accept financial risk for a defined set of HMO membership. In transferring this risk, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to coordinate substantially all of the medical care for their capitated HMO membership, including some health benefit administrative functions and claims processing. For these capitated HMO arrangements, we generally agree to reimbursement rates that target a benefit ratio. The benefit ratio measures underwriting profitability and is computed by taking total benefit expenses as a percentage of premiums revenue. Providers participating in hospital-based capitated HMO arrangements generally receive a monthly payment for all of the services within their system for their HMO membership. Providers participating in physician-based capitated HMO arrangements generally have subcontracted directly with hospitals and specialist physicians, and are responsible for reimbursing such hospitals and specialist physicians for services rendered to their HMO membership.

For approximately 8.6% of our medical membership, including 19.0% of our total Medicare Advantage membership, at December 31, 2011, we contract with physicians under risk-sharing arrangements whereby

physicians have assumed some level of risk for all or a portion of the medical costs of their HMO membership. Although these arrangements do include physician capitation payments for services rendered, we share hospital and other benefit expenses and process substantially all of the claims under these arrangements.

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 monitor the financial performance and solvency of our capitated providers. However, we remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Medical membership under these various arrangements was as follows at December 31, 2011 and 2010:

	Medical Membership			
	December 31, 2011		December 31, 2010	
Capitated HMO hospital system based	34,400	0.3%	34,800	0.3%
Capitated HMO physician group based	75,100	0.7%	52,500	0.5%
Risk-sharing	963,600	8.6%	910,700	8.9%
Other	10,111,500	90.4%	9,288,600	90.3%
Total	11,184,600	100.0%	10,286,600	100.0%

Capitation expense as a percentage of total benefit expense was as follows for the years ended December 31, 2011, 2010, and 2009:

	2011		2010		2009	
	(dollars in millions)					
Benefit Expenses:						
Capitated HMO expense	$ 505	1.8%	$ 436	1.6%	$ 459	1.9%
Other benefit expense	28,318	98.2%	26,681	98.4%	24,325	98.1%
Consolidated benefit expense	$28,823	100.0%	$ 27,117	100.0%	$ 24,784	100.0%

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 Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Physicians 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 on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating physicians 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 physicians, reviews the applications of physicians being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and the Utilization Review Accreditation Commission, or URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Certain commercial businesses, like 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 performs reviews of our compliance with standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in all of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, except Puerto Rico, and for many of our PPO markets.

Sales and Marketing

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

At December 31, 2011, we employed approximately 2,000 sales representatives, as well as approximately 900 telemarketing representatives who assisted in the marketing of Medicare products in our Retail segment by making appointments for sales representatives with prospective members. We also market our Medicare products via a strategic alliance with Wal-Mart Stores, Inc., or Wal-Mart. This alliance includes stationing Humana representatives in certain Wal-Mart stores, SAM'S CLUB locations, and Neighborhood Markets across the country providing an opportunity to enroll Medicare eligible individuals in person. In addition, we market our Medicare products through licensed independent brokers and agents including strategic alliances with State Farm ® and United Services Automobile Association, or USAA. Commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure approved by CMS. For our Retail segment, we also offer commercial health insurance and specialty products directly to individuals.

In our Employer Group 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 also sell group Medicare Advantage products through large employers.

For both our Retail and Employer Group segments, at December 31, 2011, we used licensed independent brokers and agents and approximately 1,100 licensed employees to sell our commercial insurance products. Many of our employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care 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.

Underwriting

Through the use of internally developed underwriting criteria, we determine the risk we are willing to assume and the amount of premium to charge for our commercial products. In most instances, employer and other groups must meet our underwriting standards in order to qualify to contract with us for coverage. Small group laws in some states have imposed regulations which provide for guaranteed issue of certain health insurance products and prescribe certain limitations on the variation in rates charged based upon assessment of health conditions. Beginning in 2014, the Health Insurance Reform Legislation requires all individual and group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments.

Underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior 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, including HMOs and PPOs owned by Blue Cross/Blue Shield plans. Many of our competitors have larger memberships 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 the section entitled "Risk Factors" in this 2011 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.

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 the section entitled "Risk Factors" in this 2011 Form 10-K.

Other

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, 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, and customer service.

Employees

As of December 31, 2011, we had approximately 40,000 employees, including approximately 2,050 medical professionals working under management agreements between Concentra and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

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, or if our estimates of benefit expenses are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefit 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, however involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in payment patterns and medical cost trends.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our 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. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to 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, including prescription drugs;
- increased cost of such services;
- 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 pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- the introduction of new or costly treatments, including new technologies;
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from CMS Medicare Advantage and Medicare Part D risk adjustment regulatory changes or Health Insurance Reform Legislation.

In addition, we also estimate costs associated with long-duration insurance policies including life insurance, annuities, health, and long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. These future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, withdrawal and maintenance expense assumptions from published actuarial tables, as modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time

each contract is acquired and would only change if our expected future experience deteriorated to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits. Future policy benefits payable include $938 million at December 31, 2011 associated with a closed block of long-term care policies acquired in connection with the November 30, 2007 KMG America Corporation acquisition. Long-term care policies provide for long-duration coverage and, therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual morbidity and mortality rates from those assumed in our reserves are particularly significant to our closed block of long-term care policies. We monitor the loss experience of these long-term care policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from our acquisition date assumptions, additional future adjustments to reserves could be required. During the fourth quarter of 2010, certain states approved premium rate increases for a large portion of our long-term care block that were significantly below our acquisition date assumptions. Based on these actions by the states, combined with lower interest rates and higher actual expenses as compared to acquisition date assumptions, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our long-term care policies were not adequate to provide for future policy benefits under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during the fourth quarter of 2010 we recorded $139 million of additional benefit expense, with a corresponding increase in future policy benefits payable of $170 million partially offset by a related reinsurance recoverable of $31 million included in other long-term assets.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable 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. 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. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

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 accounts with favorable medical cost experience while retaining or increasing membership in accounts 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, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in Medicare products.

Our future performance depends in large part upon our management team’s ability to execute our strategy to position us for the future. This strategy includes opportunities created by the expansion of our Medicare

programs, including our HMO and PPO products, as well as our stand-alone PDP products. We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. Over the last few years we have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We are offering both the stand-alone Medicare prescription drug coverage and Medicare Advantage health plan with prescription drug coverage in addition to our other product offerings. We offer the Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia.

The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 65% of our total premiums and services revenue in 2011 generated from our Medicare products. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

Recently enacted Health Insurance Reform Legislation created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, such as ASO and individual products, introduction of new products and benefit designs, including HumanaVitality and other wellness products, expansion of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts, including the 2010 acquisition of Concentra Inc.

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

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, to protect our proprietary rights to our systems, or to defend against cybersecurity attacks, 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. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We took steps to reduce the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. 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 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, 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.

Our business plans also include becoming a quality e-business organization by enhancing interactions with customers, brokers, agents, providers and other stakeholders through web-enabled technology. Our strategy includes sales and distribution of health benefit products through the Internet, and implementation of advanced self-service capabilities, for internal and external stakeholders.

A cybersecurity attack that bypasses our information technology, or IT, security systems causing a security breach may lead to a material disruption of our information technology business systems and/or the loss of business information. If a cybersecurity attack were to be successful, we could be adversely affected 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 customers, brokers, agents, providers, and other stakeholders.

There can be no assurance that our IT process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

Our business may be materially adversely impacted by CMS's adoption of the new coding set for diagnoses.

CMS has adopted a new coding set for diagnoses, commonly known as ICD-10, which significantly expands the number of codes utilized. We may be required to incur significant expenses in implementing the new coding set. If we do not adequately implement the new coding set, our results of operations, financial position and cash flows may be materially adversely affected.

We are involved in various legal actions and governmental and internal investigations, including, without limitation, an ongoing internal investigation and litigation and government requests for information related to certain aspects of our Florida subsidiary operations, any of which, if resolved unfavorably to us, could result in substantial monetary damages. 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 employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, securities laws 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 based on our medical necessity decisions or brought against us on the theory that we are liable for 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 and 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;
- 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 mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public, including urgent care.

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 adversely affect our ability to market our products or services, may require us to change our products or services, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits 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 78% of our total premiums and services revenue for the year ended December 31, 2011. These programs involve various risks, as described further below.

- At December 31, 2011, under our contracts with CMS we provided health insurance coverage to approximately 381,300 Medicare Advantage members in Florida. These contracts accounted for approximately 16% of our total premiums and services revenues for the year ended December 31, 2011. The loss of these and other CMS contracts 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 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, 2011, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3.0 million beneficiaries. For the year ended December 31, 2011, premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 9.8% of our total premiums and services revenue. The original 5-year South Region contract expired on March 31, 2009 and was extended through March 31, 2012. On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the new TRICARE South Region contract to us, which we expect to take effect on April 1, 2012. The new 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. We expect to account for revenues under the new TRICARE South contract net of estimated health care costs similar to an administrative services fee only agreement. As such, we expect a decline in TRICARE revenues for 2012 and an increase in our operating cost ratio as compared to 2011. Under the current TRICARE South Region contract, any variance from the negotiated target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to enroll due to the federal government's decision to increase or decrease U.S. military deployments. The loss of the TRICARE South Region contract or, in the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2011, under our contracts with the Puerto Rico Health Insurance Administration, or PRHIA, we provided health insurance coverage to approximately 529,300 Medicaid members in Puerto Rico. These contracts accounted for approximately 2% of our total premiums and services revenue for the year ended December 31, 2011.

  Effective October 1, 2010, the PRHIA awarded us three contracts for the East, Southeast, and Southwest regions for a one year term with two options to extend the contracts for an additional term of up to one year, exercisable at the sole discretion of the PRHIA. The loss of these contracts or significant changes in the Puerto Rico Medicaid program as a result of legislative action, including reductions in premium payments to us, or increases in member benefits without corresponding increases in premium payments to us may have a material adverse effect on our 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 apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process that bases our prospective payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original Medicare program. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. We generally rely on providers 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 continuing to perform audits of various companies' selected Medicare Advantage contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical record documentation in an attempt to validate provider coding practices and the presence of risk adjustment conditions which influence the calculation of premium payments to Medicare Advantage plans. To date, six Humana contracts have been selected by CMS for RADV audits for the 2007 contract year, consisting of one "pilot" audit and five "targeted" audits for Humana plans.

  On December 21, 2010, CMS posted a description of the agency's proposed RADV sampling and payment adjustment calculation methodology to its website, and invited public comment, noting that CMS may revise its sampling and payment error calculation methodology based upon the comments received. We believe the audit and payment adjustment methodology proposed by CMS is fundamentally flawed and actuarially unsound. In essence, in making the comparison referred to above, CMS relies on two interdependent sets of data to set payment rates for Medicare Advantage (MA) plans: (1) fee for service (FFS) data from the government's original Medicare program; and (2) MA data. The proposed methodology would review medical records for only one set of data (MA data), while not performing the same exercise on the other set (FFS data). However, because these two sets of data are inextricably linked, we believe CMS must audit and validate both of them before extrapolating any potential RADV audit results, in order to ensure that any resulting payment adjustment is accurate. We believe that the Social Security Act, under which the payment model was established, requires the consistent use of these data sets in determining risk-adjusted payments to MA plans. Furthermore, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums.

  CMS has received public comments, including our comments and comments from other industry participants and the American Academy of Actuaries, which expressed concerns about the failure to appropriately compare the two sets of data. On February 3, 2011, CMS issued a statement that it was closely evaluating the comments it has received on this matter and anticipates making changes to the proposed methodology based on input it has received, although we are unable to predict the extent of changes that they may make.

  We believe that the proposed methodology is actuarially unsound and in violation of the Social Security Act. We intend to defend that position vigorously. However, if CMS moves forward with implementation of the proposed methodology without changes to adequately address the data

inconsistency issues described above, it would have a material adverse effect on our revenues derived from the Medicare Advantage program and, therefore, our results of operations, financial position, and 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 payable of $329 million at December 31, 2011.

  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 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 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.

- The Budget Control Act of 2011, enacted on August 2, 2011, increased the United States debt ceiling conditioned on deficit reductions to be achieved over the next ten years. The Budget Control Act of 2011 also established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. At this time it is unclear how this automatic reduction may be applied to various Medicare healthcare programs or the timing when such reductions may begin. We expect that if such reductions were to occur, there would be a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the timing or application of any such reductions, there can be no assurances that we could completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.

- With the assistance of outside counsel, we are conducting an ongoing internal investigation related to certain aspects of our Florida subsidiary operations, and have voluntarily self-reported the existence of

this investigation to CMS, the U.S. Department of Justice and the Florida Agency for Health Care Administration. Matters under review include, without limitation, the relationships between certain of our Florida-based employees and providers in our Medicaid and/or Medicare networks, practices related to the financial support of non-profit or provider access centers for Medicaid enrollment and related enrollment processes, and loans to or other financial support of physician practices. We have reported to the regulatory authorities noted above on the progress of our investigation to date, and intend to continue to discuss with these authorities our factual findings as well as any remedial actions we may take. We may also face litigation or further government inquiry regarding certain aspects of the Medicare and Medicaid operations of certain of our Florida subsidiaries.

- 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 are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, 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, including the matters described above, 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 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.

Recently enacted health insurance reform, including The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, could 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 (and particularly how the ratio may apply to Medicare plans), lowering our Medicare payment rates and increasing our expenses associated with a non-deductible federal premium tax and other assessments; financial position, including our ability to maintain the value of our goodwill; and cash flows. In addition, if the new non-deductible federal premium tax and other assessments, including a three-year commercial reinsurance fee, were imposed as enacted, and if we are unable to adjust our business model to address these new taxes and assessments, such as through the reduction of our operating costs, there can be no assurance that the non-deductible federal premium tax and other assessments would not have a material adverse effect on our results of operations, financial position, and cash flows.

In March 2010, the President signed into law 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 Insurance Reform Legislation) which enact significant reforms to various aspects of the U.S. health insurance industry. While regulations and interpretive guidance on some provisions of the Health Insurance Reform Legislation have been issued to date by the Department of Health and Human Services (HHS), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners, there are many significant provisions of the legislation that will require additional guidance and clarification in the form of regulations and interpretations in order to fully understand the impacts of the legislation on our overall business, which we expect to occur over the next several years.

The provisions of the Health Insurance Reform Legislation include, among others, imposing significant new non-deductible federal premium taxes and other assessments on health insurers, limiting Medicare Advantage

payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products (and particularly how the ratio may apply to Medicare Advantage and possibly prescription drug plans), additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Insurance Reform Legislation also specifies required benefit designs, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers, and expands eligibility for Medicaid programs. In addition, the law will significantly increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health insurers, health plans and individuals beginning in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. Implementation dates of the provisions of the Health Insurance Reform Legislation generally vary from September 23, 2010 to as late as 2018.

Implementing regulations and related interpretive guidance continue to be issued on several significant provisions of the Health Insurance Reform Legislation. The implementation of the individual mandate as well as Medicaid expansion in the Health Insurance Reform Legislation are also being considered by the U.S. Supreme Court, seeking to have all or portions of the Health Insurance Reform Legislation declared unconstitutional. We cannot predict the results of these proceedings. Congress may also withhold the funding necessary to implement the Health Insurance Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether. Given the breadth of possible changes and the uncertainties of interpretation, implementation, and timing of these changes, which we expect to occur over the next several years, the Health Insurance Reform Legislation could change the way we do business, potentially impacting our pricing, benefit design, product mix, geographic mix, and distribution channels. In particular, implementing regulations and related guidance are forthcoming on various aspects of the minimum benefit ratio requirement's applicability to Medicare, including aggregation, credibility thresholds, and its possible application to prescription drug plans. The response of other companies to Health Insurance Reform Legislation and adjustments to their offerings, if any, could cause meaningful disruption in the local health care markets. Further, various health insurance reform proposals are also emerging at the state level. It is reasonably possible that the Health Insurance Reform Legislation and related regulations, as well as future legislative changes, 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, lowering our Medicare payment rates and increasing our expenses associated with the non-deductible federal premium tax and other assessments; our financial position, including our ability to maintain the value of our goodwill; and our cash flows. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Insurance Reform Legislation, our business may be materially adversely affected. In addition, if the new non-deductible federal premium tax and other assessments, including a three-year commercial reinsurance fee, were imposed as enacted, and if we are unable to adjust our business model to address these new taxes and assessments, such as through the reduction of our operating costs, there can be no assurance that the non-deductible federal premium tax and other assessments would not have a material adverse effect on our results of operations, financial position, and cash flows.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

The health care industry in general and health insurance are subject to substantial federal and state government regulation:

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 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. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA 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).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act mandates individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, and grants enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. On October 30, 2009, HHS issued an Interim Final Rule implementing amendments to the enforcement regulations under HIPAA. On July 14, 2010, HHS issued a Proposed Rule containing modifications to privacy standards, security standards, and enforcement actions. In addition, HHS is currently in the process of finalizing regulations addressing security breach notification requirements. HHS initially released an Interim Final Rule for breach notification requirements on August 24, 2009. HHS then drafted a Final Rule which was submitted to Office of Management and Budget but subsequently withdrawn by HHS on July 29, 2010. Currently, the Interim Final Rule remains in effect but the withdrawal suggests that when HHS issues the Final Rule, the requirements for how covered entities should respond in the event of a potential security breach involving protected health information are likely to be more onerous than those contained in the Interim Final Rule.

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. An investigation or initiation of civil or criminal actions could have a material adverse effect on our business reputation.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to the U.S. Department of Health and Human Services 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. ARRA also requires business associates to

comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires the U.S. Department of Health and Human Services to issue regulations implementing its privacy and security enhancements.

Workers' Compensation Laws and Regulations

In performing services for the workers' compensation industry through our subsidiary Concentra Inc., we must comply with applicable state workers' compensation laws. Workers' compensation laws generally require employers to assume financial responsibility for medical costs, lost wages, and related legal costs of work-related illnesses and injuries. These laws generally establish the rights of workers to receive benefits and to appeal benefit denials, prohibit charging medical co-payments or deductibles to employees, may restrict employers' rights to select healthcare providers or direct an injured employee to a specific provider to receive non-emergency workers' compensation medical care, and may include special requirements for physicians providing non-emergency care for workers' compensation patients, including requiring registration with the state agency governing workers' compensation, as well as special continuing education and training, licensing and other regulatory requirements. To the extent that we are governed by these regulations, we may be subject to additional licensing requirements, financial oversight, and procedural standards for beneficiaries 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 subsidiary Concentra Inc. 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 Concentra and its 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, including arrangements with Concentra's affiliated professional groups, 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

A federal law commonly referred to as 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 Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by

expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

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.

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.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment, including those governing the management and disposal of infectious medical waste and other waste generated at our subsidiary Concentra's occupational healthcare centers and the cleanup of contamination. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could 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: 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 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.

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, 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.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $4.7 billion and $4.3 billion as of December 31, 2011 and 2010, respectively, which exceeded aggregate minimum regulatory requirements. The amount of dividends that may be paid to our parent company in 2012 without prior approval by state regulatory authorities is approximately $970 million in the aggregate. This compares to dividends that were able to be paid in 2011 without prior regulatory approval of approximately $740 million.

Any failure to manage operating costs could hamper profitability.

The level of our operating costs impacts our profitability. While we proactively attempt to effectively manage such expenses, increases or decreases in staff-related expenses, additional investment in new products (including our opportunities in the Medicare programs), greater emphasis on small group and individual health insurance products, investments in health and well-being product offerings, expansion into new specialty markets, acquisitions, new taxes and assessments, including the new non-deductible federal premium tax and other assessments under Health Insurance Reform Legislation, such as the three-year commercial reinsurance fee, and implementation of regulatory requirements may occur from time to time.

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

Any failure by us to manage acquisitions 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, 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 this 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, or if multiple transactions are pursued simultaneously. In 2011, we acquired MD Care, Inc. and Anvita, Inc., and in 2010, we acquired Concentra Inc. 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 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. We may also be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position, and cash flows.

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

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

In any particular market, providers could refuse to contract with us, demand to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician 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 favorable contracts or place us at a competitive disadvantage, 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 physicians for an actuarially determined, fixed, per-member-per-month fee under which physicians are paid an amount to provide all required medical services to our members. 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.

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

Our pharmacy business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, and Internet companies as well as 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. In addition, some states have proposed laws to regulate online pharmacies, and we may be subject to this legislation if it is passed. Federal agencies further regulate our pharmacy operations. Pharmacies must register 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 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, 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 our pharmacy subsidiary 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. Recent events have raised

uncertainties as to 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 mail-order 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.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from our subsidiaries is restricted.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. These subsidiaries generally are regulated by states' Departments of Insurance. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium generated. A significant increase in premium volume will require additional capitalization from our parent company. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts, or, in some states, any amount. In addition, we normally notify the state Departments of Insurance prior to making payments that do not require approval. 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. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. Our 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded) and contain a change of control provision that may require us to purchase the notes under certain circumstances. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

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. In addition, rating agencies have come under recent regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain 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.

Changes in economic conditions may adversely affect our results of operations, financial position, and cash flows.

The U.S. economy continues to experience a period of slow economic growth and high unemployment. We have closely monitored the impact that this volatile economy is having on our operations. Workforce reductions have caused corresponding membership losses in our fully-insured commercial group business. Continued weakness in the U.S. economy, and any continued high unemployment, may materially adversely affect our medical membership, results of operations, financial position, and cash flows.

Additionally, the continued weakness of the U.S. economy has adversely affected the budget of individual states and of the federal government. This could result in attempts to reduce payments in our federal and state government health care coverage programs, including the Medicare, military services, and Medicaid programs, and could result in an increase in taxes and assessments on our activities. Although we could attempt to mitigate or cover our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to mitigate or cover all of such costs which may have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, general inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to us.

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

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 a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and 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 other-than- temporary impairments may be recorded in future periods.

Certain European Union member states have total fiscal obligations greater than their respective gross domestic products. This imbalance has caused investor concern over such countries ability to continue to service their debt and foster economic growth. Currently, the European debt crisis has caused credit spreads to widen and liquidity to tighten in the fixed income debt markets. A weaker European economy may transcend Europe, cause investors to lose confidence in the safety and soundness of European financial institutions and the stability of European member economies, and likewise adversely affect U.S.-based financial institutions, the stability of the global financial markets, and the U.S. economy. We have no direct exposure to sovereign issuances of Spain, Italy, Ireland, Portugal, or Greece.

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, future expansion opportunities, and capital expenditures in the foreseeable future, and to refinance or repay debt. 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, 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.

Given the current economic climate, our stock and the stocks of other companies in the insurance industry may be increasingly subject to stock price and trading volume volatility.

Over the past three years, the stock markets have experienced significant price and trading volume volatility. Company-specific issues and market developments generally in the insurance industry and in the regulatory environment may have contributed to this volatility. Our stock price has fluctuated and may continue to materially fluctuate in response to a number of events and factors, including:

- the enactment of, and the potential for additional, health insurance reform;
- general economic conditions;
- quarterly variations in operating results;
- natural disasters, terrorist attacks and epidemics;
- changes in financial estimates and recommendations by securities analysts;
- operating and stock price performance of other companies that investors may deem comparable;
- press releases or negative publicity relating to our competitors or us or relating to trends in our markets;
- regulatory changes and adverse outcomes from litigation and government or regulatory investigations;
- sales of stock by insiders;
- changes in our credit ratings;
- limitations on premium levels or the ability to raise premiums on existing policies;
- increases in minimum capital, reserves, and other financial strength requirements; and
- limitations on our ability to repurchase our common stock.

These factors could materially reduce our stock price. In addition, broad market and industry fluctuations may adversely affect the trading price of our common stock, regardless of our actual operating performance.

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 this property, our other principal operating facilities are located in Louisville, Kentucky; Green Bay, Wisconsin; Tampa Bay, Florida; Cincinnati, Ohio; and San Juan, Puerto Rico, all of which are used for customer service, enrollment, and claims processing. Our Louisville and Green Bay facilities also house other corporate functions.

We own or lease these principal operating facilities in addition to other administrative market offices and medical centers. The following table lists the location of properties we owned or leased, including our principal operating facilities, at December 31, 2011:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	9	69	2	68	148
Texas	6	38	2	36	82
California	—	21	—	14	35
Georgia	1	16	—	16	33
Colorado	—	17	—	8	25
Michigan	—	22	—	3	25
Ohio	—	8	—	17	25
Arizona	1	14	—	7	22
Illinois	—	14	—	8	22
Kentucky	—	2	9	11	22
Tennessee	—	9	—	11	20
Missouri	—	14	—	5	19
New Jersey	—	16	—	3	19
Pennsylvania	—	13	—	5	18
South Carolina	—	2	8	8	18
Maryland	—	11	—	5	16
Nevada	—	10	—	6	16
Louisiana	—	4	—	11	15
Wisconsin	—	8	1	6	15
North Carolina	—	8	—	6	14
Puerto Rico	—	—	—	14	14
Virginia	—	9	—	5	14
Oklahoma	—	7	—	5	12
Alabama	—	1	—	10	11
Connecticut	—	10	—	—	10
Indiana	—	3	—	7	10
Others	—	47	—	52	99
Total	17	393	22	347	779

Of the medical centers included in the table above, we no longer operate approximately 60 of these facilities but rather lease or sublease them to their provider operators.

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, including employment litigation, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. See “Legal Proceedings and Certain Regulatory Matters” in Note 15 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

a) *Market Information*

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2011 and 2010:

	High	Low
Year Ended December 31, 2011		
First quarter	$69.94	$ 55.04
Second quarter	$82.55	$ 69.35
Third quarter	$ 83.55	$65.65
Fourth quarter	$ 89.83	$ 68.43
Year Ended December 31, 2010		
First quarter	$ 51.94	$ 45.35
Second quarter	$ 49.49	$ 43.56
Third quarter	$ 52.78	$ 44.34
Fourth quarter	$ 60.64	$ 49.29

b) *Holders of our Capital Stock*

As of January 31, 2012, there were approximately 4,100 holders of record of our common stock and approximately 22,600 beneficial holders of our common stock.

c) *Dividends*

In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy. Declaration and payment of future dividends is at the discretion of our Board of Directors, and may be adjusted as business or market conditions change.

The following table provides details of dividends declared in 2011:

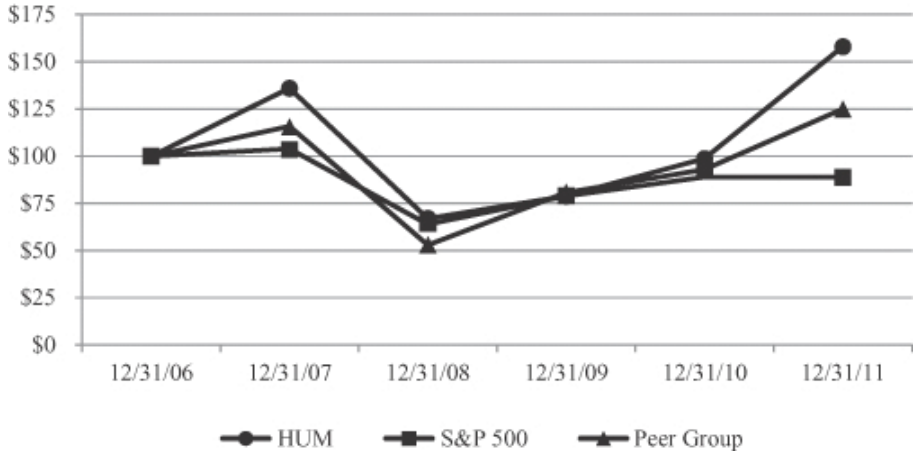
Record Date	Payment Date	Amount per Share	Total Amount (in millions)
6/30/2011	7/28/2011	$ 0.25	$ 41
9/30/2011	10/28/2011	$ 0.25	$ 41
12/30/2011	1/31/2012	$ 0.25	$ 41

d) *Equity Compensation Plan*

The information required by this part of Item 5 is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Equity Compensation Plan Information" of such Proxy Statement.

e) *Stock Performance*

The following graph compares the performance of our common stock to the Standard & Poor's Composite 500 Index ("S&P 500") and the Morgan Stanley Health Care Payer Index ("Peer Group") for the five years ended December 31, 2011. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2006.



	12/31/06	12/31/07	12/31/08	12/31/09	12/31/10	12/31/11
HUM	$ 100	$ 136	$ 67	$ 79	$ 99	$ 158
S&P 500	$ 100	$ 104	$ 64	$ 79	$ 89	$ 89
Peer Group	$ 100	$ 116	$ 53	$ 81	$ 93	$ 125

f) *Issuer Purchases of Equity Securities*

In April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion of our common shares exclusive of shares repurchased in connection with employee stock plans. The new authorization will expire June 30, 2013. Under the new share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market by block purchases, or in privately-negotiated transactions, subject to certain regulatory restrictions on volume, pricing, and timing. During 2011, we repurchased 0.8 million shares in open market transactions for $53 million at an average price of $63.73 under the previously approved share repurchase authorization and we repurchased 5.9 million shares in open market transactions for $439 million at an average price of $74.01 under the new authorization. As of February 6, 2012, the remaining authorized amount under the new authorization totaled $561 million.

In connection with employee stock plans, we acquired 0.8 million common shares for $49 million in 2011.

ITEM 6. SELECTED FINANCIAL DATA

	2011 (a)	2010 (b)	2009	2008 (c)	2007 (d)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 35,106	$ 32,712	$ 29,927	$ 28,065	$ 24,434
Services	1,360	555	520	468	405
Investment income	366	329	296	220	314
Total revenues	36,832	33,596	30,743	28,753	25,153
Operating expenses:					
Benefits	28,823	27,117	24,784	23,730	20,246
Operating costs	5,395	4,380	4,014	3,740	3,372
Depreciation and amortization	270	245	237	210	177
Total operating expenses	34,488	31,742	29,035	27,680	23,795
Income from operations	2,344	1,854	1,708	1,073	1,358
Interest expense	109	105	106	80	69
Income before income taxes	2,235	1,749	1,602	993	1,289
Provision for income taxes	816	650	562	346	455
Net income	$ 1,419	$ 1,099	$ 1,040	$ 647	$ 834
Basic earnings per common share	$ 8.58	$ 6.55	$ 6.21	$ 3.87	$ 5.00
Diluted earnings per common share	$ 8.46	$ 6.47	$ 6.15	$ 3.83	$ 4.91
Dividends declared per common share	$ 0.75	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Financial Position:					
Cash and investments	$ 10,830	$ 10,046	$ 9,111	$ 7,186	$ 6,691
Total assets	17,708	16,103	14,153	13,042	12,879
Benefits payable	3,754	3,469	3,222	3,206	2,697
Debt	1,659	1,669	1,678	1,937	1,688
Stockholders' equity	8,063	6,924	5,776	4,457	4,029
Cash flows from operations	$ 2,079	$ 2,242	$ 1,422	$ 982	$ 1,224
Key Financial Indicators:					
Benefit ratio	82.1%	82.9%	82.8%	84.6%	82.9%
Operating cost ratio	14.8%	13.2%	13.2%	13.1%	13.6%
Membership by Segment:					
Retail segment:					
Medical membership	4,673,900	3,542,200	3,729,400	4,764,900	4,780,200
Specialty membership	782,500	510,000	297,300	324,600	299,400
Employer Group segment:					
Medical membership	2,794,900	3,009,500	3,117,800	3,358,400	3,256,400
Specialty membership	6,532,600	6,517,500	6,761,900	6,244,100	6,305,200
Other Businesses:					
Medical membership	3,715,800	3,734,900	3,486,800	3,488,900	3,470,100
Consolidated:					
Total medical membership	11,184,600	10,286,600	10,334,000	11,612,200	11,506,700
Total specialty membership	7,315,100	7,027,500	7,059,200	6,568,700	6,604,600

(a) Includes the acquired operations of Anvita, Inc. from December 6, 2011 and MD Care, Inc. from December 30, 2011. Also includes the benefit of $205 million ($130 million after tax, or $0.77 per diluted common share) of favorable prior-period medical claims reserve development.

(b) Includes the acquired operations of Concentra Inc. from December 21, 2010. Also includes the benefit of $231 million ($146 million after tax, or $0.86 per diluted common share) of favorable prior-period medical claims reserve development, as well as an expense of $147 million ($93 million after tax, or $0.55 per diluted common share) for the write-down of deferred acquisition costs associated with our individual commercial medical policies and an expense of $139 million ($88 million after tax, or $0.52 per diluted common share) associated with reserve strengthening for our closed block of long-term care policies acquired in connection with the 2007 acquisition of KMG America Corporation.

(c) Includes the acquired operations of UnitedHealth Group's Las Vegas, Nevada individual SecureHorizons Medicare Advantage HMO business from April 30, 2008, the acquired operations of OSF Health Plans, Inc. from May 22, 2008, the acquired operations of Metcare Health Plans, Inc. from August 29, 2008, and the acquired operations of PHP Companies, Inc. (d/b/a Cariten Healthcare) from October 31, 2008.

(d) Includes the acquired operations of DefenseWeb Technologies, Inc. from March 1, 2007, the acquired operations of CompBenefits Corporation from October 1, 2007, and the acquired operations of KMG America Corporation from November 30, 2007. Also includes the benefit of $69 million ($43 million after tax, or $0.25 per diluted share) related to our 2006 Medicare Part D reconciliation with CMS and the settlement of some TRICARE contractual provisions related to prior years.

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

Executive Overview

General

Headquartered in Louisville, Kentucky, Humana is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. By leveraging the strengths of our core businesses, we believe that we can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the nation with whom we have relationships.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefit expenses 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 as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

2011 Business Segment Realignment

During the first quarter of 2011, we realigned our business segments to reflect our evolving business model. As a result, we reassessed and changed our operating and reportable segments in the first quarter of 2011 to reflect management's view of the business and to align our external financial reporting with our new operating and internal financial reporting model. Historical segment information has been retrospectively adjusted to reflect the effect of this change. Our new reportable segments and the basis for determining those segments are discussed below.

Business Segments

We currently manage our business with three reportable segments: Retail, Employer Group, and Health and Well-Being Services. In addition, we include businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles in an Other Businesses category. These 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 to assess performance and allocate resources.

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, as well as administrative services only products marketed to employer groups. The Health and Well-Being Services segment includes services offered to our health plan members as well as to third parties that promote health and wellness, including primary care, pharmacy, integrated wellness, and home care services. The Other Businesses category consists of our Military services, primarily our TRICARE South Region contract, Medicaid, and closed-block long-term care businesses as well as our contract with CMS to administer the LI-NET program.

The results of each segment are measured by income before income taxes. Transactions between reportable segments consist of sales of services rendered by our Health and Well-Being Services segment, primarily pharmacy and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often

utilize 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 the corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations.

Seasonality

Our Retail segment offers Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. These plans provide varying degrees of coverage. 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.

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

2011 Highlights

Consolidated

- Our strategy and commitment to the Medicare programs have led to significant growth as discussed in our Retail segment discussion below.
- As more fully described herein under the section titled "Benefit Expense Recognition" 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. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business. We experienced favorable prior-period medical claims reserve development not in the ordinary course of business, primarily in our Retail and Employer Group segments, of approximately $205 million in the aggregate, or $0.77 per diluted common share, for the year ended December 31, 2011 as compared to $231 million in the aggregate, or $0.86 per diluted common share, for the year ended December 31, 2010. Any discussion of favorable prior-period medical claims reserve development in our results of operation discussion that follows refers to amounts that were not in the ordinary course of business.
- In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy and we subsequently declared cash dividends of $0.25 per share to stockholders of record on each of June 30, 2011, September 30, 2011, and December 30, 2011.
- In addition, in April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion. The new authorization will expire June 30, 2013. As of February 6, 2012, the remaining authorized amount under the new authorization totaled $561 million.
- Comparisons to 2010 are impacted by the $147 million write-down of deferred acquisition costs associated with our individual commercial medical policies during the year ended December 31, 2010

as well as the net charge of $139 million due to reserve strengthening for our closed block of long-term care policies as discussed more fully in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Retail Segment

- On February 17, 2012, CMS issued its Advance Notice for methodological changes for 2013 Medicare Advantage capitation rates and Part C and Part D payment policies. We believe the Advance Notice indicates our payment rates from CMS will remain relatively unchanged from those for 2012, with the exception of the impact of any automatic rate reductions that would occur as a result of the Budget Control Act of 2011. These potential automatic rate reductions were not addressed in the Advance notice, but we believe they would be primarily passed through as provider payment reductions from us. (For additional information, please refer to the risk factor entitled, " *As a government contractor, we are exposed to risks that may materially affect our business or our willingness or ability to participate in government health care programs* .") However, the Advance Notice is subject to comment, and the final rates will not be published until the first Monday in April 2012. Nevertheless, we believe we can effectively design Medicare Advantage products based upon this level of rate increase while continuing to remain competitive compared to both the combination of original Medicare with a supplement policy as well as other Medicare Advantage competitors within our industry. In addition, we will continue to pursue our cost-reduction and outcome-enhancing strategies, including care coordination and disease management, which we believe will mitigate the adverse effects of the rates on our Medicare Advantage members. Nonetheless, there can be no assurance that we will be able to successfully execute operational and strategic initiatives with respect to changes in the Medicare Advantage program. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.
- Individual Medicare Advantage membership of 1,640,300 at December 31, 2011 increased 179,600 members, or 12.3%, from 1,460,700 at December 31, 2010 primarily due to a successful enrollment season associated with the 2011 plan year. January 2012 individual Medicare Advantage membership of approximately 1,813,000 increased nearly 173,000 members, or approximately 11%, from December 31, 2011, reflecting another successful enrollment season.
- Individual Medicare stand-alone PDP membership of 2,540,400 at December 31, 2011 increased 870,100 members, or 52.1%, from 1,670,300 at December 31, 2010 primarily due to sales of our new lowest premium national stand-alone Medicare Part D prescription drug plan co-branded with Wal-Mart Stores, Inc., the Humana Walmart-Preferred Rx Plan, that we began offering for the 2011 plan year. January 2012 individual Medicare stand-alone PDP membership grew to approximately 2,825,000, increasing nearly 285,000 members, or approximately 11%, from December 31, 2011, also reflecting another successful selling season for the co-branded Humana Walmart-Preferred Rx Plan.
- Comparisons to 2010 within the Retail segment are impacted by the $147 million write-down of deferred acquisition costs associated with our individual commercial medical policies during the year ended December 31, 2010 as discussed above.
- On December 6, 2011, we acquired Anvita, Inc., or Anvita, a San Diego-based health care analytics company. The Anvita acquisition provides scalable analytics solutions that produce clinical insights which we believe will enhance our ability to improve the quality and lower the cost of health care for our members and customers.
- Effective December 30, 2011, we acquired the California-based Medicare Advantage HMO MD Care, Inc., or MD Care. This acquisition expanded our Medicare footprint in California and grew our Medicare enrollment by approximately 12,100 members.
- During the second half of 2011, we entered into a definitive agreement to acquire Arcadian Management Services, Inc., which serves Medicare Advantage HMO members in 15 U.S. states,

offering us an opportunity to further expand our Medicare footprint and grow our Medicare enrollment. The closing of this acquisition is subject to regulatory approval.

Health and Well-Being Services Segment

- During the second half of 2011, we entered into a definitive agreement to acquire SeniorBridge, a chronic-care provider providing in-home care for seniors that will expand our existing clinical and home health capabilities and strengthen our offerings for members with complex chronic-care needs. The closing of this acquisition is subject to regulatory approval.
- In 2011, we launched HumanaVitality, a joint venture with Discovery Holdings Ltd., providing 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.

Other Businesses

- Comparisons to 2010 within Other Businesses are impacted by the net charge of $139 million due to reserve strengthening for our closed block of long-term care policies during the year ended December 31, 2010 as discussed above.
- As more fully discussed in Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the new TRICARE South Region contract to us, which we expect to take effect on April 1, 2012. The new 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option.

Health Insurance Reform

In March 2010, the President signed into law 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 Insurance Reform Legislation) which enact significant reforms to various aspects of the U.S. health insurance industry. While regulations and interpretive guidance on some provisions of the Health Insurance Reform Legislation have been issued to date by the Department of Health and Human Services (HHS), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners, there are many significant provisions of the legislation that will require additional guidance and clarification in the form of regulations and interpretations in order to fully understand the impacts of the legislation on our overall business, which we expect to occur over the next several years.

Implementation dates of the Health Insurance Reform Legislation vary from September 23, 2010 to as late as 2018. The following outlines certain provisions of the Health Insurance Reform Legislation:

- Changes effective for plan years which began on or after September 23, 2010 included: elimination of pre-existing condition limits for enrollees under age 19, elimination of certain annual and lifetime caps on the dollar value of benefits, expansion of dependent coverage to include adult children until age 26, a requirement to provide coverage for preventive services without cost to members, new claim appeal requirements, and the establishment of an interim high risk program for those unable to obtain coverage due to a pre-existing condition or health status.
- Effective January 1, 2011, minimum benefit ratios were mandated for all commercial fully-insured medical plans in the large group (85%), small group (80%), and individual (80%) markets, with annual rebates to policyholders if the actual benefit ratios, calculated in a manner prescribed by HHS, do not meet these minimums. Certain states were approved to apply an individual threshold lower than the 80% requirement temporarily to avoid market disruption. In 2011, we accrued for rebates, based on the

manner prescribed by HHS, with initial rebate payments to be made in mid-2012. Our benefit ratios reported herein, calculated from financial statements prepared in accordance with accounting principles generally accepted in the United States of America, or GAAP, differ from the benefit ratios calculated as prescribed by HHS under the Health Insurance Reform Legislation. The more noteworthy differences include the fact that the benefit ratio calculations prescribed by HHS are calculated separately by state and legal entity; reflect actuarial adjustments where the membership levels are not large enough to create credible size; exclude some of our health insurance products; include taxes and fees as reductions of premium; treat changes in reserves differently than GAAP; and classify rebate amounts as additions to incurred claims as opposed to adjustments to premiums for GAAP reporting.

- Medicare Advantage payment benchmarks for 2011 were frozen at 2010 levels and beginning in 2012, additional cuts to Medicare Advantage plan payments will begin to take effect (plans will receive a range of 95% in high-cost areas to 115% in low-cost areas of Medicare fee-for-service rates), with changes being phased-in over two to six years, depending on the level of payment reduction in a county. In addition, beginning in 2011, the gap in coverage for Medicare Part D prescription drug coverage began to incrementally close.
- Beginning in 2014, the Health Insurance Reform Legislation requires: all individual and group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments; the elimination of annual limits on coverage on certain plans; the establishment of state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers; the introduction of standardized plan designs based on set actuarial values; the establishment of a minimum benefit ratio of 85% for Medicare plans; and insurance industry assessments, including an annual premium-based assessment and a three-year commercial reinsurance fee. The annual premium-based assessment levied on the insurance industry is $8 billion in 2014 with increasing annual amounts thereafter and is not deductible for income tax purposes, which will significantly increase our effective income tax rate in 2014. In December 2011, the National Association of Insurance Commissioners, or NAIC, issued proposed guidance indicating the insurance industry premium-based assessment may require accrual and associated subsidiary funding consideration in 2013 instead of 2014. This proposed NAIC guidance is contradictory to final GAAP guidance issued by the Financial Accounting Standards Board, or FASB, in July 2011, which indicates the insurance industry premium-based assessment should be accrued beginning in 2014, the year in which it is payable. Refer to *Recently Issued Accounting Pronouncements* in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The Health Insurance Reform Legislation also specifies required benefit designs, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and expands eligibility for Medicaid programs. In addition, the law will significantly increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health insurers, health plans and individuals beginning in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described herein.

In addition, certain provisions in the Health Insurance Reform Legislation tie Medicare Advantage premiums to the achievement of certain quality performance measures (Star Ratings). Beginning in 2012, Medicare Advantage plans with an overall Star Rating of three or more stars (out of five) will be eligible for a quality bonus in their basic premium rates. Initially quality bonuses were limited to the few plans that achieved four or more stars as an overall rating, but CMS has expanded the quality bonus to three Star plans for a three year period through 2014. Recent Star Ratings issued by CMS indicated that 98% of our Medicare Advantage members are now in plans that will qualify for quality bonus payments in 2013. Notwithstanding successful efforts to improve our Star Ratings and other quality measures for 2012 and 2013 and the continuation of such efforts, there can be no assurances that we will be successful in maintaining or improving our Star Ratings in

future years. 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.

As discussed above, implementing regulations and related interpretive guidance continue to be issued on several significant provisions of the Health Insurance Reform Legislation. The implementation of the individual mandate as well as Medicaid expansion in the Health Insurance Reform Legislation are also being considered by the U.S. Supreme Court, seeking to have all or portions of the Health Insurance Reform Legislation declared unconstitutional. We cannot predict the results of these proceedings. Congress may also withhold the funding necessary to implement the Health Insurance Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether. Given the breadth of possible changes and the uncertainties of interpretation, implementation, and timing of these changes, which we expect to occur over the next several years, the Health Insurance Reform Legislation could change the way we do business, potentially impacting our pricing, benefit design, product mix, geographic mix, and distribution channels. In particular, implementing regulations and related guidance are forthcoming on various aspects of the minimum benefit ratio requirement's applicability to Medicare, including aggregation, credibility thresholds, and its possible application to prescription drug plans. The response of other companies to the Health Insurance Reform Legislation and adjustments to their offerings, if any, could cause meaningful disruption in the local health care markets. Further, various health insurance reform proposals are also emerging at the state level. It is reasonably possible that the Health Insurance Reform Legislation and related regulations, as well as future legislative changes, 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, lowering our Medicare payment rates and increasing our expenses associated with the non-deductible federal premium tax and other assessments; our financial position, including our ability to maintain the value of our goodwill; and our cash flows. If the new non-deductible federal premium tax and other assessments, including a three-year commercial reinsurance fee, were imposed as enacted, and if we are unable to adjust our business model to address these new taxes and assessments, such as through the reduction of our operating costs, there can be no assurance that the non-deductible federal premium tax and other assessments would not have a material adverse effect on our results of operations, financial position, and 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 consist of sales of services rendered by our Health and Well-Being Services segment, primarily pharmacy and behavioral health services, to our Retail and Employer Group customers and are described in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Comparison of Results of Operations for 2011 and 2010

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2011 and 2010:

Consolidated

	2011	2010	Change Dollars	Change Percentage
		(dollars in millions, except per common share results)		
Revenues:				
Premiums:				
Retail	$ 21,402	$19,052	$2,350	12.3%
Employer Group	8,877	9,080	(203)	(2.2)%
Other Businesses	4,827	4,580	247	5.4%
Total premiums	35,106	32,712	2,394	7.3%
Services:				
Retail	16	11	5	45.5%
Employer Group	356	395	(39)	(9.9)%
Health and Well-Being Services	903	34	869	nm
Other Businesses	85	115	(30)	(26.1)%
Total services	1,360	555	805	145.0%
Investment income	366	329	37	11.2%
Total revenues	36,832	33,596	3,236	9.6%
Operating expenses:				
Benefits	28,823	27,117	1,706	6.3%
Operating costs	5,395	4,380	1,015	23.2%
Depreciation and amortization	270	245	25	10.2%
Total operating expenses	34,488	31,742	2,746	8.7%
Income from operations	2,344	1,854	490	26.4%
Interest expense	109	105	4	3.8%
Income before income taxes	2,235	1,749	486	27.8%
Provision for income taxes	816	650	166	25.5%
Net income	$ 1,419	$ 1,099	$ 320	29.1%
Diluted earnings per common share	$ 8.46	$ 6.47	$ 1.99	30.8%
Benefit ratio (a)	82.1%	82.9%		(0.8)%
Operating cost ratio (b)	14.8%	13.2%		1.6%
Effective tax rate	36.5%	37.2%		(0.7)%

(a) Represents total benefit expenses as a percentage of premiums revenue.
(b) Represents total operating costs as a percentage of total revenues less investment income.
nm – not meaningful

Summary

Net income was $1.4 billion, or $8.46 per diluted common share, in 2011 compared to $1.1 billion, or $6.47 per diluted common share, in 2010 primarily due to improved operating performance in the Retail and Health and Well-Being Services segments and the negative impact of certain charges described below on 2010 results that did not recur in 2011. Share repurchase activity also contributed to the year-over-year increase in diluted earnings per common share. Our diluted earnings per common share include the beneficial impact of favorable

prior-period medical claims reserve development of approximately $0.77 per diluted common share for 2011 compared to $0.86 per diluted common share for 2010. Net income for the 2010 period also included the negative impact of a $147 million ($0.55 per diluted common share) write-down of deferred acquisition costs associated with our individual commercial medical policies in our Retail Segment, and a net charge of $139 million ($0.52 per diluted common share) for reserve strengthening associated with our closed block of long-term care policies in our Other Businesses as discussed in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Premiums Revenue

Consolidated premiums increased $2.4 billion, or 7.3%, from 2010 to $35.1 billion for 2011, primarily due to an increase in Retail segment premiums, partially offset by a decline in Employer Group segment premiums. The increase in Retail segment premiums primarily resulted from higher average individual Medicare Advantage membership. The decrease in Employer Group segment premiums primarily resulted from lower average fully-insured commercial group medical membership. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and increases in average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue increased $805 million, or 145.0%, from 2010 to $1.4 billion for 2011, primarily due to an increase in primary care services revenue in our Health and Well-Being Services segment, primarily as a result of the acquisition of Concentra on December 21, 2010.

Investment Income

Investment income totaled $366 million for 2011, an increase of $37 million from 2010, primarily reflecting higher interest rates as well as higher average invested balances as a result of the reinvestment of operating cash flows.

Benefit Expenses

Consolidated benefit expenses were $28.8 billion for 2011, an increase of $1.7 billion, or 6.3%, from 2010. The increases were primarily due to a $1.8 billion, or 11.3%, year-over-year increase in Retail segment benefit expenses in 2011, primarily driven by an increase in the average number of Medicare members, partially offset by a decline in Employer Group segment benefit expenses.

The consolidated benefit ratio for 2011 was 82.1%, declining 80 basis points from the 2010 benefit ratio of 82.9%, primarily driven by a decline in the Retail segment benefit ratio and a net charge for reserve strengthening associated with our closed block of long-term care policies in our Other Businesses in 2010 that did not recur in 2011.

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 $1.0 billion, or 23.2%, during 2011 compared to 2010, primarily due an increase in operating costs in our Health and Well-Being Segment as a result of the acquisition of Concentra on December 21, 2010, as well as an increase in operating costs in our Retail segment as a result of increased expenses associated with servicing higher average Medicare Advantage membership. Operating costs for 2010 include $147 million for the write-down of deferred acquisition costs associated with our individual commercial medical policies in our Retail Segment.

The consolidated operating cost ratio for 2011 was 14.8%, increasing 160 basis points from the 2010 operating cost ratio of 13.2%. The $147 million write-down of deferred acquisition costs in 2010 increased the operating cost ratio 50 basis points for 2010. Excluding the impact of the write-down of deferred acquisition costs in 2010, the increase primarily reflects the greater percentage of our revenues derived from Concentra, acquired December 21, 2010, in our Health and Well-Being Services segment, which carries a higher operating cost ratio on external revenues than our other segments, as well as an increase in the Retail and Employer Group segment operating cost ratios.

Depreciation and Amortization

Depreciation and amortization for 2011 totaled $270 million, an increase of $25 million, or 10.2%, from 2010, primarily reflecting depreciation and amortization expense associated with our Concentra operations, acquired on December 21, 2010.

Interest Expense

Interest expense was $109 million for 2011, compared to $105 million for 2010, an increase of $4 million, or 3.8%.

Income Taxes

Our effective tax rate during 2011 was 36.5% compared to the effective tax rate of 37.2% in 2010. The higher tax rate for 2010 primarily was due to the cumulative adjustment associated with estimating the retrospective aspect of new limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Insurance Reform Legislation. See Note 10 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

	2011	2010	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	1,640,300	1,460,700	179,600	12.3 %
Individual Medicare stand-alone PDP	2,540,400	1,670,300	870,100	52.1 %
Total individual Medicare	4,180,700	3,131,000	1,049,700	33.5 %
Individual commercial	493,200	411,200	82,000	19.9 %
Total individual medical members	4,673,900	3,542,200	1,131,700	31.9 %
Individual specialty membership (a)	782,500	510,000	272,500	53.4 %

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2011	2010	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 18,100	$16,265	$ 1,835	11.3 %
Individual Medicare stand-alone PDP	2,317	1,959	358	18.3 %
Total individual Medicare	20,417	18,224	2,193	12.0 %
Individual commercial	861	746	115	15.4 %
Individual specialty	124	82	42	51.2 %
Total premiums	21,402	19,052	2,350	12.3 %
Services	16	11	5	45.5 %
Total premiums and services revenue	$21,418	$ 19,063	$2,355	12.4 %
Income before income taxes	$ 1,587	$ 1,289	$ 298	23.1 %
Benefit ratio	81.2%	82.0%		(0.8)%
Operating cost ratio	11.2%	11.1%		0.1 %

Pretax Results

- Retail segment pretax income was $1.6 billion in 2011, an increase of $298 million, or 23.1%, from $1.3 billion in 2010, primarily driven by higher average individual Medicare membership and a lower benefit ratio, partially offset by a higher operating cost ratio, discussed below. Pretax income for 2010 included the negative impact of a $147 million write-down of deferred acquisition costs associated with our individual commercial medical policies. In addition, the Retail segment's pretax income for 2011 included the beneficial effect of an estimated $147 million in favorable prior-period medical claims reserve development versus $198 million in 2010.

Enrollment

- Individual Medicare Advantage membership increased 179,600 members, or 12.3%, from December 31, 2010 to December 31, 2011 due to a successful enrollment season associated with the 2011 plan year as well as age-in enrollment throughout the year. Individual Medicare Advantage membership at December 31, 2011 included approximately 12,100 members acquired with our acquisition of MD Care as of December 30, 2011.
- Individual Medicare stand-alone PDP membership increased 870,100 members, or 52.1%, from December 31, 2010 to December 31, 2011 primarily from higher gross sales year-over-year, particularly due to our low-price-point Humana Walmart-Preferred Rx Plan that we began offering for the 2011 plan year, supplemented by dual eligible and age-in enrollments throughout the year.
- Individual specialty membership increased 272,500, or 53.4%, from December 31, 2010 to December 31, 2011 primarily driven by increased sales in dental offerings.

Premiums revenue

- Retail segment premiums increased $2.4 billion, or 12.3%, from 2010 to 2011 primarily due to a 10.3% increase in average individual Medicare Advantage membership. Individual Medicare stand-alone PDP premiums revenue increased $358 million, or 18.3%, in 2011 compared to 2010 primarily due to a 41.9% increase in average individual PDP membership, partially offset by a decrease in individual Medicare stand-alone PDP per member premiums. This was primarily a result of sales of our low-price-point Humana Walmart-Preferred Rx Plan that we began offering for the 2011 plan year.

Benefit expenses

- The Retail segment benefit ratio decreased 80 basis points from 82.0% in 2010 to 81.2% in 2011. The decline primarily reflects a lower Medicare Advantage benefit ratio due to lower cost trends arising out of our cost-reduction and outcome-enhancing strategies, including care coordination and disease management, as well as a significant increase in our individual Medicare stand-alone PDP membership in 2011 that carries a lower benefit ratio, partially offset by lower favorable prior-period medical claims reserve development in 2011 than in 2010. Favorable reserve development decreased the Retail segment benefit ratio by approximately 70 basis points in 2011 versus approximately 100 basis points in 2010.

Operating costs

- The Retail segment operating cost ratio of 11.2% for 2011 increased 10 basis points from 11.1% for 2010. The $147 million write-down of deferred acquisition costs in 2010 increased the operating cost ratio 80 basis points in 2010. Excluding the impact of the write-down of deferred acquisition costs, the increase in the operating cost ratio year-over-year primarily reflects increased expenses associated with the Medicare sales season for 2012 offerings which began a month earlier than in the prior year and staffing necessary to service anticipated Medicare membership additions. Further, a higher percentage of membership in individual Medicare stand-alone PDP products contributed to the higher operating cost ratio, in light of the Humana Walmart-Preferred Rx Plan, first offered in 2011, which carries a higher operating cost ratio than other Medicare products.

Employer Group Segment

			Change	
	2011	2010	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,180,200	1,252,200	(72,000)	(5.7)%
ASO	1,292,300	1,453,600	(161,300)	(11.1)%
Group Medicare Advantage	290,600	273,100	17,500	6.4%
Medicare Advantage ASO	27,600	28,200	(600)	(2.1)%
Total group Medicare Advantage	318,200	301,300	16,900	5.6%
Group Medicare stand-alone PDP	4,200	2,400	1,800	75.0%
Total group Medicare	322,400	303,700	18,700	6.2%
Total group medical members	2,794,900	3,009,500	(214,600)	(7.1)%
Group specialty membership (a)	6,532,600	6,517,500	15,100	0.2%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2011	2010	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$4,782	$5,169	$(387)	(7.5)%
Group Medicare Advantage	3,152	3,021	131	4.3%
Group Medicare stand-alone PDP	8	5	3	60.0%
Total group Medicare	3,160	3,026	134	4.4%
Group specialty	935	885	50	5.6%
Total premiums	8,877	9,080	(203)	(2.2)%
Services	356	395	(39)	(9.9)%
Total premiums and services revenue	$9,233	$9,475	$(242)	(2.6)%
Income before income taxes	$ 242	$ 288	$ (46)	(16.0)%
Benefit ratio	82.4%	82.4%		0.0%
Operating cost ratio	17.8%	17.5%		0.3%

Pretax Results

- Employer Group segment pretax income decreased $46 million, or 16%, to $242 million in 2011 primarily due to the impact of minimum benefit ratios required under the Health Insurance Reform Legislation which became effective in 2011. The Employer Group segment's pretax income for 2011 included the beneficial effect of an estimated $52 million in favorable prior-period medical claims reserve development versus $33 million in 2010.

Enrollment

- Fully-insured commercial group medical membership decreased 72,000 members, or 5.7%, from December 31, 2010 to December 31, 2011 primarily due to continued pricing discipline in a highly competitive environment for large group business partially offset by small group business membership gains.
- Group ASO commercial medical membership decreased 161,300 members, or 11.1%, from December 31, 2010 to December 31, 2011 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.

Premiums revenue

- Employer Group segment premiums decreased by $203 million, or 2.2%, from 2010 to $8.9 billion for 2011 primarily due to lower average commercial group medical membership year-over-year and rebates associated with minimum benefit ratios required under the Health Insurance Reform Legislation which became effective in 2011, partially offset by an increase in group Medicare Advantage membership. Rebates result in the recognition of lower premiums revenue, as amounts are set aside for payments to commercial customers during the following year.

Benefit expenses

- The Employer Group segment benefit ratio of 82.4% for 2011 was unchanged from 2010 due to offsetting factors. Factors increasing the 2011 ratio compared to the 2010 ratio include growth in our group Medicare Advantage products which generally carry a higher benefit ratio than our fully-insured commercial group products and the effect of rebates accrued in 2011 associated with the minimum benefit ratios required under the Health Insurance Reform Legislation. Factors decreasing the 2011

ratio compared to the 2010 ratio include the beneficial effect of higher favorable prior-period medical claims reserve development in 2011 versus 2010 and lower utilization of benefits in our commercial group products in 2011. Fully-insured group Medicare Advantage members represented 10.4% of total Employer Group segment medical membership at December 31, 2011 compared to 9.1% at December 31, 2010. Favorable reserve development decreased the Employer Group segment benefit ratio by approximately 60 basis points in 2011 versus 40 basis points in 2010.

Operating costs

- The Employer Group segment operating cost ratio of 17.8% for 2011 increased 30 basis points from 17.5% for 2010 primarily reflecting the impact of lower premiums revenue due to the minimum benefit ratio regulatory requirements which became effective in 2011.

Health and Well-Being Services Segment

	2011	2010	Change Dollars	Change Percentage
		(in millions)		
Revenues:				
Services:				
Primary care services	$ 880	$ 21	$ 859	nm
Integrated wellness services	12	13	(1)	(7.7)%
Pharmacy solutions	11	0	11	100 %
Total services revenues	903	34	869	nm
Intersegment revenues:				
Pharmacy solutions	9,886	8,410	1,476	17.6%
Primary care services	185	170	15	8.8%
Integrated wellness services	175	167	8	4.8%
Home care services	84	39	45	115.4%
Total intersegment revenues	10,330	8,786	1,544	17.6%
Total services and intersegment revenues	$11,233	$ 8,820	$ 2,413	27.4%
Income before income taxes	$ 353	$ 219	$ 134	61.2%
Operating cost ratio	96.1%	97.2%		(1.1)%

nm – not meaningful

Pretax results

- Health and Well-Being Services segment pretax income increased $134 million, or 61.2%, from 2010 to $353 million in 2011 primarily due to growth in our pharmacy solutions business together with the addition of the Concentra business, acquired on December 21, 2010.

Services revenue

- Primary care services revenue increased $859 million from 2010 to $880 million in 2011 primarily due to the acquisition of Concentra on December 21, 2010.

Intersegment revenues

- Intersegment revenues increased $1.5 billion, or 17.6%, from 2010 to $10.3 billion for 2011 primarily due to growth in our pharmacy solutions business as it serves our growing membership, particularly Medicare stand-alone PDP.

Operating costs

- The Health and Well-Being Services segment operating cost ratio decreased 110 basis points from 2010 to 96.1% for 2011 reflecting scale efficiencies associated with growth in our pharmacy solutions business together with the addition of our acquired Concentra operations which carry a lower operating cost ratio than other lines of business in this segment.

Other Businesses

Pretax income for our Other Businesses of $84 million for 2011 compared to pretax losses of $2 million for 2010. Pretax losses for 2010 include the impact of a net charge of $139 million associated with reserve strengthening for our closed block of long-term care policies. Excluding this charge, the year-over-year decline primarily reflects a decrease in pretax income associated with our contract with CMS to administer the LI-NET program.

Comparison of Results of Operations for 2010 and 2009

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2010 and 2009:

Consolidated

			Change	
	2010	2009	Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 19,052	$ 18,349	$ 703	3.8%
Employer Group	9,080	7,466	1,614	21.6%
Other Businesses	4,580	4,112	468	11.4%
Total premiums	32,712	29,927	2,785	9.3%
Services:				
Retail	11	10	1	10.0%
Employer Group	395	370	25	6.8%
Health and Well-Being Services	34	17	17	100.0%
Other Businesses	115	123	(8)	(6.5)%
Total services	555	520	35	6.7%
Investment income	329	296	33	11.1%
Total revenues	33,596	30,743	2,853	9.3%
Operating expenses:				
Benefits	27,117	24,784	2,333	9.4%
Operating costs	4,380	4,014	366	9.1%
Depreciation and amortization	245	237	8	3.4%
Total operating expenses	31,742	29,035	2,707	9.3%
Income from operations	1,854	1,708	146	8.5%
Interest expense	105	106	(1)	(0.9)%
Income before income taxes	1,749	1,602	147	9.2%
Provision for income taxes	650	562	88	15.7%
Net income	$ 1,099	$ 1,040	$ 59	5.7%
Diluted earnings per common share	$ 6.47	$ 6.15	$ 0.32	5.2%
Benefit ratio (a)	82.9%	82.8%		0.1%
Operating cost ratio (b)	13.2%	13.2%		0.0%
Effective tax rate	37.2%	35.1%		2.1%

(a) Represents total benefit expenses as a percentage of premiums revenue.
(b) Represents total operating costs as a percentage of total revenues less investment income.

Summary

Net income was $1.1 billion, or $6.47 per diluted common share, in 2010 compared to $1.0 billion, or $6.15 per diluted common share, in 2009 primarily as a result of an increase in average Medicare Advantage membership and favorable prior-period medical claims reserve development in 2010 in both our Retail and Employer Group segments. Our diluted earnings per common share for 2010 include the beneficial impact of favorable prior-period medical claims reserve development of approximately $0.86 per diluted common share. These increases were partially offset by a $147 million ($0.55 per diluted common share) write-down of deferred acquisition costs associated with our individual commercial medical policies in our Retail segment and a net charge of $139 million ($0.52 per diluted common share) for reserve strengthening associated with our closed block of long-term care policies in our Other Businesses in 2010 as discussed in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Net income for 2009 also included the favorable impact of the reduction of the liability for unrecognized tax benefits ($0.10 per diluted common share) as a result of Internal Revenue Service audit settlements.

Premiums revenue

Consolidated premiums increased $2.8 billion, or 9.3%, from 2009 to $32.7 billion for 2010. The increase primarily was due to higher premiums revenue in the Employer Group and Retail segments primarily as a result of higher average Medicare Advantage membership and an increase in per member premiums, as well as increased premiums for Other Businesses as a result of our new contract with CMS to administer the LI-NET program in 2010.

Services Revenue

Consolidated services revenue increased $35 million, or 6.7%, from 2009 to $555 million for 2010, primarily due to an increase in services revenue in our Employer Group segment primarily as a result of a new group Medicare ASO account in 2010 partially offset by a decline in commercial ASO membership, as well as an increase in primary care services revenue in our Health and Well-Being Services segment primarily as a result of the acquisition of Concentra on December 21, 2010.

Investment Income

Investment income totaled $329 million for 2010, an increase of $33 million from $296 million for 2009, primarily reflecting higher average invested balances as a result of the reinvestment of operating cash flows, partially offset by lower interest rates.

Benefit Expenses

Consolidated benefit expenses were $27.1 billion for 2010, an increase of $2.3 billion, or 9.4%, from $24.8 billion for 2009. The increase primarily was driven by an increase in the average number of Medicare Advantage members.

The consolidated benefit ratio for 2010 was 82.9%, essentially unchanged, increasing only 10 basis points from the 2009 benefit ratio of 82.8%.

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 $366 million, or 9.1%, during 2010 compared to 2009, primarily due to the $147 million write-down of deferred acquisition costs associated with our individual commercial medical

policies in 2010, increased Medicare investment spending for our 2011 offerings, and operating costs associated with servicing higher average Medicare Advantage membership, partially offset by a decrease in the number of our employees as a result of our administrative cost reduction strategies, including planned workforce reductions in 2010. Excluding employees added with the acquisition of Concentra on December 21, 2010, the number of employees decreased by 800 to 27,300 at December 31, 2010 from 28,100 at December 31, 2009, or 2.8%, as we aligned the size of our workforce with our membership.

The consolidated operating cost ratio for 2010 of 13.2% remained unchanged from the 2009 ratio as an increase in the Retail segment operating cost ratio was offset by declines in the Employer Group and Health and Well-Being Services segment operating cost ratios.

Depreciation and Amortization

Depreciation and amortization for 2010 totaled $245 million compared to $237 million for 2009, an increase of $8 million, or 3.4%, primarily reflecting depreciation expense associated with capital expenditures.

Interest Expense

Interest expense was $105 million for 2010, compared to $106 million for 2009, a decrease of $1 million, or 0.9%.

Income Taxes

Our effective tax rate during 2010 was 37.2% compared to the effective tax rate of 35.1% in 2009. The increase from 2009 to 2010 primarily was due to the reduction of the $17 million liability for unrecognized tax benefits as a result of audit settlements which reduced the effective income tax rate by 1.0% during 2009. In addition, the tax rate for 2010 reflects the estimated impact of new limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by recent health insurance reforms. See Note 10 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	
	2010	2009	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	1,460,700	1,406,600	54,100	3.8%
Individual Medicare stand-alone PDP	1,670,300	1,925,400	(255,100)	(13.2)%
Total individual Medicare	3,131,000	3,332,000	(201,000)	(6.0)%
Individual commercial	411,200	397,400	13,800	3.5%
Total individual medical members	3,542,200	3,729,400	(187,200)	(5.0)%
Individual specialty membership (a)	510,000	297,300	212,700	71.5%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2010	2009	Change Dollars	Change Percentage
		(dollars in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$16,265	$ 15,333	$ 932	6.1%
Individual Medicare stand-alone PDP	1,959	2,323	(364)	(15.7)%
Total individual Medicare	18,224	17,656	568	3.2%
Individual commercial	746	638	108	16.9%
Individual specialty	82	55	27	49.1%
Total premiums	19,052	18,349	703	3.8%
Services	11	10	1	10.0%
Total premiums and services revenue	$ 19,063	$ 18,359	$ 704	3.8%
Income before income taxes	$ 1,289	$ 1,359	$ (70)	(5.2)%
Benefit ratio	82.0%	81.7%		0.3%
Operating cost ratio	11.1%	10.8%		0.3%

Pretax Results

- Retail segment pretax income was $1.3 billion in 2010, a decrease of $70 million, or 5.2%, from 2009 primarily due to the negative impact of a $147 million write-down of deferred acquisition costs associated with our individual commercial medical policies in 2010 and a decline in average individual Medicare stand-alone PDP membership from 2009 to 2010, partially offset by the beneficial impact of an estimated $198 million in favorable prior-period medical claims reserve development in 2010.

Enrollment

- Individual Medicare Advantage membership increased 54,100 members, or 3.8%, from December 31, 2009 to December 31, 2010, with sales of our PPO products driving the majority of the increase.
- Individual Medicare stand-alone PDP membership decreased 255,100 members, or 13.2%, from December 31, 2009 to December 31, 2010 primarily from our competitive positioning as we realigned stand-alone PDP premium and benefit designs to correspond with our historical prescription drug claims experience.
- Individual specialty membership increased 212,700, or 71.5%, from December 31, 2009 to December 31, 2010, primarily driven by increased sales in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $703 million, or 3.8%, from 2009 to 2010 primarily due to higher average individual Medicare Advantage membership and an increase in per member premiums, partially offset by a decline in average individual stand-alone PDP membership. Individual Medicare Advantage premiums revenue increased $932 million, or 6.1%, from 2009 to 2010. Average individual Medicare Advantage membership increased 4.4% in 2010 compared to 2009. Individual Medicare Advantage per member premiums increased approximately 1.6% during 2010 compared to 2009. Individual Medicare stand-alone PDP premiums revenue decreased $364 million, or 15.7%, from 2009 to 2010 primarily due to a 14.8% decrease in average individual PDP membership.

Benefit expenses

- The Retail segment benefit ratio increased 30 basis points from 81.7% in 2009 to 82.0% in 2010 primarily driven by a 40 basis point increase in the Medicare benefit ratio primarily as a result of

higher average membership in products that generally carry higher benefit ratios, partially offset by favorable prior-period medical claims reserve development. This favorable development decreased the Retail segment benefit ratio by approximately 100 basis points in 2010.

Operating costs

- The Retail segment operating cost ratio of 11.1% for 2010 increased 30 basis points from 10.8% for 2009. The $147 million write-down of deferred acquisition costs in 2010 increased the operating cost ratio 80 basis points. Excluding the impact of the write-down of deferred acquisition costs, the decrease in the operating cost ratio year-over-year primarily reflects efficiency gains associated with servicing higher average individual Medicare Advantage membership as well as our continued focus on administrative cost reductions, partially offset by increased Medicare investment spending for our 2011 offerings.

Employer Group Segment

	2010	2009	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,252,200	1,442,100	(189,900)	(13.2)%
ASO	1,453,600	1,571,300	(117,700)	(7.5)%
Group Medicare Advantage	273,100	101,900	171,200	168.0%
Medicare Advantage ASO	28,200	0	28,200	100.0%
Total group Medicare Advantage	301,300	101,900	199,400	195.7%
Group Medicare stand-alone PDP	2,400	2,500	(100)	(4.0)%
Total group Medicare	303,700	104,400	199,300	190.9%
Total group medical members	3,009,500	3,117,800	(108,300)	(3.5)%
Group specialty membership (a)	6,517,500	6,761,900	(244,400)	(3.6)%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2010	2009	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$5,169	$5,547	$ (378)	(6.8)%
Group Medicare Advantage	3,021	1,080	1,941	179.7%
Group Medicare stand-alone PDP	5	5	0	0.0%
Total group Medicare	3,026	1,085	1,941	178.9%
Group specialty	885	834	51	6.1%
Total premiums	9,080	7,466	1,614	21.6%
Services	395	370	25	6.8%
Total premiums and services revenue	$ 9,475	$ 7,836	$1,639	20.9%
Income (loss) before income taxes	$ 288	$ (13)	$ 301	nm
Benefit ratio	82.4%	84.2%		(1.8)%
Operating cost ratio	17.5%	19.5%		(2.0)%

nm – not meaningful

Pretax Results

- Employer Group segment pretax income of $288 million in 2010 increased $301 million from 2009 primarily due to an increase in group Medicare Advantage membership, decreased utilization and our continued focus on pricing discipline primarily associated with our fully-insured commercial group products, as well as administrative cost reductions and the previously mentioned favorable prior-period medical claims reserve development. The Employer Group segment's pretax income for 2010 included the beneficial effect of an estimated $33 million in favorable prior-period medical claims reserve development.

Enrollment

- Fully-insured group Medicare Advantage membership increased 171,200 members from December 31, 2009 to December 31, 2010. Approximately 109,600 of the members were associated with a new contract added during the first quarter of 2010.
- During 2010, we added 28,200 group Medicare Advantage ASO members due to a new account in 2010.
- Fully-insured commercial group medical membership decreased 189,900 members, or 13.2%, from December 31, 2009 to December 31, 2010 primarily due to continued pricing discipline.
- Group ASO commercial medical membership decreased 117,700 members, or 7.5%, from December 31, 2009 to December 31, 2010 primarily reflecting the loss of a large group account on July 1, 2010.

Premiums revenue

- Employer Group segment premiums increased $1.6 billion, or 21.6%, from 2009 to 2010 primarily due to increased fully-insured group Medicare Advantage membership and an increase in fully-insured commercial group per member premiums, partially offset by a decline in fully-insured commercial group medical membership year-over-year. Per member premiums for commercial fully-insured group accounts increased 7.6% during 2010 compared to 2009.

Benefit expenses

- The Employer Group segment benefit ratio of 82.4% for 2010 decreased 180 basis points from 84.2% for 2009 primarily due to medical trend that was lower than trend assumed in pricing as well as continued pricing discipline, in each case particularly for our commercial business, and favorable prior-period medical claims reserve development in 2010. These decreases were partially offset by growth in our group Medicare Advantage business which generally carries a higher benefit ratio than our fully-insured commercial group business. Medical trend was favorable, primarily affected by lower utilization of services as well as the use of services at lower levels of intensity than in the prior year. The favorable development decreased the Employer Group segment benefit ratio by approximately 40 basis points in 2010. Fully-insured group Medicare Advantage members represented 9.1% of total Employer Group segment medical membership at December 31, 2010 compared to 3.3% at December 31, 2009.

Operating costs

- The Employer Group segment operating cost ratio of 17.5% for 2010 decreased 200 basis points from 19.5% for 2009 primarily reflecting administrative scale efficiencies associated with an increase in average fully-insured group Medicare Advantage membership and our continued focus on administrative cost reductions.

Health and Well-Being Services Segment

	2010	2009	Change Dollars	Change Percentage
	(in millions)			
Revenues:				
Services:				
Primary care services	$ 21	$ 3	$ 18	600.0%
Integrated wellness services	13	14	(1)	(7.1)%
Total services revenues	34	17	17	100.0%
Intersegment revenues:				
Pharmacy solutions	8,410	8,630	(220)	(2.5)%
Primary care services	170	149	21	14.1%
Integrated wellness services	167	150	17	11.3%
Home care services	39	23	16	69.6%
Total intersegment revenues	8,786	8,952	(166)	(1.9)%
Total services and intersegment revenues	$ 8,820	$8,969	$ (149)	(1.7)%
Income before income taxes	$ 219	$ 183	$ 36	19.7%
Operating cost ratio	97.2%	97.8%		(0.6)%

Pretax results

- Health and Well-Being Services segment pretax income increased $36 million, or 19.7%, from 2009 to $219 million in 2010 primarily due to growth in both our mail order pharmacy business and our CAC medical centers. The opening of our new facility for processing specialty prescription drugs in late 2009 and continued growth from our processing facility opened in 2008 contributed to the growth in our mail order business in 2010.

Services revenue

- Services revenue increased $17 million, or 100.0%, from 2009 to $34 million in 2010 primarily due to an increase in primary care services revenue primarily as a result of the acquisition of Concentra on December 21, 2010.

Intersegment revenues

- Intersegment revenues decreased $166 million, or 1.9%, from 2009 to $8.8 billion for 2010 primarily due to a decline in our pharmacy solutions business primarily as a result of a decrease in average Medicare stand-alone PDP membership from our competitive positioning as we realigned stand-alone PDP premium and benefit designs to correspond with our historical prescription drug claims experience.

Operating costs

- The Health and Well-Being Services segment operating cost ratio decreased 60 basis points from 2009 to 97.2% for 2010 reflecting growth in our CAC medical centers as well as LifeSynch, our integrated behavioral health and wellness business, which carry lower operating cost ratios than other lines of business in this segment.

Other Businesses

Pretax losses for our Other Businesses of $2 million for 2010 compared to pretax income of $97 million for 2009. The decline in operating performance from 2009 to 2010 primarily resulted from a net charge of $139 million

associated with reserve strengthening for our closed block of long-term care policies in 2010, partially offset by pretax income in 2010 associated with our new contract with CMS to administer the LI-NET program, under which we began providing services in the first quarter of 2010.

Liquidity

Our primary sources of cash include receipts of premiums, services revenues, 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 include 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. The use of operating cash flows may be limited by regulatory requirements 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.

Cash and cash equivalents decreased to $1.4 billion at December 31, 2011 from $1.7 billion at December 31, 2010. The change in cash and cash equivalents for the years ended December 31, 2011, 2010 and 2009 is summarized as follows:

	2011	2010	2009
		(in millions)	
Net cash provided by operating activities	$ 2,079	$ 2,242	$ 1,422
Net cash used in investing activities	(1,358)	(1,811)	(1,859)
Net cash (used in) provided by financing activities	(1,017)	(371)	80
(Decrease) increase in cash and cash equivalents	$ (296)	$ 60	$ (357)

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in earnings, enrollment activity, and changes in working capital items as discussed below. Cash flows were positively impacted by Medicare enrollment gains in 2011 and 2010 because premiums generally are collected in advance of claim payments by a period of up to several months. Conversely, during 2009, cash flows were negatively impacted by the payment of run-off claims associated with enrollment losses in our stand-alone PDP business.

Comparisons of our operating cash flows also are impacted by other changes in our working capital. The most significant drivers of changes in our working capital are typically the timing of payments of benefit expenses 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, 2011, 2010 and 2009:

				Change	
	2011	2010	2009	2011	2010
			(in millions)		
IBNR (1)	$2,056	$2,051	$1,903	$ 5	$ 148
Military services benefits payable (2)	339	255	279	84	(24)
Reported claims in process (3)	376	137	358	239	(221)
Other benefits payable (4)	983	1,026	682	(43)	344
Total benefits payable	$ 3,754	$3,469	$3,222	285	247
Payables from acquisition				(29)	0
Total benefits payable				$256	$ 247

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).
(2) Military services benefits payable primarily results from the timing of the cost of providing health care services to beneficiaries and the payment to the provider. A corresponding receivable for reimbursement by the federal government is included in the base receivable in the receivables table that follows.
(3) 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.
(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable in 2011 primarily was due to an increase in the amount of processed but unpaid claims, including amounts due to our pharmacy benefit administrator, which fluctuate due to month-end cutoff, and an increase in Military services benefits payable. The increase in benefits payable in 2010 and 2009 primarily was due to an increase in amounts owed to providers under capitated and risk sharing arrangements as well as an increase in IBNR, both primarily as a result of Medicare Advantage membership growth, partially offset by a decrease in the amount of processed but unpaid claims, including pharmacy claims, which fluctuate due to the month-end cutoff.

The detail of total net receivables was as follows at December 31, 2011, 2010 and 2009:

				Change	
	2011	2010	2009	2011	2010
			(in millions)		
Military services:					
Base receivable	$ 467	$ 425	$451	$ 42	$ (26)
Change orders	1	2	2	(1)	0
Military services subtotal	468	427	453	41	(26)
Medicare	336	216	238	120	(22)
Commercial and other	315	368	183	(53)	185
Allowance for doubtful accounts	(85)	(52)	(51)	(33)	(1)
Total net receivables	$1,034	$959	$823	75	136
Reconciliation to cash flow statement:					
Provision for doubtful accounts				31	19
Receivables from acquisition				0	(109)
Change in receivables per cash flow statement resulting in cash from operations				$106	$ 46

Military services base receivables consist of estimated claims owed from the federal government for health care services provided to beneficiaries and underwriting fees. The claim reimbursement component of military services base receivables is generally collected over a three to four month period. The timing of claim reimbursements resulted in the $42 million increase in base receivables for 2011 as compared to 2010, the $26 million decrease in base receivables for 2010 as compared to 2009, and the $15 million increase in base receivables for 2009 as compared to 2008.

Medicare receivables are impacted by the timing of accruals and related collections associated with the CMS risk-adjustment model.

Commercial and other receivables for 2011 and 2010 include $144 million and $109 million, respectively, of patient services receivables acquired with the acquisition of Concentra in December 2010. In addition, the allowance for doubtful accounts increased $33 million from 2010 to 2011 primarily due to the Concentra acquisition. The increase in Concentra receivables and the related allowance in 2011 result from the requirement to record acquired balances at fair value at the acquisition date. Excluding the receivables acquired with Concentra, the timing of reimbursements from the Puerto Rico Health Insurance Administration for our Medicaid business primarily resulted in the increase in commercial and other receivables for 2010 as compared to 2009 followed by a decrease from 2010 to 2011.

In addition to the timing of receipts for premiums and services fees and payments of benefit expenses, other working capital items impacting operating cash flows over the past three years primarily resulted from the timing of payments for the Medicare Part D risk corridor provisions of our contracts with CMS as well as changes in the timing of collections of pharmacy rebates.

Cash Flow from Investing Activities

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $850 million in 2011, $827 million in 2010, and $2.0 billion in 2009. Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our Concentra and other medical facilities and administrative facilities necessary for activities such as claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $346 million in 2011, $222 million in 2010, and $185 million in 2009, with 2011 reflecting increased spending associated with growth in our primary care services and pharmacy businesses in our Health and Well-Being Services segment. Excluding acquisitions, we expect total capital expenditures in 2012 of approximately $350 million. Cash consideration paid for acquisitions, net of cash acquired, of $226 million in 2011, $833 million in 2010, and $12 million in 2009 primarily related to the Anvita and MD Care acquisitions in 2011 and the Concentra acquisition in 2010.

Cash Flow from Financing Activities

Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $378 million less than claims payments during 2011, $237 million less than claim payments during 2010, and $493 million higher than claims payments during 2009. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

During 2011, we repurchased 6.7 million shares for $492 million under the stock repurchase plans authorized by the Board of Directors in December 2009 and April 2011. During 2010, we repurchased 1.99 million shares for $100 million under the stock repurchase plan authorized by the Board of Directors in December 2009. We also acquired common shares in connection with employee stock plans for an aggregate cost of $49 million in 2011, $8 million in 2010, and $23 million in 2009.

During 2011, we paid dividends to stockholders of $82 million as discussed further below. No dividends were paid during 2010 or 2009.

In 2009, net borrowings under our then existing credit agreement decreased $250 million primarily from the repayment of amounts borrowed to fund a 2008 acquisition.

The remainder of the cash used in or provided by financing activities in 2011, 2010, and 2009 primarily resulted from proceeds from stock option exercises, the change in the book overdraft, and the change in the securities lending payable. The decrease in securities lending since 2009 resulted from lower margins earned under the program which terminated in the fourth quarter of 2011.

Future Sources and Uses of Liquidity

Dividends

In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of dividends declared in 2011:

Record Date	Payment Date	Amount per Share	Total Amount (in millions)
6/30/2011	7/28/2011	$0.25	$41
9/30/2011	10/28/2011	$0.25	$41
12/30/2011	1/31/2012	$0.25	$41

Stock Repurchase Authorization

In April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion of our common shares exclusive of shares repurchased in connection with employee stock plans. The new authorization will expire June 30, 2013. Under the new share repurchase authorization, shares could be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions, subject to certain regulatory restrictions on volume, pricing, and timing. As of February 6, 2012, the remaining authorized amount under the new authorization totaled $561 million.

Senior Notes

We previously issued $500 million of 6.45% senior notes due June 1, 2016, $500 million of 7.20% senior notes due June 15, 2018, $300 million of 6.30% senior notes due August 1, 2018, and $250 million of 8.15% senior notes due June 15, 2038. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded) and contain a change of control provision that may require us to purchase the notes under certain circumstances. All four series of 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. Our senior notes are more fully discussed in Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Credit Agreement

In November 2011, we amended and restated our 3-year $1.0 billion unsecured revolving credit agreement which was set to expire in December 2013 and replaced it with a 5-year $1.0 billion unsecured revolving agreement expiring November 2016. Under the new 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. The LIBOR spread, currently 120 basis points, varies depending on our credit ratings ranging from 87.5 to 147.5 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 17.5 basis points, may fluctuate between 12.5 and 27.5 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 new credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the new credit agreement contains customary restrictive and financial covenants as well as customary

events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $6.0 billion at December 31, 2011 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $8.1 billion and actual leverage ratio of 0.6:1, as measured in accordance with the new credit agreement as of December 31, 2011. In addition, the new credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2011, we had no borrowings outstanding under the new credit agreement. We have outstanding letters of credit of $14 million secured under the new credit agreement. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2011, we had $986 million of remaining borrowing capacity under the new 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.

Other Long-Term Borrowings

Other long-term borrowings of $36 million at December 31, 2011 represent junior subordinated debt. The junior subordinated debt, which is due in 2037, may be called by us without penalty in 2012 and bears a fixed annual interest rate of 8.02% payable quarterly until 2012, and then payable at a floating rate based on LIBOR plus 310 basis points.

Liquidity Requirements

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, 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, 2011 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 $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. The 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 were $494 million at December 31, 2011 and $553 million at December 31, 2010. During 2011, our subsidiaries paid dividends of $1.1 billion to the parent compared to $747 million in 2010 and $774 million in 2009. Refer to our parent company financial statements and accompanying notes in Schedule I – Parent Company Financial Information. As described in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Insurance Reform," in December 2011, the NAIC issued proposed guidance indicating the insurance industry premium-based assessment may require accrual and associated subsidiary funding consideration in 2013 instead of 2014. This proposed NAIC guidance is contradictory to final GAAP guidance issued by the FASB in July 2011, which indicates the insurance industry premium-based assessment should be accrued beginning in 2014, the year in which it is payable.

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, 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.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $4.7 billion and $4.3 billion as of December 31, 2011 and 2010, respectively, which exceeded aggregate minimum regulatory requirements. The amount of dividends that may be paid to our parent company in 2012 without prior approval by state regulatory authorities is approximately $970 million in the aggregate. This compares to dividends that were able to be paid in 2011 without prior regulatory approval of approximately $740 million.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2011 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$1,585	$ 0	$ 0	$ 500	$1,085
Interest (1)	1,094	111	221	205	557
Operating leases (2)	850	207	332	188	123
Purchase obligations (3)	245	117	95	18	15
Future policy benefits payable and other long-term liabilities (4)	1,987	68	237	162	1,520
Total (5)	$5,761	$ 503	$885	$1,073	$ 3,300

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2025. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include 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. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

(5) Excludes the pending acquisitions of Arcadian Management Services, Inc. and SeniorBridge, both announced in the second half of 2011 and subject to regulatory approval. Refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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 (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, 2011, 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 our military services 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 65% of our total premiums and services revenue for the year ended December 31, 2011, 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 August 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 2012, and all of our product offerings filed with CMS for 2012 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process that bases our prospective payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original Medicare program. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. We generally rely on providers 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 continuing to perform audits of various companies' selected Medicare Advantage contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical record documentation in an attempt to validate provider coding practices and the presence of risk adjustment conditions which influence the calculation of premium payments to Medicare Advantage plans.

On December 21, 2010, CMS posted a description of the agency's proposed RADV sampling and payment adjustment calculation methodology to its website, and invited public comment, noting that CMS may revise its sampling and payment error calculation methodology based upon the comments received. We believe the audit and payment adjustment methodology proposed by CMS is fundamentally flawed and actuarially unsound. In essence, in making the comparison referred to above, CMS relies on two interdependent sets of data to set payment rates for Medicare Advantage (MA) plans: (1) fee for service (FFS) data from the government's original Medicare program; and (2) MA data. The proposed methodology would review medical records for only one set of data (MA data), while not performing the same exercise on the other set (FFS data). However, because these two sets of data are inextricably linked, we believe CMS must audit and validate both of them before determining the financial implications of any potential RADV audit results, in order to ensure that any resulting payment adjustment is accurate. We believe that the Social Security Act, under which the payment model was established, requires the consistent use of these data sets in determining risk-adjusted payments to MA plans. Furthermore, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums.

CMS has received public comments, including our comments and comments from other industry participants and the American Academy of Actuaries, which expressed concerns about the failure to appropriately compare the two sets of data. On February 3, 2011, CMS issued a statement that it was closely evaluating the comments it has received on this matter and anticipates making changes to the proposed methodology based on input it has received, although we are unable to predict the extent of changes that they may make.

To date, six Humana contracts have been selected by CMS for RADV audits for the 2007 contract year, consisting of one "pilot" audit and five "targeted" audits for Humana plans. We believe that the proposed methodology for these audits is actuarially unsound and in violation of the Social Security Act. We intend to defend that position vigorously. However, if CMS moves forward with implementation of the proposed methodology without changes to adequately address the data inconsistency issues described above, it would have a material adverse effect on our revenues derived from the Medicare Advantage program and, therefore, our results of operations, financial position, and cash flows.

At December 31, 2011, our military services business, which accounted for approximately 10% of our total premiums and services revenue for the year ended December 31, 2011, primarily consisted of the TRICARE South Region contract. The original 5-year South Region contract expired on March 31, 2009 and was extended through March 31, 2012. On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the new TRICARE South Region contract to us, which we expect to take effect on April 1, 2012. The new 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option.

Under the current TRICARE South Region contract, any variance from the negotiated target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to enroll due to the federal government's decision to increase or decrease U.S. military deployments. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs may have a material adverse effect on our results of operations, financial position, and cash flows.

Our Medicaid business, which accounted for approximately 3% of our total premiums and services revenue for the year ended December 31, 2011, consists of contracts in Puerto Rico and Florida, with the vast majority in Puerto Rico. Effective October 1, 2010, as amended in May 2011, the Puerto Rico Health Insurance Administration, or PRHIA, awarded us three contracts for the East, Southeast, and Southwest regions for a three year term through June 30, 2013.

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

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 related primarily to benefit expenses 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.

Benefit Expense Recognition

Benefit expenses are recognized in the period in which services are provided and include 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, 2011	Percentage of Total	December 31, 2010	Percentage of Total
	(dollars in millions)			
IBNR	$ 2,056	54.8%	$ 2,051	59.1%
Reported claims in process	376	10.0%	137	3.9%
Other benefits payable	983	26.2%	1,026	29.6%
Benefits payable, excluding military services	3,415	91.0%	3,214	92.6%
Military services benefits payable	339	9.0%	255	7.4%
Total benefits payable	$ 3,754	100.0%	$ 3,469	100.0%

Military services benefits payable primarily consists of our estimate of incurred healthcare services provided to beneficiaries which are in turn reimbursed by the federal government as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. This amount is generally offset by a corresponding receivable due from the federal government, as more fully-described in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Cash Flow from Operating Activities."

Estimating IBNR is complex and involves a significant amount of judgment. Changes in this estimate can materially affect, either favorably or unfavorably, our results of operations and overall financial position. Accordingly, it represents a critical accounting estimate. Most benefit claims are paid within a few months of the member receiving service from a physician or other health care provider. As a result, these liabilities generally are described as having a "short-tail". As such, we expect that substantially all of the December 31, 2011 estimate of benefits payable will be known and paid during 2012.

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 three months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent three 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 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 weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent three 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 three 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. Increased electronic claim submissions from providers have decreased the receipt cycle time over the last several years. 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, and epidemics 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 three 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 three months. Each of these factors requires significant judgment by management.

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 three months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2011 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)		
1.60%	$(263)	(4.75)%	$(269)
1.20%	$(198)	(4.25)%	$(241)
0.80%	$(132)	(3.50)%	$(198)
0.40%	$ (66)	(3.00)%	$(170)
0.30%	$ (49)	(2.50)%	$(142)
0.20%	$ (33)	(2.00)%	$(113)
0.10%	$ (16)	(1.50)%	$ (85)

(a) Reflects estimated potential changes in benefits payable at December 31, 2011 caused by changes in completion factors for incurred months prior to the most recent three months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2011 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent three 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, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefit expenses as well as adjustments to prior year estimated accruals.

	2011	2010	2009
		(in millions)	
Balances at January 1	$ 3,214	$ 2,943	$ 2,898
Acquisitions	29	0	0
Incurred related to:			
Current year	25,821	24,186	21,944
Prior years	(372)	(434)	(253)
Total incurred	25,449	23,752	21,691
Paid related to:			
Current year	(22,729)	(21,269)	(19,211)
Prior years	(2,548)	(2,212)	(2,435)
Total paid	(25,277)	(23,481)	(21,646)
Balances at December 31	$ 3,415	$ 3,214	$ 2,943

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 benefit expenses ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2011		2010		2009	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$(189)	(3.8)%	$ (213)	(4.7)%	$(151)	(3.5)%
Completion factors	(183)	1.2%	(221)	1.6%	(102)	0.8%
Total	$ (372)		$ (434)		$ (253)	

(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. The amount of redundancy over the last three years primarily has been impacted by the growth in our Medicare products, coupled with the application of consistent reserving practices. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

During 2011 and 2010, we experienced prior year favorable reserve releases not in the ordinary course of business of approximately $205 million and $231 million, respectively. This favorable reserve development primarily resulted from improvements in the claims processing environment and, to a lesser extent, better than originally estimated utilization. In addition, in 2010, a shortening of the cycle time associated with provider claim submissions was a contributing factor. The improvements in the claims processing environment benefited all lines of business during 2011, but were most prominent in our Medicare PFFS line of business in 2010. As a result of these improvements, we experienced a significant increase in claim overpayment recoveries during 2011 for claims with 2010 and 2009 dates of service and during 2010 for claims with 2009 and 2008 dates of service, primarily as a result of increased audits of provider billings, as well as system enhancements that improved the claim recovery functionality. This increase resulted in our historical completion factors being understated for those periods since they had been developed using our previous historical experience. The remaining reserve redundancy primarily resulted from our consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions as described above. We believe we have consistently applied our methodology in determining our best estimate for benefits payable.

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, 2011 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefit expenses associated with military services and provisions associated with future policy benefits excluded from the previous table were as follows for the years ended December 31, 2011, 2010 and 2009:

	2011	2010	2009
		(in millions)	
Military services	$3,247	$3,059	$ 3,020
Future policy benefits	127	306	73
Total	$ 3,374	$3,365	$3,093

Our current TRICARE contract contains provisions whereby the federal government bears a substantial portion of the risk of financing health benefits. The federal government both reimburses us for our cost of providing health benefits and bears responsibility for 80% of any variance from the annual targeted health care cost and actual health care cost as more fully described in Item 7. Management's Discussion and Analysis of

Financial Condition and Results of Operations under the section titled "Military Services." Therefore, the impact on our income from operations from changes in estimate for TRICARE benefits payable is reduced substantially by corresponding adjustments to revenues. The net change in income from operations as determined retrospectively, after giving consideration to claim development occurring in the current period, was a decrease of approximately $14 million for 2010 and an increase of approximately $9 million for 2009. The impact from changes in estimates for 2011 is not yet determinable as the amount of prior period development recorded in 2012 will change as our December 31, 2011 benefits payable estimate develops throughout 2012.

Future policy benefits payable of $1.7 billion and $1.5 billion at December 31, 2011 and 2010, respectively, represent liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. These reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, withdrawal and maintenance expense assumptions from published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is acquired and would only change if our expected future experience deteriorated to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits.

Future policy benefits payable include $938 million at December 31, 2011 and $825 million at December 31, 2010 associated with a closed block of long-term care policies acquired in connection with the November 30, 2007 KMG acquisition. Long-term care policies provide for long-duration coverage and, therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual morbidity and mortality rates from those assumed in our reserves are particularly significant to our closed block of long-term care policies. We monitor the loss experience of these long-term care policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases and/or loss experience vary from our acquisition date assumptions, future adjustments to reserves could be required. During the fourth quarter of 2010, certain states approved premium rate increases for a large portion of our long-term care block that were significantly below our acquisition date assumptions. Based on these actions by the states, combined with lower interest rates and higher actual expenses as compared to acquisition date assumptions, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our long-term care policies were not adequate to provide for future policy benefits under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during the fourth quarter of 2010 we recorded $139 million of additional benefit expense, with a corresponding increase in future policy benefits payable of $170 million partially offset by a related reinsurance recoverable of $31 million included in other long-term assets. In addition, future policy benefits payable include amounts of $224 million at December 31, 2011 and $229 million at December 31, 2010 which are subject to 100% coinsurance agreements as more fully described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

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 our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per member basis for each month of coverage. Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and beginning January 1, 2011, for estimated rebates to policyholders under the minimum benefit ratios required under the Health Insurance Reform Legislation. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on available data and historical trends. We routinely monitor the collectibility 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 the current period's revenue.

We bill and collect premium remittances from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from CMS for our Medicare products resulting from the periodic changes in risk-adjustment scores for our membership are recognized when the amounts become determinable, based on the submission of diagnosis data to CMS, and the collectibility is reasonably assured.

Medicare Part D Provisions

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. We estimate and recognize an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in the consolidated balance sheets based on the timing of expected settlement.

The estimate of the settlement associated with risk corridor provisions requires us to consider factors that may not be certain at period end, including member eligibility and risk adjustment score differences with CMS as well as pharmacy rebates from manufacturers. These factors have an offsetting effect on changes in the risk corridor estimate. In 2011, we paid $380 million related to our reconciliation with CMS regarding the 2010 Medicare Part D risk corridor provisions compared to our estimate of $388 million at December 31, 2010. In 2010, we paid $180 million related to our reconciliation with CMS regarding the 2009 Medicare Part D risk corridor provisions compared to our estimate of $145 million at December 31, 2009. The net liability associated with the 2011 risk corridor estimate, which will be settled in 2012, was $329 million at December 31, 2011.

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. Beginning in 2011, the Health Reform Legislation 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 in our consolidated statements of cash flows. 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. Gross financing receipts were $2.5 billion and gross financing withdrawals were $2.9 billion during 2011. CMS subsidy and brand name prescription drug discount activity recorded to the consolidated balance sheets at December 31, 2011 was $363 million to other current assets and $139 million to trade accounts payable and accrued expenses.

In order to allow plans offering enhanced benefits the maximum flexibility in designing alternative prescription drug coverage, CMS provided a demonstration payment option in lieu of the reinsurance subsidy for plans offering enhanced coverage, or coverage beyond CMS's defined standard benefits. The demonstration payment option, available to plans through 2010, was an arrangement in which CMS agreed to pay a capitation amount to a plan for assuming the government's portion of prescription drug costs in the catastrophic layer of coverage. The capitation amount represented a fixed monthly amount per member to provide prescription drug coverage in the catastrophic layer. We chose the demonstration payment option for some of our plans that offered enhanced coverage for plan years through 2010. This capitation amount, derived from our annual bid submissions, was recorded as premiums revenue. The variance between the capitation amount and actual drug costs in the catastrophic layer was subject to risk sharing as part of the risk corridor settlement.

Settlement of the reinsurance and low-income cost subsidies as well as the brand name prescription drug discounts and risk corridor payment is based on a reconciliation made approximately 9 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.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. Rates paid to Medicare Advantage 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 original Medicare program. We generally rely on providers 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. We estimate risk-adjustment revenues based on the submission of diagnosis data to CMS. The risk-adjustment model is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Military services

In 2011, revenues derived from our military services business represented approximately 10% of consolidated premiums and services revenue. Military services premiums and services revenue primarily is derived from our TRICARE South Region contract with the Department of Defense. The current TRICARE contract for the South Region includes multiple revenue generating activities. We allocate the consideration to the various components of the contract based on the relative fair value of the components. TRICARE revenues consist generally of (1) an insurance premium for assuming underwriting risk for the cost of civilian health care services delivered to eligible beneficiaries; (2) health care services provided to beneficiaries which are in turn

reimbursed by the federal government; and (3) administrative services fees related to claim processing, customer service, enrollment, and other services. We recognize the insurance premium as revenue ratably over the period coverage is provided. Health care services reimbursements are recognized as revenue in the period health services are provided. Administrative services fees are recognized as revenue in the period services are performed.

The current TRICARE South Region contract contains provisions whereby the federal government bears a substantial portion of the risk associated with financing the cost of health benefits. Annually, we negotiate a target health care cost amount, or target cost, with the federal government and determine an underwriting fee. Any variance from the target cost is shared. We earn more revenue or incur additional costs based on the variance of actual health care costs versus the negotiated target cost. We receive 20% for any cost underrun, subject to a ceiling that limits the underwriting profit to 10% of the target cost. We pay 20% for any cost overrun, subject to a floor that limits the underwriting loss to negative 4% of the target cost. A final settlement occurs 12 to 18 months after the end of each contract year to which it applies. We defer the recognition of any revenues for favorable contingent underwriting fee adjustments related to cost underruns until the amount is determinable and the collectibility is reasonably assured. We estimate and recognize unfavorable contingent underwriting fee adjustments related to cost overruns currently in operations as an increase in benefit expenses. We continually review these benefit expense estimates of future payments to the government for cost overruns and make necessary adjustments to our reserves.

The military services contracts contain provisions to negotiate change orders. Change orders occur when we perform services or incur costs under the directive of the federal government that were not originally specified in our contract. Under federal regulations we may be entitled to an equitable adjustment to the contract price in these situations. Change orders may be negotiated and settled at any time throughout the year. We record revenue applicable to change orders when services are performed and these amounts are determinable and the collectibility is reasonably assured.

Patient Services

Patient services revenue associated with the December 21, 2010 acquisition of Concentra includes (1) workers' compensation injury care and related services and (2) other healthcare services related to employer needs or statutory requirements. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

The provider reimbursement methods for workers' compensation injury care and related services vary on a state-by-state basis. Most states have fee schedules pursuant to which all healthcare providers are uniformly reimbursed. The fee schedules are determined by each state and generally prescribe the maximum amounts that may be reimbursed for a designated procedure. In the states without fee schedules, healthcare providers are reimbursed based on usual, customary, and reasonable fees charged in the particular state in which the services are provided. We include billings for services in revenue net of allowance for estimated differences between list prices and allowable fee schedule rates or amounts allowed as usual, customary and reasonable, as applicable.

Revenue for other healthcare services is recognized on a fee-for-service basis at estimated collectible amounts at the time services are rendered. Our fees are determined in advance for each type of service performed.

Investment Securities

Investment securities totaled $9.5 billion, or 53% of total assets at December 31, 2011, and $8.4 billion, or 52% of total assets at December 31, 2010. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2011 and at December 31, 2010. The fair value of debt securities were as follows at December 31, 2011 and 2010:

	December 31, 2011	Percentage of Total	December 31, 2010	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 725	7.7%	$ 712	8.5%
Mortgage-backed securities	1,784	18.9%	1,664	19.9%
Tax-exempt municipal securities	2,856	30.2%	2,433	29.1%
Mortgage-backed securities:				
Residential	44	0.4%	56	0.6%
Commercial	381	4.0%	321	3.8%
Asset-backed securities	83	0.9%	150	1.8%
Corporate debt securities	3,580	37.9%	3,032	36.2%
Redeemable preferred stock	0	0.0%	5	0.1%
Total debt securities	$ 9,453	100.0%	$ 8,373	100.0%

Approximately 95% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2011. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $332 million at December 31, 2011 and $344 million at December 31, 2010. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities and special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.1 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, and education, and supported by the revenues of that project, accounted for $1.4 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $634 million and $597 million at December 31, 2011 and 2010, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was $3 million at December 31, 2011 and December 31, 2010. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio.

The percentage of corporate securities associated with the financial services industry was 19.3% at December 31, 2011 and 29.4% at December 31, 2010.

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, 2011:

	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, 2011						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 117	$ 0	$ 0	$ 0	$ 117	$ 0
Mortgage-backed securities	67	(1)	18	(1)	85	(2)
Tax-exempt municipal securities	53	0	48	(2)	101	(2)
Mortgage-backed securities:						
Residential	3	0	24	(2)	27	(2)
Commercial	14	0	0	0	14	0
Asset-backed securities	16	0	4	0	20	0
Corporate debt securities	355	(10)	41	(1)	396	(11)
Total debt securities	$625	$ (11)	$135	$ (6)	$ 760	$ (17)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when 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. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and 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. 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. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the 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 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 other than temporary 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 other-than-temporary impairments may be recorded in future periods.

The recoverability of our residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. Our residential and commercial

mortgage-backed securities at December 31, 2011 primarily were composed of senior tranches having high credit support, with 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA at December 31, 2011.

Several European countries, including Spain, Italy, Ireland, Portugal, and Greece, have been subject to credit deterioration due to weakness in their economic and fiscal situations. We have no direct exposure to sovereign issuances of these five countries.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2011 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 and tighter liquidity conditions in the current markets than when the securities were purchased. At December 31, 2011, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2011.

There were no material other-than-temporary impairments in 2011, 2010, or 2009.

Goodwill and Long-lived Assets

At December 31, 2011, goodwill and other long-lived assets represented 23% of total assets and 51% of total stockholders' equity, compared to 23% and 55%, respectively, at December 31, 2010.

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. The realignment of our business segments and corresponding change in our reportable segments, more fully described in Note 16 to the consolidated financial statements included in Item 8.-Financial Statements and Supplementary Data, resulted in a change in the composition of our reporting units. Accordingly, we reassigned goodwill to our reporting units as of January 1, 2011 using the relative fair value approach based on an evaluation of future discounted cash flows as discussed in Note 8 to the consolidated financial statements included in Item 8.-Financial Statements and Supplementary Data. A significant portion of our historical goodwill was supported by future cash flows associated with our mail-order pharmacy and behavioral health businesses now grouped with our Health & Well-Being Services businesses. This, in addition with the Concentra acquisition on December 21, 2010, resulted in the allocation of a substantial portion of our goodwill to the Health & Well-Being Services segment. We completed an interim impairment test as of January 1, 2011 based on the new reporting units which did not result in an impairment loss.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of 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 ultimate outcome of the Health Insurance Reform Legislation the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill.

Beginning in 2012, we are allowed to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. Refer to *Recently Issued Accounting Pronouncements* in Note 2 to the consolidated financial statements included in Item 8.-Financial Statements and Supplementary Data.

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. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008, fixing the average interest rate under our senior notes at 6.08%. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2011 or December 31, 2010.

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, 2011. Our net unrealized position improved $328 million from a net unrealized gain position of $197 million at December 31, 2010 to a net unrealized gain position of $525 million at December 31, 2011. At December 31, 2011, we had gross unrealized losses of $17 million on our investment portfolio primarily due to an increase in market interest rates and tighter liquidity conditions in the current markets than when the securities were purchased, and as such, there were no material other-than-temporary impairments during 2011. While we believe that these impairments are temporary 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 other-than-temporary 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 3.9 years as of December 31, 2011 and 4.0 years as of December 31, 2010. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $420 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, 2011 and 2010. 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 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points four times, and have changed by less than 100 basis points five 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, 2011						
Investment income	$(26)	$(21)	$(11)	$35	$69	$104
Interest expense (a)	0	0	0	0	0	0
Pretax	$(26)	$(21)	$(11)	$35	$69	$104
As of December 31, 2010						
Investment income	$(31)	$(20)	$(10)	$36	$71	$107
Interest expense (a)	0	0	0	0	0	0
Pretax	$(31)	$(20)	$(10)	$36	$71	$107

(a) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2011 or December 31, 2010.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.

CONSOLIDATED BALANCE SHEETS

	December 31, 2011	December 31, 2010
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,377	$ 1,673
Investment securities	7,743	6,873
Receivables, less allowance for doubtful accounts of $85 in 2011 and $52 in 2010:	1,034	959
Other current assets	1,027	632
Total current assets	11,181	10,137
Property and equipment, net	912	815
Long-term investment securities	1,710	1,500
Goodwill	2,740	2,568
Other long-term assets	1,165	1,083
Total assets	$ 17,708	$ 16,103
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 3,754	$ 3,469
Trade accounts payable and accrued expenses	1,783	1,681
Book overdraft	306	409
Unearned revenues	213	185
Total current liabilities	6,056	5,744
Long-term debt	1,659	1,669
Future policy benefits payable	1,663	1,493
Other long-term liabilities	267	273
Total liabilities	9,645	9,179
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	0	0
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 193,230,310 shares issued in 2011 and 190,244,741 shares issued in 2010	32	32
Capital in excess of par value	1,938	1,737
Retained earnings	6,825	5,529
Accumulated other comprehensive income	303	120
Treasury stock, at cost, 29,225,996 shares in 2011 and 21,795,051 shares in 2010	(1,035)	(494)
Total stockholders' equity	8,063	6,924
Total liabilities and stockholders' equity	$ 17,708	$ 16,103

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,		
	2011	2010	2009
	(in millions, except per share results)		
Revenues:			
Premiums	$35,106	$ 32,712	$29,927
Services	1,360	555	520
Investment income	366	329	296
Total revenues	36,832	33,596	30,743
Operating expenses:			
Benefits	28,823	27,117	24,784
Operating costs	5,395	4,380	4,014
Depreciation and amortization	270	245	237
Total operating expenses	34,488	31,742	29,035
Income from operations	2,344	1,854	1,708
Interest expense	109	105	106
Income before income taxes	2,235	1,749	1,602
Provision for income taxes	816	650	562
Net income	$ 1,419	$ 1,099	$ 1,040
Basic earnings per common share	$ 8.58	$ 6.55	$ 6.21
Diluted earnings per common share	$ 8.46	$ 6.47	$ 6.15
Other comprehensive income, net of tax:			
Net unrealized investment gains, net of tax expense of $109 million in 2011, $47 million in 2010, and $131 million in 2009	$ 190	$ 82	$ 230
Less: Reclassification adjustment for net realized gains included in net income, net of tax expense of $4 million in 2011, $2 million in 2010, and $7 million in 2009	(7)	(4)	(13)
Other comprehensive income, net of tax	183	78	217
Comprehensive income	$ 1,602	$ 1,177	$ 1,257

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

Humana Inc.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock						
	Issued Shares	Amount	Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2009	187,857	$ 31	$ 1,574	$ 3,390	$ (175)	$ (363)	$ 4,457
Net income				1,040			1,040
Net unrealized investment gains, net of tax expense of $131 million					230		230
Reclassification adjustment for net realized gains included in net income, net of tax expense of $7 million					(13)		(13)
Common stock repurchases						(23)	(23)
Stock-based compensation			66				66
Restricted stock grants	978	0					0
Restricted stock forfeitures	(87)	0	0				0
Stock option exercises	1,053	1	18				19
Stock option and restricted stock tax benefit			0				0
Balances, December 31, 2009	189,801	32	1,658	4,430	42	(386)	5,776
Net income				1,099			1,099
Net unrealized investment gains, net of tax expense of $47 million					82		82
Reclassification adjustment for net realized gains included in net income, net of tax expense of $2 million					(4)		(4)
Common stock repurchases						(108)	(108)
Stock-based compensation			63				63
Restricted stock grants and restricted stock unit vesting	5	0					0
Restricted stock forfeitures	(127)	0	0				0
Stock option exercises	566	0	17				17
Stock option and restricted stock tax benefit			(1)				(1)
Balances, December 31, 2010	190,245	32	1,737	5,529	120	(494)	6,924
Net income				1,419			1,419
Net unrealized investment gains, net of tax expense of $109 million					190		190
Reclassification adjustment for net realized gains included in net income, net of tax expense of $4 million					(7)		(7)
Common stock repurchases						(541)	(541)
Dividends declared			0	(123)			(123)
Stock-based compensation			67				67
Restricted stock grants and restricted stock unit vesting	11	0					0
Restricted stock forfeitures	(105)	0	0				0
Stock option exercises	3,079	0	134				134
Stock option and restricted stock tax benefit			0				0
Balances, December 31, 2011	193,230	$ 32	$ 1,938	$ 6,825	$ 303	$ (1,035)	$ 8,063

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

Humana Inc.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2011	2010	2009
		(in millions)	
Cash flows from operating activities			
Net income	$ 1,419	$ 1,099	$ 1,040
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	303	263	250
Stock-based compensation	67	63	66
Net realized capital gains	(11)	(6)	(20)
Provision (benefit) from deferred income taxes	22	(199)	(27)
Provision for doubtful accounts	31	19	19
Changes in operating assets and liabilities, net of effect of businesses acquired:			
Receivables	(106)	(46)	(60)
Other assets	(183)	81	113
Benefits payable	256	247	17
Other liabilities	194	722	14
Unearned revenues	26	(46)	(9)
Other	61	45	19
Net cash provided by operating activities	2,079	2,242	1,422
Cash flows from investing activities			
Acquisitions, net of cash acquired	(226)	(833)	(12)
Purchases of property and equipment	(346)	(222)	(185)
Proceeds from sales of property and equipment	10	0	1
Purchases of investment securities	(3,678)	(4,589)	(7,197)
Maturities of investment securities	1,569	1,750	1,271
Proceeds from sales of investment securities	1,259	2,012	3,951
Change in securities lending collateral	54	71	312
Net cash used in investing activities	(1,358)	(1,811)	(1,859)
Cash flows from financing activities			
Receipts from CMS contract deposits	2,517	1,757	2,354
Withdrawals from CMS contract deposits	(2,895)	(1,994)	(1,861)
Repayments under credit agreement	0	0	(250)
Change in securities lending payable	(56)	(71)	(312)
Change in book overdraft	(103)	35	150
Common stock repurchases	(541)	(108)	(23)
Dividends paid	(82)	0	0
Excess tax benefit from stock-based compensation	15	2	5
Proceeds from stock option exercises and other, net	128	8	17
Net cash (used in) provided by financing activities	(1,017)	(371)	80
(Decrease) increase in cash and cash equivalents	(296)	60	(357)
Cash and cash equivalents at beginning of year	1,673	1,613	1,970
Cash and cash equivalents at end of year	$ 1,377	$ 1,673	$ 1,613
Supplemental cash flow disclosures:			
Interest payments	$ 114	$ 112	$ 113
Income tax payments, net	$ 874	$ 785	$ 627
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 266	$ 1,044	$ 12
Less: Fair value of liabilities assumed	(40)	(211)	0
Cash paid for acquired businesses, net of cash acquired	$ 226	$ 833	$ 12

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

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Headquartered in Louisville, Kentucky, Humana is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 76% of our premiums and services revenue from contracts with the federal government in 2011. Under our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, we provide health insurance coverage for Medicare Advantage members in Florida, accounting for approximately 16% of our consolidated premiums and services revenue in 2011. CMS is the federal government's agency responsible for administering the Medicare program. Under federal government contracts with the Department of Defense we primarily provide health insurance coverage to TRICARE members, accounting for approximately 10% of our consolidated premiums and services revenue in 2011.

Health Insurance Reform

In March 2010, the President signed into law 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 Insurance Reform Legislation) which enact significant reforms to various aspects of the U.S. health insurance industry. There are many significant provisions of the legislation that will require additional guidance and clarification in the form of regulations and interpretations in order to fully understand the impacts of the legislation on our overall business, which we expect to occur over the next several years.

Certain significant provisions of the Health Insurance Reform Legislation include, among others, mandated coverage requirements, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of state-based exchanges coupled with programs designed to spread risk among insurers, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. Implementation dates of the Health Insurance Reform Legislation vary from September 30, 2010 to as late as 2018.

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 the Company is the primary beneficiary. Generally, we do not own medical practices but instead enter into exclusive long-term management agreements with the affiliated Professional Associations, or P.A.s, that operate the 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 consolidated 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 sharing provisions related to our Medicare and TRICARE 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.

Beginning with the filing of this Form 10-K for year ended December 31, 2011, we adopted new guidance requiring the presentation of other comprehensive income in a statement presented with equal prominence to the other primary financial statements. As a result, we present net income, other comprehensive income, and total comprehensive income in a single continuous statement referred to as the consolidated statement of comprehensive income. The adoption of this guidance had no impact on our results of operations, including diluted earnings per share common share, financial condition or cash flows. See *Recently Issued Accounting Pronouncements* within this note.

Realignment of Business Segments

During the first quarter of 2011, we realigned our business segments to reflect our evolving business model. We currently manage and report our operating results using the following segments: Retail, Employer Group, and Health and Well-Being Services. We also disclose results for Other Businesses. All respective amounts related to the segment change have been retrospectively adjusted throughout the financial statements. Our segment information is more fully described in Note 16.

As a result of changing our reportable segments, we also changed the classification of certain revenues and costs in our consolidated statements of comprehensive income. Beginning January 1, 2011, costs of certain health and well-being services were reclassified as benefits expense including costs incurred by our wholly-owned mail order pharmacy from transactions with our members that were historically classified as selling, general and administrative (and now titled operating costs), as well as depreciation and amortization expenses. The effect of this reclassification is to account for the cost of providing these benefits to our members similarly whether the services are provided via a third party provider or internally through a stand-alone subsidiary. Likewise, co-share amounts from our members associated with our wholly-owned mail order pharmacy operations, historically classified as other revenue, are now classified as a reduction of benefits expense. The remaining items previously classified as other revenue, primarily consisting of patient service revenue associated with our Concentra Inc. subsidiary, which was acquired in December 2010, were combined with our previous administrative services fee revenue and are now classified as services revenue. Prior period amounts have been reclassified to conform to the new presentation. These adjustments had no impact on net income, cash flows or equity. Further, none of these adjustments impacted our regulated subsidiaries.

After giving effect to this reclassification, consolidated benefit expenses include depreciation and amortization expenses primarily from the delivery of pharmacy services by our wholly-owned pharmacy business included in our Health and Well-Being Services segment. The amount of this expense was $33 million in 2011, $18 million in 2010, and $13 million in 2009.

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 entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as

current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits and venture capital investments, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of comprehensive income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when 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. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and 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. 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. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the 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.

We participated in a securities lending program to optimize investment income. The program was terminated in the fourth quarter of 2011. We loaned certain investment securities for short periods of time in exchange for collateral initially equal to at least 102% of the fair value of the investment securities on loan. The fair value of the loaned investment securities was monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned investment securities fluctuated. The collateral, which may have been in the form of cash or U.S. Government securities, was deposited by the borrower with an independent lending agent. Any cash collateral was recorded on our consolidated balance sheets in other current assets, along with a liability to reflect our obligation to return the collateral included with trade accounts payable and accrued expenses. The cash collateral was invested by the lending agent according to our investment guidelines, primarily in money market funds, certificates of deposit, and short-term corporate and asset-backed securities, and accounted for consistent with our investment securities. Collateral received in the form of securities was not recorded in our consolidated balance sheets because, absent default by the borrower, we did not have the right to sell, pledge or otherwise reinvest securities collateral. Loaned securities continued to be carried as investment securities on the consolidated balance sheets. Earnings on the invested cash collateral, net of expense, associated with the securities lending payable were recorded as investment income.

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.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Premiums Revenue

We bill and collect premium remittances from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from CMS for our Medicare products resulting from the periodic changes in risk-adjustment scores for our membership are recognized when the amounts become determinable, based on the submission of diagnosis data to CMS, and the collectibility is reasonably assured.

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 beginning January 1, 2011, adjustments to recognize rebates to policyholders under the minimum benefit ratios required under Health Insurance Reform Legislation. 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 collectibility 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. We estimate and recognize an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in the 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. Beginning in 2011, the Health Reform Legislation 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 in our consolidated statements of cash flows. 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.

For plans where we provide enhanced benefits and selected the alternative demonstration payment option in lieu of the reinsurance subsidy, we receive a monthly per member capitation amount from CMS determined from our annual bid submissions. The capitation amount we receive from CMS for assuming the government's portion of prescription drug costs in the catastrophic layer of coverage is recorded as premiums revenue. The variance between the capitation amount and actual drug costs in the catastrophic layer is subject to risk sharing as part of the risk corridor settlement. The demonstration provision terminated at the end of 2010. See Note 6 for detail regarding amounts recorded to the consolidated balance sheets related to the risk corridor settlement and subsidies from CMS.

Settlement of the reinsurance and low-income cost subsidies as well as the brand name prescription drug discounts and risk corridor payment is based on a reconciliation made approximately 9 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.

Military services

Military services premiums and services revenue primarily is derived from our TRICARE South Region contract with the Department of Defense, or DoD. We allocate the consideration to the various components of the contract based on the relative fair value of the components. TRICARE revenues consist generally of (1) an insurance premium for assuming underwriting risk for the cost of civilian health care services delivered to eligible beneficiaries; (2) health care services provided to beneficiaries which are in turn reimbursed by the federal government; and (3) administrative services fees related to claim processing, customer service, enrollment, and other services. We recognize the insurance premium as revenue ratably over the period coverage is provided. Health care services reimbursements are recognized as revenue in the period health services are provided. Administrative services fees are recognized as revenue in the period services are performed. Our TRICARE South Region contract contains provisions to share the risk associated with financing the cost of health benefits with the federal government. We earn more revenue or incur additional costs based on the variance of actual health care costs versus a negotiated target cost. We defer the recognition of any contingent revenues for favorable variances until the end of the contract period when the amount is determinable and the collectibility is reasonably assured. We estimate and recognize contingent benefit expense for unfavorable variances currently in our results of operations. We continually review the contingent benefit expense estimates of future payments to the government for cost overruns relative to our negotiated target cost and make necessary adjustments to our reserves.

Revenues also may include change orders attributable to our military services contracts. Change orders represent equitable adjustments for services not originally specified in the contracts. Revenues for these adjustments are recognized when a settlement amount becomes determinable and the collectibility is reasonably assured.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Services Revenue

Patient services revenue

Patient services include workers' compensation injury care and related services as well as other healthcare services related to employer needs or statutory requirements. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, 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. 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 benefit expenses related to these stop loss insurance contracts. We routinely monitor the collectibility 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.

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.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal business. 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 one-year term and may be cancelled upon 30 days notice by the employer group.

Life insurance, annuities, health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year due to contractual and regulatory requirements . As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 17.

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 7 years for computer software, and 20 to 40 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 other 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.

Goodwill and Other 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 unit that is expected to benefit from a specific acquisition. As discussed previously under *Realignment of Business Segments* within this Note 2, during the first quarter of 2011, we realigned our business segments to reflect our evolving business model. As a result, we reassigned goodwill to our new reporting units as of January 1, 2011 using the relative fair value approach based on an evaluation of future discounted cash flows as discussed in Note 8.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of 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. Impairment tests completed for 2011, including an interim test completed January 1 in connection with the segment realignment, 2010 and 2009 did not result in an impairment loss. Beginning in 2012, we are allowed to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. See *Recently Issued Accounting Pronouncements* within this note.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefit Expense Recognition

Benefit expenses include 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 prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care physicians 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 the consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefit 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.

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 liability 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 do not anticipate recording a material premium deficiency liability, 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 including life insurance, annuities, health, and long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. These reserves are recognized on a net level premium method based on interest, mortality, morbidity, withdrawal and maintenance expense assumptions from published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefit expenses in the period the changes occur.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks frequently result in overdraft balances for accounting purposes and 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.

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.

Derivative Financial Instruments

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of comprehensive income. We were not party to any interest-rate swap agreements in 2011, 2010, or 2009. Prior to 2009, we were parties to interest-rate swap agreements that converted the fixed interest rates on our senior notes to a variable rate and were accounted for as fair value hedges.

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). However, for awards granted to retirement eligible employees, the compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. 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. In addition, we report certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. Additional detail regarding our stock-based compensation plans is included in Note 12.

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.

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 debt 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 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 a quoted 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 analyses, 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 advisor. 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, including venture capital investments as well as auction rate 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. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

In September 2011, the Financial Accounting Standards Board, or FASB, issued new guidance that will allow entities to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. Previous guidance required an entity to test goodwill for impairment, on at least an annual basis, by comparing the fair value of a reporting unit with its carrying amount. If the fair value of a reporting unit is less than its carrying amount, then the second step of the test must be performed to measure the

jamount of the impairment loss, if any. Under the new guidance, we would not be required to calculate the fair value of a reporting unit unless we determine, based on the qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. The new guidance includes a number of events and circumstances for an entity to consider in conducting the qualitative assessment. The new guidance is effective, for us, beginning with annual and interim impairment tests performed in 2012. As the new guidance only affects the manner of assessment of goodwill for impairment, it will not have a material impact on our results of operations, financial condition, or cash flows.

In July 2011, the FASB issued new guidance regarding how health insurers should recognize and classify fees mandated by the Health Insurance Reform Legislation. The Health Insurance Reform Legislation imposes a non-deductible annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The guidance requires that the liability for the fee be estimated and recorded 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 to expense over the calendar year that it is payable. The new guidance is effective for us when the fee is initially imposed in calendar year 2014.

In June 2011, the FASB issued new guidance requiring the presentation of other comprehensive income in a statement presented with equal prominence to the other primary financial statements. The new guidance eliminates the current option to report other comprehensive income and its components in the statement of stockholders' equity and requires one of two alternatives for the presentation of items of net income and other comprehensive income: (1) in a single continuous statement referred to as the statement of comprehensive income, or (2) in two separate, but consecutive statements. Under either alternative, each component of net income and each component of other comprehensive income, together with totals for each, as well as total comprehensive income would need to be displayed. The new guidance is effective for us, beginning with the filing of our Form 10-Q for the three months ending March 31, 2012, with retrospective application required. As permitted, we early adopted the new guidance with the filing of this Form 10-K for year ended December 31, 2011, electing to present net income and other comprehensive income in a single continuous statement of comprehensive income. As the new guidance only affects the presentation of other comprehensive income, it did not have a material impact on our results of operations, financial condition, or cash flows.

In May 2011, the FASB issued new guidance intended to improve the comparability of fair value measurements presented and disclosed in financial statements prepared in accordance with accounting principles generally accepted in the United States of America and those prepared in accordance with international financial reporting standards. While the new guidance is largely consistent with existing fair value measurement principles, it expands existing disclosure requirements for fair value measurements and makes other amendments which could change how existing fair value measurement guidance is applied. The new guidance will be effective for us beginning with the filing of our Form 10-Q for the three months ending March 31, 2012. The adoption of the new guidance will not have a material impact on our results of operations, financial condition, or cash flows .

3. ACQUISITIONS

Effective December 30, 2011, we acquired the California-based Medicare Advantage health maintenance organization (HMO) MD Care, Inc., or MD Care. This acquisition expanded our Medicare footprint in California and grew our Medicare enrollment.

On December 6, 2011, we acquired Anvita, Inc., or Anvita, a San Diego-based health care analytics company. The Anvita acquisition provides scalable analytics solutions that produce clinical insights which we expect to enhance our ability to improve the quality and lower the cost of health care for our members and

customers. The preliminary allocation of the purchase price resulted in goodwill of $117 million and other intangible assets of $60 million. The goodwill was assigned to the Retail segment and is not deductible for tax purposes. The other intangible assets, which primarily consist of technology and customer contracts, have a weighted average useful life of 6.5 years. The purchase price allocation is preliminary, subject to completion of valuation analyses, including, for example, refining assumptions used to calculate the fair value of other intangible assets.

On December 21, 2010, we acquired Concentra Inc., or Concentra, a health care company based in Addison, Texas, for $805 million. During 2011, we accrued and paid $6 million related to the final determination of working capital that existed at the acquisition date and recorded immaterial adjustments to the acquisition date fair value of Concentra's net tangible assets acquired with a corresponding adjustment to goodwill. Through its affiliated clinicians, Concentra delivers occupational medicine, urgent care, physical therapy, and wellness services to workers and the general public through its operation of medical centers and worksite medical facilities. The Concentra acquisition provides us entry into the primary care space on a national scale, offering additional means for achieving health and wellness solutions and providing an expandable platform for growth with a management team experienced in physician asset management and alternate site care. The total consideration of $811 million exceeded our estimated fair value of the net tangible assets acquired by approximately $725 million, of which we allocated $188 million to other intangible assets and $537 million to goodwill. The goodwill was assigned to the Health and Well-Being Services segment. The other intangible assets, which primarily consist of customer relationships and trade name, have a weighted average useful life of 13.7 years. Approximately $58 million of the acquired goodwill is deductible for tax purposes.

The results of operations and financial condition of MD Care, Anvita, and Concentra have been included in our consolidated statements of comprehensive income and consolidated balance sheets from the acquisition dates. Acquisition-related costs recognized in connection with these acquisitions were not material. The pro forma financial information assuming the acquisitions had occurred as of January 1, 2010 was not material to our results of operations.

During the second half of 2011, we entered into definitive agreements to acquire Arcadian Management Services, Inc., or Arcadian, a Medicare Advantage HMO, and SeniorBridge, a chronic-care provider providing in-home care for seniors. Arcadian serves Medicare Advantage HMO members in 15 U.S. states, offering us an opportunity to expand our Medicare footprint and grow our Medicare enrollment. SeniorBridge will expand our existing clinical and home health capabilities and strengthen our offerings for members with complex chronic-care needs. The closings of these acquisitions are subject to federal and/or state regulatory approvals.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2011 and 2010, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2011				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 705	$ 20	$ 0	$ 725
Mortgage-backed securities	1,701	85	(2)	1,784
Tax-exempt municipal securities	2,709	149	(2)	2,856
Mortgage-backed securities:				
Residential	46	0	(2)	44
Commercial	356	25	0	381
Asset-backed securities	82	1	0	83
Corporate debt securities	3,329	262	(11)	3,580
Total debt securities	$ 8,928	$ 542	$ (17)	$ 9,453
December 31, 2010				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 698	$ 14	$ 0	$ 712
Mortgage-backed securities	1,615	50	(1)	1,664
Tax-exempt municipal securities	2,440	37	(44)	2,433
Mortgage-backed securities:				
Residential	58	1	(3)	56
Commercial	306	15	0	321
Asset-backed securities	148	2	0	150
Corporate debt securities	2,906	140	(14)	3,032
Redeemable preferred stock	5	0	0	5
Total debt securities	$ 8,176	$ 259	$ (62)	$ 8,373

We participated in a securities lending program where we loaned certain investment securities for short periods of time in exchange for collateral, consisting of cash or U.S. Government securities, initially equal to at least 102% of the fair value of the investment securities on loan. We terminated the securities lending program in the fourth quarter of 2011. Investment securities with a fair value of $54 million at December 31, 2010 were on loan.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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, 2011 and 2010, 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, 2011						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 117	$ 0	$ 0	$ 0	$ 117	$ 0
Mortgage-backed securities	67	(1)	18	(1)	85	(2)
Tax-exempt municipal securities	53	0	48	(2)	101	(2)
Mortgage-backed securities:						
Residential	3	0	24	(2)	27	(2)
Commercial	14	0	0	0	14	0
Asset-backed securities	16	0	4	0	20	0
Corporate debt securities	355	(10)	41	(1)	396	(11)
Total debt securities	$ 625	$ (11)	$135	$ (6)	$ 760	$ (17)
December 31, 2010						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 142	$ 0	$ 0	$ 0	$ 142	$ 0
Mortgage-backed securities	110	(1)	6	0	116	(1)
Tax-exempt municipal securities	1,168	(33)	98	(11)	1,266	(44)
Mortgage-backed securities:						
Residential	0	0	33	(3)	33	(3)
Commercial	0	0	3	0	3	0
Asset-backed securities	17	0	0	0	17	0
Corporate debt securities	384	(10)	31	(4)	415	(14)
Total debt securities	$1,821	$ (44)	$171	$ (18)	$1,992	$ (62)

Approximately 95% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2011. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2011, 12% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 45% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, and education, and supported by the revenues of that project, accounted for the remaining 55% of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. Our investment policy limits investments in a single issuer and requires diversification among various asset types. In addition, 22% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The recoverability of our residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. Our residential and commercial mortgage-backed securities at December 31, 2011 primarily were composed of senior tranches having high credit support, with 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA at December 31, 2011.

The percentage of corporate securities associated with the financial services industry was 19.3% at December 31, 2011 and 29.4% at December 31, 2010.

Several European countries, including Spain, Italy, Ireland, Portugal, and Greece, have been subject to credit deterioration due to weakness in their economic and fiscal situations. We have no direct exposure to sovereign issuances of these five countries.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2011 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 and tighter liquidity conditions in the current markets than when the securities were purchased. At December 31, 2011, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2011.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2011, 2010, and 2009:

	2011	2010	2009
		(in millions)	
Gross realized gains	$ 33	$ 35	$ 123
Gross realized losses	(22)	(29)	(103)
Net realized capital gains	$ 11	$ 6	$ 20

There were no material other-than-temporary impairments in 2011, 2010, or 2009.

The contractual maturities of debt securities available for sale at December 31, 2011, 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	$ 427	$ 431
Due after one year through five years	1,841	1,905
Due after five years through ten years	2,688	2,863
Due after ten years	1,787	1,962
Mortgage and asset-backed securities	2,185	2,292
Total debt securities	$8,928	$ 9,453

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2011 and 2010, respectively, for financial assets measured at fair value on a recurring basis:

	Fair Value	Fair Value Measurements Using: Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2011				
Cash equivalents	$ 1,205	$ 1,205	$ 0	$ 0
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	725	0	725	0
Mortgage-backed securities	1,784	0	1,784	0
Tax-exempt municipal securities	2,856	0	2,840	16
Mortgage-backed securities:				
Residential	44	0	44	0
Commercial	381	0	381	0
Asset-backed securities	83	0	82	1
Corporate debt securities	3,580	0	3,556	24
Redeemable preferred stock	0	0	0	0
Total debt securities	9,453	0	9,412	41
Securities lending invested collateral	0	0	0	0
Total invested assets	$10,658	$ 1,205	$ 9,412	$ 41
December 31, 2010				
Cash equivalents	$ 1,606	$ 1,606	$ 0	$ 0
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	712	0	712	0
Mortgage-backed securities	1,664	0	1,664	0
Tax-exempt municipal securities	2,433	0	2,381	52
Mortgage-backed securities:				
Residential	56	0	56	0
Commercial	321	0	321	0
Asset-backed securities	150	0	148	2
Corporate debt securities	3,032	0	3,025	7
Redeemable preferred stock	5	0	0	5
Total debt securities	8,373	0	8,307	66
Securities lending invested collateral	50	25	25	0
Total invested assets	$ 10,029	$ 1,631	$ 8,332	$ 66

There were no material transfers between Level 1 and Level 2 during 2011, 2010, or 2009.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our Level 3 assets had a fair value of $41 million at December 31, 2011, or less than 0.5% of our total invested assets. During the years ended December 31, 2011, 2010, and 2009, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2011			2010			2009		
	Auction Rate Securities	Private Placements/ Venture Capital	Total	Auction Rate Securities	Private Placements/ Venture Capital	Total	Auction Rate Securities	Private Placements/ Venture Capital	Total
	(in millions)								
Beginning balance at January 1	$ 52	$ 14	$ 66	$ 69	$ 24	$ 93	$ 74	$ 18	$ 92
Total gains or losses:									
Realized in earnings	1	1	2	0	6	6	0	0	0
Unrealized in other comprehensive income	1	0	1	2	(4)	(2)	0	5	5
Purchases	0	17	17	0	3	3	0	0	0
Sales	(38)	(7)	(45)	(3)	(13)	(16)	(1)	0	(1)
Settlements	0	0	0	(16)	(2)	(18)	(4)	(2)	(6)
Transfers into Level 3	0	0	0	0	0	0	0	3	3
Balance at December 31	$ 16	$ 25	$ 41	$ 52	$ 14	$ 66	$ 69	$ 24	$ 93

Financial Liabilities

Our long-term debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our long-term debt outstanding was $1,659 million at December 31, 2011 and $1,669 million at December 31, 2010. The fair value of our long-term debt was $1,834 million at December 31, 2011 and $1,746 million at December 31, 2010. The fair value of our long-term debt is determined based on 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.

6. 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 consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2011 and 2010:

	2011		2010	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 2	$ 363	$ 1	$ 16
Trade accounts payable and accrued expenses	(331)	(139)	(389)	(170)
Net current (liability) asset	$ (329)	$ 224	$ (388)	$ (154)

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

7. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2011 and 2010:

	2011	2010
	(in millions)	
Land	$ 18	$ 18
Buildings and leasehold improvements	523	476
Equipment	606	540
Computer software	935	1,025
	2,082	2,059
Accumulated depreciation	(1,170)	(1,244)
Property and equipment, net	$ 912	$ 815

Depreciation expense was $249 million in 2011, $225 million in 2010, and $213 million in 2009, including amortization expense for capitalized internally developed and purchased software of $139 million in 2011, $136 million in 2010, and $127 million in 2009.

8. GOODWILL AND OTHER INTANGIBLE ASSETS

The realignment of our business segments and corresponding change in our reportable segments, more fully described in Note 16, resulted in a change in the composition of our reporting units, the unit of accounting for goodwill. Accordingly, we reassigned goodwill to our reporting units as of January 1, 2011 using the relative fair value approach based on an evaluation of future discounted cash flows. A significant portion of our historical goodwill was supported by future cash flows associated with our mail-order pharmacy and behavioral health businesses now grouped with our Health & Well-Being Services businesses. This, in addition with the Concentra acquisition on December 21, 2010, resulted in the allocation of a substantial portion of our goodwill to the Health & Well-Being Services segment as outlined in the table below. Changes in the carrying amount of goodwill for our new reportable segments for the years ended December 31, 2011 and 2010 (retrospectively adjusted) were as follows:

	Retail	Employer Group	Health & Well-Being Services	Other Businesses	Total
			(in millions)		
Balance at December 31, 2009	$565	$ 53	$ 1,318	$ 57	$ 1,993
Acquisitions	0	0	538	0	538
Subsequent payments/adjustments	28	9	0	0	37
Balance at December 31, 2010	593	62	1,856	57	2,568
Acquisitions	161	0	8	0	169
Subsequent payments/adjustments	0	0	3	0	3
Balance at December 31, 2011	$ 754	$ 62	$ 1,867	$ 57	$ 2,740

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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, 2011 and 2010:

	Weighted Average Life	2011			2010		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	10.6 yrs	$429	$ 182	$ 247	$ 414	$ 146	$268
Trade names and technology	15.1 yrs	135	6	129	87	2	85
Provider contracts	15.9 yrs	44	15	29	43	12	31
Noncompetes and other	6.9 yrs	40	10	30	19	4	15
Total other intangible assets	11.7 yrs	$648	$ 213	$ 435	$563	$ 164	$399

Amortization expense for other intangible assets was approximately $54 million in 2011, $38 million in 2010 and $37 million in 2009. 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,:	
2012	$ 64
2013	60
2014	56
2015	49
2016	43

9. BENEFITS PAYABLE

Activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2011, 2010 and 2009:

	2011	2010	2009
		(in millions)	
Balances at January 1	$ 3,214	$ 2,943	$ 2,898
Acquisitions	29	0	0
Incurred related to:			
Current year	25,821	24,186	21,944
Prior years	(372)	(434)	(253)
Total incurred	25,449	23,752	21,691
Paid related to:			
Current year	(22,729)	(21,269)	(19,211)
Prior years	(2,548)	(2,212)	(2,435)
Total paid	(25,277)	(23,481)	(21,646)
Balances at December 31	$ 3,415	$ 3,214	$ 2,943

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).

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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. The amount of redundancy over the last three years primarily has been impacted by the growth in our Medicare products, coupled with the application of consistent reserving practices. During 2011 and 2010, we experienced prior year favorable reserve releases not in the ordinary course of business of approximately $205 million and $231 million, respectively. This favorable reserve development primarily resulted from improvements in the claims processing environment and, to a lesser extent, better than originally estimated utilization. In addition, in 2010, a shortening of the cycle time associated with provider claim submissions was a contributing factor. The improvements in the claims processing environment benefited all lines of business during 2011, but were most prominent in our Medicare PFFS line of business in 2010. As a result of these improvements, we experienced a significant increase in claim overpayment recoveries during 2011 for claims with 2010 and 2009 dates of service and during 2010 for claims with 2009 and 2008 dates of service, primarily as a result of increased audits of provider billings, as well as system enhancements that improved the claim recovery functionality. This increase resulted in our historical completion factors being understated for those periods since they had been developed using our previous historical experience. The remaining reserve redundancy primarily resulted from our consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions as described above.

Military services benefits payable of $339 million and $255 million at December 31, 2011 and 2010, respectively, primarily consisted of our estimate of incurred healthcare services provided to beneficiaries which are in turn reimbursed by the federal government, as more fully described in Note 2. This amount is generally offset by a corresponding receivable due from the federal government.

Benefit expenses associated with military services and provisions associated with future policy benefits excluded from the previous table were as follows for the years ended December 31, 2011, 2010 and 2009:

	2011	2010	2009
		(in millions)	
Military services	$3,247	$3,059	$3,020
Future policy benefits	127	306	73
Total	$3,374	$3,365	$3,093

The increase in benefit expenses associated with future policy benefits payable during 2010 relates to reserve strengthening for our closed block of long-term care policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 17.

10. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2011, 2010 and 2009:

	2011	2010	2009
		(in millions)	
Current provision:			
Federal	$ 732	$ 786	$ 533
States and Puerto Rico	62	63	56
Total current provision	794	849	589
Deferred provision (benefit)	22	(199)	(27)
Provision for income taxes	$816	$ 650	$562

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2011, 2010 and 2009 due to the following:

	2011	2010	2009
		(in millions)	
Income tax provision at federal statutory rate	$ 782	$612	$561
States, net of federal benefit and Puerto Rico	35	31	29
Tax exempt investment income	(25)	(24)	(21)
Nondeductible executive compensation	11	13	0
Contingent tax benefits	0	0	(17)
Other, net	13	18	10
Provision for income taxes	$816	$650	$562

The provision for income taxes for 2011 and 2010 reflects an $11 million and $13 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Insurance Reform Legislation.

The liability for unrecognized tax benefits was $17 million at December 31, 2008. This liability, which was released in 2009 as a result of settlements associated with the completion of the audit of our U.S. income tax returns for 2005 and 2006, reduced tax expense $17 million in 2009. As of December 31, 2011, we do not have material uncertain tax positions reflected in our consolidated balance sheet.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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, 2011 and 2010 were as follows:

	Assets (Liabilities)	
	2011	2010
	(in millions)	
Net operating loss carryforward	$ 181	$ 137
Future policy benefits payable	179	153
Benefits payable	111	89
Compensation and other accrued expenses	95	127
Deferred acquisition costs	35	34
Capital loss carryforward	13	13
Unearned premiums	11	10
Other	20	19
Total deferred income tax assets	645	582
Valuation allowance	(28)	(28)
Total deferred income tax assets, net of valuation allowance	617	554
Depreciable property and intangible assets	(347)	(276)
Investment securities	(191)	(66)
Prepaid expenses	(49)	(47)
Total deferred income tax liabilities	(587)	(389)
Total net deferred income tax assets	$ 30	$ 165
Amounts recognized in the consolidated balance sheets:		
Other current assets	$ 0	$ 76
Other long-term assets	46	89
Trade accounts payable and accrued expenses	(16)	0
Total net deferred income tax assets	$ 30	$ 165

At December 31, 2011, we had approximately $494 million of net operating losses to carry forward related to prior acquisitions. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2012 through 2031. A significant portion of these losses are in a subsidiary that will not be included in the Humana Inc. consolidated tax return until 2013, and, therefore, may not be used until that point. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $77 million of net operating loss carryforwards related to prior acquisitions. For the remainder of the net operating loss carryforwards, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2010 and prior years. Our 2011 tax returns are under advance review by the IRS under its Compliance Assurance Process, or CAP. With few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2008. As of December 31, 2011, we are not aware of any material adjustments that may be proposed.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

11. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2011 and 2010:

	2011	2010
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 6.45% due June 1, 2016	$ 530	$ 535
$500 million, 7.20% due June 15, 2018	507	508
$300 million, 6.30% due August 1, 2018	319	322
$250 million, 8.15% due June 15, 2038	267	267
Total senior notes	1,623	1,632
Other long-term borrowings	36	37
Total long-term debt	$1,659	$1,669

Senior Notes

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 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded) and contain a change of control provision that may require us to purchase the notes under certain circumstances.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes, resulting in a weighted-average effective interest rate fixed at 6.08%. The unamortized carrying value adjustment was $74 million as of December 31, 2011 and $84 million as of December 31, 2010.

Credit Agreement

In November 2011, we amended and restated our 3-year $1.0 billion unsecured revolving credit agreement which was set to expire in December 2013 and replaced it with a 5-year $1.0 billion unsecured revolving agreement expiring November 2016. Under the new 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. The LIBOR spread, currently 120 basis points, varies depending on our credit ratings ranging from 87.5 to 147.5 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 17.5 basis points, may fluctuate between 12.5 and 27.5 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 new credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the new credit agreement contains customary restrictive and financial covenants as well as customary

events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $6.0 billion at December 31, 2011 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $8.1 billion and actual leverage ratio of 0.6:1, as measured in accordance with the new credit agreement as of December 31, 2011. In addition, the new credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2011, we had no borrowings outstanding under the new credit agreement. We have outstanding letters of credit of $14 million secured under the new credit agreement. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2011, we had $986 million of remaining borrowing capacity under the new 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.

Other Long-Term Borrowings

Other long-term borrowings of $36 million at December 31, 2011 represent junior subordinated debt. The junior subordinated debt, which is due in 2037, may be called by us without penalty in 2012 and bears a fixed annual interest rate of 8.02% payable quarterly until 2012, and then payable at a floating rate based on LIBOR plus 310 basis points.

12. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees. Prior to 2011, our contribution to these plans included contributions to our employees' retirement accounts based on a percentage of compensation as well as matching contributions based on the amount of our employees' contributions to the plans. Beginning in 2011, we ceased making retirement account contributions and increased our matching contributions. The cost of these plans amounted to approximately $126 million in 2011, $113 million in 2010, and $109 million in 2009, all of which was funded currently to the extent it was deductible for federal income tax purposes. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $87.61 on December 30, 2011, approximately 17% of the retirement and savings plan's assets were invested in our common stock, or approximately 3.7 million shares, representing 2% of the shares outstanding as of December 31, 2011. At December 31, 2011, approximately 6.1 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 awards, including restricted stock units, have been granted to executive officers, directors and key employees. The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. The stock awards of retirement-eligible participants will continue to vest upon retirement from the Company. Our equity award program includes a retirement provision that treats all employees with a combination of age and years of service 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, 2011, 2010, and 2009:

	2011	2010	2009
		(in millions)	
Stock-based compensation expense by type:			
Stock options	$ 16	$ 22	$ 20
Restricted stock awards	51	41	46
Total stock-based compensation expense	67	63	66
Tax benefit recognized	(25)	(23)	(24)
Stock-based compensation expense, net of tax	$ 42	$ 40	$ 42

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes. 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 awards vested during the period. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock award vesting totaled $44 million in 2011, $15 million in 2010, and $16 million in 2009. There was no capitalized stock-based compensation expense during these years.

At December 31, 2011, there were 27.8 million shares reserved for stock award plans, including 19.5 million shares of common stock available for future grants assuming all stock options or 8.7 million shares available for future grants assuming all restricted stock awards.

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 composite stock prices reported 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 to 10 years after grant.

The weighted-average fair value of each option granted during 2011, 2010, and 2009 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:

	2011	2010	2009
Weighted-average fair value at grant date	$28.29	$19.58	$14.24
Expected option life (years)	4.8	5.2	4.6
Expected volatility	46.8%	43.8%	39.2%
Risk-free interest rate at grant date	1.7%	2.7%	1.9%
Dividend yield(1)	0.5%	None	None

(1) As discussed in Note 14, in April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy.

When valuing employee stock options, we stratify the employee population into three homogenous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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, 2011:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2010	5,795	$ 46.86
Granted	448	71.79
Exercised	(3,079)	43.63
Forfeited	(20)	43.66
Options outstanding at December 31, 2011	3,144	$ 53.60
Options exercisable at December 31, 2011	1,552	$ 55.68

As of December 31, 2011, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $108 million, and a weighted-average remaining contractual term of 3.7 years. As of December 31, 2011, exercisable stock options had an aggregate intrinsic value of $50 million, and a weighted-average remaining contractual term of 2.5 years. The total intrinsic value of stock options exercised during 2011 was $88 million, compared with $11 million during 2010 and $24 million during 2009. Cash received from stock option exercises totaled $134 million in 2011, $17 million in 2010, and $18 million in 2009.

Total compensation expense not yet recognized related to nonvested options was $13 million at December 31, 2011. We expect to recognize this compensation expense over a weighted-average period of approximately 2.1 years.

Restricted Stock Awards

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant and generally vest three years from the date of grant. The weighted-average grant date fair value of our restricted stock awards was $67.70 in 2011, $49.29 in 2010, and $41.16 in 2009. Activity for our restricted stock awards was as follows for the year ended December 31, 2011:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock awards at December 31, 2010	2,459	$ 51.38
Granted	1,291	67.70
Vested	(584)	67.87
Forfeited	(250)	56.70
Nonvested restricted stock awards at December 31, 2011	2,916	$ 53.93

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The fair value of shares vested during the years ended was $36 million in 2011, $30 million in 2010, and $22 million in 2009. Total compensation expense not yet recognized related to nonvested restricted stock awards was $63 million at December 31, 2011. We expect to recognize this compensation expense over a weighted-average period of approximately 2.0 years. There are no other contractual terms covering restricted stock awards once vested.

13. 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, 2011, 2010 and 2009:

	2011	2010	2009
	(dollars in millions, share amounts in thousands)		
Net income available for common stockholders	$ 1,419	$ 1,099	$ 1,040
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	165,413	167,782	167,364
Dilutive effect of:			
Employee stock options	959	676	677
Restricted stock awards	1,455	1,340	1,030
Shares used to compute diluted earnings per common share	167,827	169,798	169,071
Basic earnings per common share	$ 8.58	$ 6.55	$ 6.21
Diluted earnings per common share	$ 8.46	$ 6.47	$ 6.15
Number of antidilutive stock options and restricted stock awards excluded from computation	864	3,820	5,675

14. STOCKHOLDERS' EQUITY

Dividends

In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of dividends declared in 2011:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
6/30/2011	7/28/2011	$ 0.25	$ 41
9/30/2011	10/28/2011	$ 0.25	$ 41
12/30/2011	1/31/2012	$ 0.25	$ 41

Stock Repurchases

In April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion of our common shares exclusive of shares repurchased in connection with employee stock plans. The new authorization will expire June 30, 2013. Under the new share repurchase authorization, shares could be purchased from time to time at prevailing prices

in the open market, by block purchases, or in privately-negotiated transactions, subject to certain regulatory restrictions on volume, pricing, and timing. During 2011, we repurchased 0.8 million shares in open market transactions for $53 million at an average price of $63.73 under the previously approved share repurchase authorization and we repurchased 5.9 million shares in open market transactions for $439 million at an average price of $74.01 under the new authorization. During 2010, we repurchased 1.99 million shares for $100 million under the old stock repurchase plan authorized by the Board of Directors in December 2009 at an average price of $50.17. No shares were repurchased in open market transactions during 2009. As of February 6, 2012, the remaining authorized amount under the new authorization totaled $561 million.

In connection with employee stock plans, we acquired 0.8 million common shares for $49 million in 2011, 0.2 million common shares for $8 million in 2010, and 0.6 million common shares for $23 million in 2009.

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, 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.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $4.7 billion and $4.3 billion as of December 31, 2011 and 2010, respectively, which exceeded aggregate minimum regulatory requirements. The amount of dividends that may be paid to our parent company in 2012 without prior approval by state regulatory authorities is approximately $970 million in the aggregate. This compares to dividends that were able to be paid in 2011 without prior regulatory approval of approximately $740 million.

15. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2025. 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 years ended December 31, 2011, 2010 and 2009:

	2011	2010	2009
		(in millions)	
Rent expense	$ 207	$155	$161
Sublease rental income	(10)	(9)	(9)
Net rent expense	$197	$ 146	$152

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Future annual minimum payments due subsequent to December 31, 2011 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31:			
2012	$ 207	$ (1)	$ 206
2013	182	(1)	181
2014	150	0	150
2015	112	0	112
2016	76	0	76
Thereafter	123	0	123
Total	$ 850	$ (2)	$ 848

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 $117 million in 2012, $60 million in 2013, $35 million in 2014, $11 million in 2015, and $22 million thereafter. Purchase obligations exclude agreements that are cancelable 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 (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, 2011, 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 our military services 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.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Government Contracts

Our Medicare products, which accounted for approximately 65% of our total premiums and services revenue for the year ended December 31, 2011, 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 August 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 2012, and all of our product offerings filed with CMS for 2012 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process that bases our prospective payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original Medicare program. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. We generally rely on providers 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 continuing to perform audits of various companies' selected Medicare Advantage contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical record documentation in an attempt to validate provider coding practices and the presence of risk adjustment conditions which influence the calculation of premium payments to Medicare Advantage plans.

On December 21, 2010, CMS posted a description of the agency's proposed RADV sampling and payment adjustment calculation methodology to its website, and invited public comment, noting that CMS may revise its sampling and payment error calculation methodology based upon the comments received. We believe the audit and payment adjustment methodology proposed by CMS is fundamentally flawed and actuarially unsound. In essence, in making the comparison referred to above, CMS relies on two interdependent sets of data to set payment rates for Medicare Advantage (MA) plans: (1) fee for service (FFS) data from the government's original Medicare program; and (2) MA data. The proposed methodology would review medical records for only one set of data (MA data), while not performing the same exercise on the other set (FFS data). However, because these two sets of data are inextricably linked, we believe CMS must audit and validate both of them before determining the financial implications of any potential RADV audit results, in order to ensure that any resulting payment adjustment is accurate. We believe that the Social Security Act, under which the payment model was established, requires the consistent use of these data sets in determining risk-adjusted payments to MA plans. Furthermore, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums.

CMS has received public comments, including our comments and comments from other industry participants and the American Academy of Actuaries, which expressed concerns about the failure to

appropriately compare the two sets of data. On February 3, 2011, CMS issued a statement that it was closely evaluating the comments it has received on this matter and anticipates making changes to the proposed methodology based on input it has received, although we are unable to predict the extent of changes that they may make.

To date, six Humana contracts have been selected by CMS for RADV audits for the 2007 contract year, consisting of one "pilot" audit and five "targeted" audits for Humana plans. We believe that the proposed methodology for these audits is actuarially unsound and in violation of the Social Security Act. We intend to defend that position vigorously. However, if CMS moves forward with implementation of the proposed methodology without changes to adequately address the data inconsistency issues described above, it would have a material adverse effect on our revenues derived from the Medicare Advantage program and, therefore, our results of operations, financial position, and cash flows.

At December 31, 2011, our military services business, which accounted for approximately 10% of our total premiums and services revenue for the year ended December 31, 2011, primarily consisted of the TRICARE South Region contract. The original 5-year South Region contract expired on March 31, 2009 and was extended through March 31, 2012. On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the new TRICARE South Region contract to us, which we expect to take effect on April 1, 2012. The new 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option.

Under the current TRICARE South Region contract, any variance from the negotiated target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to enroll due to the federal government's decision to increase or decrease U.S. military deployments. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs may have a material adverse effect on our results of operations, financial position, and cash flows.

Our Medicaid business, which accounted for approximately 3% of our total premiums and services revenue for the year ended December 31, 2011, consists of contracts in Puerto Rico and Florida, with the vast majority in Puerto Rico. Effective October 1, 2010, as amended in May 2011, the Puerto Rico Health Insurance Administration, or PRHIA, awarded us three contracts for the East, Southeast, and Southwest regions for a three year term through June 30, 2013.

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

Legal Proceedings and Certain Regulatory Matters

Provider Litigation

Humana Military Healthcare Services, Inc. ("Humana Military") was named as a defendant in Sacred Heart Health System, Inc., et al. v. Humana Military Healthcare Services Inc., Case No. 3:07-cv-00062 MCR/EMT (the "Sacred Heart" Complaint), a purported class action lawsuit filed on February 5, 2007 in the U.S. District Court for the Northern District of Florida asserting contract and fraud claims against Humana Military. The Sacred Heart Complaint alleged, among other things, that, Humana Military breached its network agreements with a class of hospitals in six states, including the seven named plaintiffs, that contracted for reimbursement of

outpatient services provided to beneficiaries of the DoD's TRICARE health benefits program ("TRICARE"). The Complaint alleged that Humana Military breached its network agreements when it failed to reimburse the hospitals based on negotiated discounts for non-surgical outpatient services performed on or after October 1, 1999, and instead reimbursed them based on published CHAMPUS Maximum Allowable Charges (so-called "CMAC rates"). Humana Military denied that it breached the network agreements with the hospitals and asserted a number of defenses to these claims. The Complaint sought, among other things, the following relief for the purported class members: (i) damages as a result of the alleged breach of contract by Humana Military, (ii) taxable costs of the litigation, (iii) attorneys fees, and (iv) any other relief the court deems just and proper. Separate and apart from the class relief, named plaintiff Sacred Heart Health System Inc. requested damages and other relief for its individual claim against Humana Military for fraud in the inducement to contract. On September 25, 2008, the district court certified a class consisting of all institutional healthcare service providers in TRICARE former Regions 3 and 4 which had network agreements with Humana Military to provide outpatient non-surgical services to CHAMPUS/TRICARE beneficiaries as of November 18, 1999, excluding those network providers who contractually agreed with Humana Military to submit any such disputes with Humana Military to arbitration. On March 3, 2010, the Court of Appeals reversed the district court's class certification order and remanded the case to the district court for further proceeding. On June 28, 2010, the plaintiffs sought leave of the district court to amend their complaint to join additional hospital plaintiffs. Humana Military filed its response to the motion on July 28, 2010. The district court granted the plaintiffs' motion to join 33 additional hospitals on September 24, 2010. On October 27, 2010, the plaintiffs filed their Fourth Amended Complaint claiming the U.S. District Court for the Northern District of Florida has subject matter jurisdiction over the case because the allegations in the complaint raise a substantial question under federal law. The amended complaint asserts no other material changes to the allegations or relief sought by the plaintiffs. Humana Military's Answer to the Fourth Amended Complaint was filed on November 30, 2010. We are currently involved in discovery on this matter, with trial currently scheduled for October 2012.

On March 2, 2009, in a case styled *Southeast Georgia Regional Medical Center, et al. v. Humana Military Healthcare Services, Inc.*, the named plaintiffs filed an arbitration demand, seeking relief on the same grounds as the plaintiffs in the *Sacred Heart* litigation. The arbitration plaintiffs originally sought certification of a class consisting of all institutional healthcare service providers that had contracts with Humana Military to provide outpatient non-surgical services and whose agreements provided for dispute resolution through arbitration. Humana Military submitted its response to the demand for arbitration on May 1, 2009. The plaintiffs have subsequently withdrawn their motion for class certification. On June 18, 2010, plaintiffs submitted their amended arbitration complaint. Humana Military's answer to the complaint was submitted on July 9, 2010. An arbitration trial was held from September 26, 2011 to October 7, 2011. On January 20, 2012, the Arbitration Panel issued an Interim Award granting relief in favor of the plaintiffs on their claims for breach of contract and in favor of Humana Military on its counterclaim for recoupment based upon improper coding and billing for services on the part of the plaintiffs. The Arbitration Panel reserved decision on the award of damages pending submission of additional evidence and argument by the parties.

Florida Matters

As previously disclosed, with the assistance of outside counsel, we are conducting an ongoing internal investigation related to certain aspects of our Florida subsidiary operations. We have voluntarily self-reported the existence of this investigation to CMS, the U.S. Department of Justice, and the Florida Agency for Health Care Administration. Matters under review include, without limitation, the relationships between certain of our Florida-based employees and providers in our Medicaid and/or Medicare networks, practices related to the financial support of non-profit or provider access centers for Medicaid enrollment and related enrollment processes, and loans to or other financial support of physician practices. We have reported to these regulatory authorities on the progress of our investigation to date, and intend to continue to discuss with these authorities

our factual findings as well as any remedial actions we have taken or may take. We also may face litigation or further government inquiry regarding certain aspects of the Medicare and Medicaid operations of certain of our Florida subsidiaries.

On December 16, 2010, an individual filed a qui tam suit captioned *United States of America ex rel. Marc Osheroff v. Humana et al.* in the Southern District of Florida, against us, several of our health plan subsidiaries, and certain other companies that operate medical centers in Miami-Dade County, Florida. After the U.S. government declined to intervene, the Court ordered the complaint unsealed, and the individual plaintiff amended his complaint and served the Company on December 8, 2011. The Amended Complaint alleges certain civil violations by our CAC Medical Centers in Florida, including offering various amenities such as transportation and meals, to Medicare and dual eligible individuals in our community center settings. The Amended Complaint seeks damages and penalties on behalf of the United States under the Anti-Inducement and Anti-Kickback Statutes and the False Claims Act. We expect to file motions to dismiss on behalf of Humana and our subsidiaries.

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised our legal counsel that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices.

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 and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, provider contracting, competitive practices, commission payments, privacy issues, utilization management practices, 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, including employment litigation, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. 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. 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. We also are subject to claims relating to performance 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. Under state guaranty assessment laws, 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.

Personal injury claims and claims for extracontractual damages arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the

extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for such contingencies 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 the inherently unpredictable nature of legal proceedings 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 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 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 affect our reputation.

16. SEGMENT INFORMATION

During the first quarter of 2011, we realigned our business segments to reflect our evolving business model. As a result, we reassessed and changed our operating and reportable segments in the first quarter of 2011 to reflect management's view of the business and to align our external financial reporting with our new operating and internal financial reporting model. All respective amounts related to the segment change have been retrospectively adjusted throughout the financial statements as discussed in Note 2. Our new reportable segments and the basis for determining those segments are discussed below.

We currently manage our business with three reportable segments: Retail, Employer Group, and Health and Well-Being Services. In addition, we include businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles in an Other Businesses category. These 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 to assess performance and allocate resources.

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, as well as administrative services only products marketed to employer groups. The Health and Well-Being Services segment includes services offered to our health plan members as well as to third parties that promote health and wellness, including primary care, pharmacy, integrated wellness, and home care services. The Other Businesses category consists of our Military services, primarily our TRICARE South Region contract, Medicaid, and closed-block long-term care businesses as well as our contract with CMS to administer the LI-NET program.

Our Health and Well-Being 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

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

operations of *Right*SourceRx®, 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, selecting and establishing prices charged by 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 Health and Well-Being 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.

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 $4.2 billion, $3.5 billion, and $3.5 billion for years ended December 31, 2011, 2010, and 2009, respectively.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments consist of sales of services rendered by our Health and Well-Being Services segment, primarily pharmacy and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize 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 included with intersegment eliminations in the tables presenting segment results below.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our segment results were as follows for the years ended December 31, 2011, 2010, and 2009:

	Retail	Employer Group	Health and Well-Being Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2011						
Revenues—external customers						
Premiums:						
Medicare Advantage	$ 18,100	$ 3,152	$ 0	$ 0	$ 0	$ 21,252
Medicare stand-alone PDP	2,317	8	0	253	0	2,578
Total Medicare	20,417	3,160	0	253	0	23,830
Fully-insured	861	4,782	0	0	0	5,643
Specialty	124	935	0	0	0	1,059
Military services	0	0	0	3,616	0	3,616
Medicaid and other	0	0	0	958	0	958
Total premiums	21,402	8,877	0	4,827	0	35,106
Services revenue:						
Provider	0	0	892	0	0	892
ASO and other	16	356	0	85	0	457
Pharmacy	0	0	11	0	0	11
Total services revenue	16	356	903	85	0	1,360
Total revenues—external customers	21,418	9,233	903	4,912	0	36,466
Intersegment revenues						
Services	0	14	8,510	0	(8,524)	0
Products	0	0	1,820	0	(1,820)	0
Total intersegment revenues	0	14	10,330	0	(10,344)	0
Investment income	76	48	0	54	188	366
Total revenues	21,494	9,295	11,233	4,966	(10,156)	36,832
Operating expenses:						
Benefits	17,383	7,318	0	4,411	(289)	28,823
Operating costs	2,405	1,650	10,798	461	(9,919)	5,395
Depreciation and amortization	119	85	82	10	(26)	270
Total operating expenses	19,907	9,053	10,880	4,882	(10,234)	34,488
Income from operations	1,587	242	353	84	78	2,344
Interest expense	0	0	0	0	109	109
Income (loss) before income taxes	$ 1,587	$ 242	$ 353	$ 84	$ (31)	$ 2,235

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, were approximately 76% for 2011, 76% for 2010 and 73% for 2009.

Retail segment benefit expenses for 2011 and 2010 include $147 million and $198 million, respectively, related to prior year favorable reserve releases not in the ordinary course of business as discussed more fully in Note 9. Retail segment operating costs for 2010 include $147 million for the write-down of deferred acquisition costs associated with our individual commercial medical policies as discussed more fully in Note 17.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Employer Group segment benefit expenses for 2011 and 2010 include $52 million and $33 million, respectively, related to prior year favorable reserve releases not in the ordinary course of business as discussed more fully in Note 9.

Benefit expenses for Other Businesses for 2010 include $139 million for reserve strengthening associated with our closed block of long-term care policies as discussed more fully in Note 17.

	Retail	Employer Group	Health and Well-Being Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2010						
Revenues—external customers						
Premiums:						
Medicare Advantage	$16,265	$ 3,021	$ 0	$ 0	$ 0	$19,286
Medicare stand-alone PDP	1,959	5	0	355	0	2,319
Total Medicare	18,224	3,026	0	355	0	21,605
Fully-insured	746	5,169	0	0	0	5,915
Specialty	82	885	0	0	0	967
Military services	0	0	0	3,462	0	3,462
Medicaid and other	0	0	0	763	0	763
Total premiums	19,052	9,080	0	4,580	0	32,712
Services revenue:						
Provider	0	0	34	0	0	34
ASO and other	11	395	0	115	0	521
Pharmacy	0	0	0	0	0	0
Total services revenue	11	395	34	115	0	555
Total revenues—external customers	19,063	9,475	34	4,695	0	33,267
Intersegment revenues						
Services	0	12	7,494	0	(7,506)	0
Products	0	0	1,292	0	(1,292)	0
Total intersegment revenues	0	12	8,786	0	(8,798)	0
Investment income	80	42	0	43	164	329
Total revenues	19,143	9,529	8,820	4,738	(8,634)	33,596
Operating expenses:						
Benefits	15,624	7,486	0	4,253	(246)	27,117
Operating costs	2,113	1,662	8,575	475	(8,445)	4,380
Depreciation and amortization	117	93	26	12	(3)	245
Total operating expenses	17,854	9,241	8,601	4,740	(8,694)	31,742
Income (loss) from operations	1,289	288	219	(2)	60	1,854
Interest expense	0	0	0	0	105	105
Income (loss) before income taxes	$ 1,289	$ 288	$ 219	$ (2)	$ (45)	$ 1,749

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Employer Group	Health and Well-Being Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2009						
Revenues—external customers						
Premiums:						
Medicare Advantage	$ 15,333	$ 1,080	$ 0	$ 0	$ 0	$ 16,413
Medicare stand-alone PDP	2,323	5	0	0	0	2,328
Total Medicare	17,656	1,085	0	0	0	18,741
Fully-insured	638	5,547	0	0	0	6,185
Specialty	55	834	0	0	0	889
Military services	0	0	0	3,427	0	3,427
Medicaid and other	0	0	0	685	0	685
Total premiums	18,349	7,466	0	4,112	0	29,927
Services revenue:						
Provider	0	0	17	0	0	17
ASO and other	10	370	0	123	0	503
Pharmacy	0	0	0	0	0	0
Total services revenue	10	370	17	123	0	520
Total revenues—external customers	18,359	7,836	17	4,235	0	30,447
Intersegment revenues						
Services	0	14	8,003	0	(8,017)	0
Products	0	0	949	0	(949)	0
Total intersegment revenues	0	14	8,952	0	(8,966)	0
Investment income	88	48	0	23	137	296
Total revenues	18,447	7,898	8,969	4,258	(8,829)	30,743
Operating expenses:						
Benefits	14,988	6,289	0	3,705	(198)	24,784
Operating costs	1,985	1,533	8,768	431	(8,703)	4,014
Depreciation and amortization	115	89	18	25	(10)	237
Total operating expenses	17,088	7,911	8,786	4,161	(8,911)	29,035
Income (loss) from operations	1,359	(13)	183	97	82	1,708
Interest expense	0	0	0	0	106	106
Income (loss) before income taxes	$ 1,359	$ (13)	$ 183	$ 97	$ (24)	$ 1,602

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

17. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 2% of our consolidated premiums and services revenue for the year ended December 31, 2011. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years . As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. These reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, withdrawal and maintenance expense assumptions from published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is acquired and would only change if our expected future experience deteriorated to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits. Long-term care policies provide for long-duration coverage and, therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual morbidity and mortality rates from those assumed in our reserves are particularly significant to our closed block of long-term care policies. We monitor the loss experience of these long-term care policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases and/or loss experience vary from our acquisition date assumptions, future adjustments to reserves could be required.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2011 and 2010.

	2011		2010	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 114	$ 0	$ 74	$ 0
Trade accounts payable and accrued expenses	0	(58)	0	(53)
Long-term liabilities	0	(1,663)	0	(1,493)
Total asset (liability)	$ 114	$ (1,721)	$ 74	$ (1,546)

In addition, future policy benefits payable include amounts of $224 million at December 31, 2011 and $229 million at December 31, 2010 which are subject to 100% coinsurance agreements as more fully described in Note 18.

Benefit expense associated with future policy benefits payable was $127 million in 2011, $306 million in 2010, and $73 million in 2009. Benefit expense for 2010 included a net charge of $139 million associated with our long-term care policies discussed further below. Amortization of deferred acquisition costs included in operating costs was $34 million in 2011, $198 million in 2010, and $52 million in 2009. Amortization expense for 2010 included a write-down of deferred acquisition costs of $147 million discussed further below.

Future policy benefits payable include $938 million at December 31, 2011 and $825 million at December 31, 2010 associated with a closed block of long-term care policies acquired in connection with the November 30, 2007 acquisition of KMG . During the fourth quarter of 2010, certain states approved premium rate increases for a large portion of our long-term care block that were significantly below our acquisition date assumptions. Based on these actions by the states, combined with lower interest rates and higher actual expenses as compared to acquisition date assumptions, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our long-term care policies were not adequate to provide for future policy benefits under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during the fourth quarter of 2010 we recorded $139 million of additional benefit expense, with a corresponding increase in future policy benefits payable of $170 million partially offset by a related reinsurance recoverable of $31 million included in other long-term assets.

Deferred acquisition costs included $54 million and $36 million associated with our individual commercial medical policies at December 31, 2011 and December 31, 2010, respectively. Future policy benefits payable associated with our individual commercial medical policies were $233 million at December 31, 2011 and $180 million at December 31, 2010. In light of the Health Insurance Reform Legislation, including mandating that 80% of premiums revenue be expended on medical costs for individual commercial medical policies beginning in 2011, we completed a deferred acquisition cost recoverability analysis for our individual commercial medical policies during 2010. Our recoverability test indicated that a substantial portion of unamortized deferred acquisition costs associated with the individual commercial medical block of business were not recoverable from future income. As a result, during 2010 we recorded a write-down of deferred acquisition costs of $147 million with a corresponding charge to operating costs.

18. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, 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 that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Reinsurance recoverables, included in other long-term assets, were $436 million at December 31, 2011 and $421 million at December 31, 2010. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 51% at December 31, 2011 and approximately 54% at December 31, 2010. Premiums ceded were $34 million in 2011, $34 million in 2010 and $33 million in 2009.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2011 presented below:

Reinsurer	Total Recoverable (in millions)	A.M. Best Rating at December 31, 2011
Protective Life Insurance Company	$ 198	A+ (superior)
All others	238	A++ to B++ (superior to good)
	$ 436	

The all other category represents approximately 20 reinsurers with individual balances less than $70 million. Two of these reinsurers have placed $25 million of cash and securities in trusts, an amount at least equal to the recoverable from the reinsurer.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Humana Inc.:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of comprehensive income, of stockholders' equity and of cash flows, present fairly, in all material respects, the financial position of Humana Inc. and its subsidiaries ("Company") at December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the accompanying index appearing under Item 15(a)(2) present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, 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 these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. 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.

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.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 24, 2012

Humana Inc .
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2011 and 2010 follows:

	2011			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$9,191	$ 9,284	$ 9,301	$9,056
Income before income taxes	497	726	699	313
Net income	315	460	445	199
Basic earnings per common share	1.88	2.76	2.71	1.22
Diluted earnings per common share	1.86	2.71	2.67	1.20

	2010			
	First	Second (1)	Third	Fourth (2)
	(in millions, except per share results)			
Total revenues	$ 8,380	$8,589	$8,351	$8,276
Income before income taxes	417	536	622	174
Net income	259	340	393	107
Basic earnings per common share	1.54	2.02	2.35	0.64
Diluted earnings per common share	1.52	2.00	2.32	0.63

(1) Includes an expense of $147 million ($93 million after tax, or $0.55 per diluted common share) for the write-down of deferred acquisition costs associated with our individual commercial medical policies as more fully described in Note 17 to the consolidated financial statements.

(2) Includes an expense of $139 million ($88 million after tax, or $0.52 per diluted common share) associated with reserve strengthening for our closed block of long-term care policies acquired in connection with the 2007 acquisition of KMG America Corporation as more fully described in Note 17 to the consolidated financial statements.

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 Business Ethics Policy. 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, 2011, 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, 2011. 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*. Based on our assessment, we determined that, as of December 31, 2011, 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, 2011 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 page 127.

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, 2011 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Michael B. McCallister
Chairman and Chief Executive Officer

James H. Bloem
Senior Vice President, Chief Financial Officer and Treasurer

Steven E. McCulley
Vice President and Controller, Principal Accounting Officer

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 Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 24, 2012, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer
Michael B. McCallister	59	Chairman and Chief Executive Officer	09/89(1)
Bruce D. Broussard	49	President	12/11(2)
James E. Murray	58	Executive Vice President and Chief Operating Officer	08/90(3)
James H. Bloem	61	Senior Vice President and Chief Financial Officer and Treasurer	02/01(4)
Bonita C. Hathcock	63	Senior Vice President and Chief Human Resources Officer	05/99(5)
Paul B. Kusserow	50	Senior Vice President and Chief Strategy & Corporate Development Officer	02/09(6)
Brian P. LeClaire	51	Senior Vice President and Chief Service & Information Officer	08/11(7)
Thomas J. Liston	50	Senior Vice President – Senior Products	01/97(8)
V. Rajamannar Madabhushi	50	Senior Vice President and Chief Innovation and Marketing Officer	04/09(9)
Heidi S. Margulis	58	Senior Vice President – Public Affairs	12/95(10)
Christopher M. Todoroff	49	Senior Vice President and General Counsel	08/08(11)
Steven E. McCulley	50	Vice President and Controller (Principal Accounting Officer)	08/04(12)

(1) Mr. McCallister has served as the Chairman of the Board since August 2010, and as Chief Executive Officer and a member of the Board of Directors since February 2000. Mr. McCallister joined the Company in June 1974.

(2) Mr. Broussard was elected President in December 2011. 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.

(3) Mr. Murray currently serves as Executive Vice President and Chief Operating Officer, having held this position since December 2011. Mr. Murray has held the position of Chief Operating Officer since February 2006, and was the Chief Operating Officer – Market and Business Segment Operations from September 2002 to February 2006. Mr. Murray joined the Company in December 1989.

(4) Mr. Bloem currently serves as Senior Vice President, Chief Financial Officer and Treasurer, having held this position since July 2002. Mr. Bloem joined the Company in February 2001.

(5) Ms. Hathcock currently serves as Senior Vice President and Chief Human Resources Officer, having held this position since May 1999 when she joined the Company.

(6) Mr. Kusserow currently serves as Senior Vice President and Chief Strategy and Corporate Development Officer, having held this position since February 2009 when he joined the Company. Prior to joining the Company, Mr. Kusserow served as Managing Director of Private Equity at the Chicago-based investment firm B.C. Ziegler and Company. He also served as Managing Director and Chief Investment Officer of the Ziegler HealthVest Fund, where he focused on early-stage investments in health care services and health care IT. From 2004 to 2007, he was Managing Director of San Ysidro Capital Partners LLC, a health care services consulting and investment advisory firm.

(7) Mr. LeClaire currently serves as Senior Vice President and Chief Service and Information Officer, having held this position since August 2011. Prior to that, he served as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(8) Mr. Liston currently serves as Senior Vice President – Senior Products, having held this position since July 2008. Prior to that, Mr. Liston held the position of Senior Vice President – Strategy and Corporate Development from July 2000 to June 2008. Mr. Liston joined the Company in December 1994.

(9) Mr. Rajamannar currently serves as Senior Vice President and Chief Innovation and Marketing Officer having held this position since April 2009 when he joined the Company. Prior to joining the Company, Mr. Rajamannar had 24 years of global business management experience, including 15 years with Citigroup, the New York-based banking conglomerate. Mr. Rajamannar most recently served as Executive Vice President and Chief Marketing Officer of the Global Cards division of Citigroup. As Executive Vice President of Citigroup's Credit Cards Business from 2006 to 2008, he managed the bank's value, cash and rewards businesses, as well as the automotive and telecommunications sectors. He also headed the new product development and new payment technologies groups. From 2003 to 2005 he was Chairman and Chief Executive Officer of Diners Club North America.

(10) Ms. Margulis currently serves as Senior Vice President—Public Affairs, having held this position since January 2000. Ms. Margulis joined the Company in November 1985.

(11) Mr. Todoroff currently serves as Senior Vice President and General Counsel, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(12) Mr. McCulley currently serves as Vice President and Controller (Principal Accounting Officer), having held this position since August 2004. Prior to that, he served as Vice President and Controller from January 2001 to August 2004. Mr. McCulley joined the Company in May 1990.

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.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Ethics for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Ethics 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 Ethics 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, known as the Humana Inc. Principles of Business Ethics, which includes provisions ranging from restrictions on gifts to conflicts of interest. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Principles of Business Ethics was adopted by our Board of Directors in February 2004 as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Principles of Business Ethics is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics 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 our Internet web site 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 to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- 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. Principles of Business Ethics and any waivers thereto; and
- the Code of Ethics for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Any waivers or amendments for directors or executive officers to the Humana Inc. Principles of Business Ethics and the Code of Ethics for the Chief Executive Officer and Senior Financial Officers will be promptly displayed on our web site. Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012.

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 Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Corporate Governance—Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Corporate Governance—Committee Composition" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the captions "Corporate Governance – Organization & Compensation Committee—Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

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

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the captions "Stock Ownership Information – Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Equity Compensation Plan Information" of such Proxy Statement.

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

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 26, 2012 appearing under the caption "Audit Committee Report" of such 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 Financial Information
Schedule II	Valuation and Qualifying Accounts

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)	By-Laws of Humana Inc., as amended on January 4, 2007 (incorporated herein by reference to Exhibit 3 to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2006).
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).
(b)	First Supplemental 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 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).
(c)	Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006).
(d)	Third 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 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).
(e)	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).
(f)	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).
(g)	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 11 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.

10(a)*	1996 Stock Incentive Plan for Employees (incorporated herein by reference to Annex A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on May 9, 1996).
(b)*	1996 Stock Incentive Plan for Employees as amended in 1998 (incorporated herein by reference to Exhibit C to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on May 14, 1998).
(c)*	Humana Inc. Non-Qualified Stock Option Plan for Employees (incorporated herein by reference to Exhibit 99 to Humana Inc.'s Registration Statement on Form S-8 (Registration Statement No. 333-86801), filed on September 9, 1999).
(d)*	Form of Company's Stock Option Agreement under the 1996 Stock Incentive Plan for Employees (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Current Report on Form 8-K filed on August 26, 2004).
(e)*	Form of Company's Stock Option Agreement under the 1996 Stock Incentive Plan for Employees (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Current Report on Form 8-K filed on August 26, 2004).
(f)*	Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(g)*	Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(g) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(h)*	Humana Inc. Amended and Restated 2003 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 27, 2006).
(i)*	Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 1, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).
(j)*	Form of Change of Control Agreement amended on October 23, 2008 (incorporated herein by reference to Exhibit 10(n) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
(k)*	Employment Agreement, dated as of May 16, 2008, by and between Humana Inc. and Michael B. McCallister (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on May 21, 2008).
(l)*	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).
(m)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on August 28, 2008) (incorporated by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
(n)*	Severance policy as amended and restated on October 23, 2007 (incorporated herein by reference to Exhibit 10(r) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2007).

(o)*	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).
(p)*	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 17, 2011).
(q)*	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).
(r)*	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).
(s)*	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).
(t)*	Form of Company's Restricted Stock Agreement under the 1996 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(cc) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2004).
(u)*	Form of Company's Restricted Stock Agreement with Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(u) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(v)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Humana Inc.'s Current Report on Form 8-K filed December 21, 2005).
(w)*	Form of Company's Combined Option and Restricted Stock Agreement with Non-Compete/Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(w) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(x)*	Form of Company's Restricted Stock Agreement with Non-Compete/Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(x) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(y) †*	Form of Company's Restricted Stock Unit Agreement with Non-Compete/Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan.
(z)	Five-Year Credit Agreement, dated as of November 22, 2011 (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on November 28, 2011).
(aa)	Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as September 1, 2003 (incorporated herein by reference to Exhibit 10(gg) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2004).
(bb)**	Amendment of Solicitation/Modification of Contract, dated as of January 16, 2009, by and between Humana Military Healthcare Services, Inc. and the United States Department of Defense TRICARE Management Activity (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K, filed on March 3, 2009).
(cc)	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).
(dd)	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).
(ee)	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).

(ff)	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).
(gg)	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).
(hh)	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).
(ii)	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).
(jj)*	Form of Company's Restricted Stock Unit Agreement with Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(kk)*	Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Non-Qualified Stock Options without Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).
(ll) **	Amendment of Solicitation/Modification of Contract, dated as of January 6, 2011, by and between Humana Military Healthcare Services, Inc. and the United States Department of Defense TRICARE Management Activity (incorporated herein by reference to Exhibit 10(ll) to Humana Inc.'s Annual Report on Form 10-K filed on February 17, 2011).
(mm) †**	Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011.
(nn) *	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).
(oo) †*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit).
(pp) †*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit).
(qq) †*	Form of Company's Restricted Stock Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan
(rr) †*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan
(ss) *	Form of Company's Restricted Stock Agreement and Agreement not to Compete or Solicit under the Amended and Restated 2003 Stock Incentive Plan.
(tt) *	Employment Agreement, dated as of November 2, 2011, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana's Current Report on Form 8-K, filed on November 4, 2011).
12 †	Computation of ratio of earnings to fixed charges.
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.INS†	XBRL Instance Document
101.SCH†	XBRL Taxonomy Extension Schema Document
101.CAL†	XBRL Taxonomy Calculation Linkbase Document
101.DEF†	XBRL Taxonomy Definition Linkbase Document
101.LAB†	XBRL Taxonomy Label Linkbase Document
101.PRE†	XBRL Taxonomy Presentation Linkbase Document

* Exhibits 10(a) through and including 10(y), 10(jj), 10(kk) and 10(nn) through and including 10(ss) are compensatory plans or management contracts.

** Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, 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.

Attached as Exhibit 101 to this report are the following documents formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2010 and 2011; (ii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2009, 2010 and 2011; (iii) the Consolidated Statements of Cash Flows for the years ended December 31, 2009, 2010 and 2011; and (iv) Notes to Consolidated Financial Statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2011	2010
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 187	$ 314
Investment securities	307	239
Receivable from operating subsidiaries	572	494
Other current assets	75	56
Total current assets	1,141	1,103
Property and equipment, net	543	479
Investments in subsidiaries	9,971	8,759
Other long-term assets	55	36
Total assets	$11,710	$10,377
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 1,364	$ 1,241
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	44	65
Other current liabilities	400	366
Total current liabilities	1,836	1,700
Long-term debt	1,623	1,633
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	179	111
Total liabilities	3,647	3,453
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	0	0
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 193,230,310 shares issued in 2011 and 190,244,741 shares issued in 2010	32	32
Capital in excess of par value	1,938	1,737
Retained earnings	6,825	5,529
Accumulated other comprehensive income	303	120
Treasury stock, at cost, 29,225,996 shares in 2011 and 21,795,051 shares in 2010	(1,035)	(494)
Total stockholders' equity	8,063	6,924
Total liabilities and stockholders' equity	$11,710	$10,377

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,		
	2011	2010	2009
		(in millions)	
Revenues:			
Management fees charged to operating subsidiaries	$ 1,272	$1,175	$ 1,057
Investment and other income, net	8	14	4
	1,280	1,189	1,061
Expenses:			
Operating costs	1,270	956	836
Depreciation	164	166	162
Interest	107	103	104
	1,541	1,225	1,102
Loss before income taxes and equity in net earnings of subsidiaries	(261)	(36)	(41)
(Benefit) provision for income taxes	(81)	35	(44)
(Loss) income before equity in net earnings of subsidiaries	(180)	(71)	3
Equity in net earnings of subsidiaries	1,599	1,170	1,037
Net income	$ 1,419	$1,099	$ 1,040
Other comprehensive income, net of tax:			
Net unrealized investment gains, net of tax expense of $109 million in 2011, $47 million in 2010, and $131 million in 2009	$ 190	$ 82	$ 230
Less: Reclassification adjustment for net realized gains included in net income, net of tax expense of $4 million in 2011, $2 million in 2010, and $7 million in 2009	(7)	(4)	(13)
Other comprehensive income, net of tax	183	78	217
Comprehensive income	$ 1,602	$1,177	$1,257

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,		
	2011	2010	2009
		(in millions)	
Net cash provided by operating activities	$1,106	$ 1,219	$ 911
Cash flows from investing activities:			
Acquisitions	(223)	(840)	(6)
Purchases of investment securities	(632)	(633)	(597)
Proceeds from sale of investment securities	10	16	2
Maturities of investment securities	548	697	278
Purchases of property and equipment, net	(225)	(166)	(143)
Capital contributions to operating subsidiaries	(214)	(230)	(132)
Change in securities lending collateral	0	1	0
Net cash used in investing activities	(736)	(1,155)	(598)
Cash flows from financing activities:			
Repayments under credit agreement	0	0	(250)
Change in book overdraft	(21)	2	35
Change in securities lending payable	0	(1)	0
Common stock repurchases	(541)	(108)	(23)
Dividends paid	(82)	0	0
Tax benefit from stock-based compensation	15	2	5
Proceeds from stock option exercises and other	132	9	17
Net cash used in financing activities	(497)	(96)	(216)
(Decrease) increase in cash and cash equivalents	(127)	(32)	97
Cash and cash equivalents at beginning of year	314	346	249
Cash and cash equivalents at end of year	$ 187	$ 314	$ 346

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. Certain prior period amounts have been reclassified to conform to current period presentation.

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 $1.1 billion in 2011, $747 million in 2010, and $774 million in 2009.

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.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 1.11% to 6.65% and are payable in 2012 and 2014. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2011, 2010 and 2009.

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, 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.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS—(Continued)

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $4.7 billion and $4.3 billion as of December 31, 2011 and 2010, respectively, which exceeded aggregate minimum regulatory requirements. The amount of dividends that may be paid to our parent company in 2012 without prior approval by state regulatory authorities is approximately $970 million in the aggregate. This compares to dividends that were able to be paid in 2011 without prior regulatory approval of approximately $740 million.

4. ACQUISITIONS

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of acquisitions.

5. INCOME TAXES

Refer to Note 10 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of income taxes. The release of the liability for unrecognized tax benefits in 2009 as a result of settlements associated with the completion of the audit of our U.S. income tax returns for 2005 and 2006, reduced tax expense $17 million in 2009.

6. DEBT

Refer to Note 11 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 14 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and the April 2011 approval by our Board of Directors of the initiation of a quarterly cash dividend policy.

Humana Inc.

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2011, 2010, and 2009
(in millions)

	Balance at Beginning of Period	Acquired 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:						
2011	$ 52	$ 0	$ 31	$ 22	$ (20)	$ 85
2010	51	0	19	(1)	(17)	52
2009	49	0	19	2	(19)	51
Deferred tax asset valuation allowance:						
2011	(28)	0	0	0	0	(28)
2010	(30)	0	2	0	0	(28)
2009	(28)	0	(2)	0	0	(30)

(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.

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/ JAMES H. BLOEM

James H. Bloem
Senior Vice President,
Chief Financial Officer and Treasurer
(Principal Financial Officer)

Date: February 24, 2012

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/ JAMES H. BLOEM **James H. Bloem**	Senior Vice President, Chief Financial Officer and Treasurer (Principal Financial Officer)	February 24, 2012
/s/ STEVEN E. MCCULLEY **Steven E. McCulley**	Vice President and Controller (Principal Accounting Officer)	February 24, 2012
/s/ MICHAEL B. MCCALLISTER **Michael B. McCallister**	Chairman and Chief Executive Officer	February 24, 2012
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 24, 2012
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 24, 2012
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Lead Director	February 24, 2012
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 24, 2012
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 24, 2012
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 24, 2012
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 24, 2012
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 24, 2012
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 24, 2012

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
UNDER THE AMENDED AND RESTATED 2003 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of _____ (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 _____, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Amended and Restated 2003 Stock Incentive Plan (the **"Plan"**), for certain employees and non-employee Directors of the Company and its subsidiaries was approved by the Company's Board of Directors (the **"Board"**) 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 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 _____ Restricted Stock Units. Each Restricted Stock Unit represents the right of the Grantee to receive (i) one (1) Share on the date of distribution provided for in Section 1.E. In addition, the 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 the 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 and DERs shall vest in full on the earliest of (i) the third anniversary of the Date of Grant, (ii) the death or Disability of Grantee, or (iii) a Change in Control.

D. Forfeiture. Upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units have vested pursuant to Section I.C., other than a termination in the event of Grantee's Retirement, the Restricted Stock Units and DERs shall thereupon be forfeited immediately by Grantee. In the event of Grantee's Retirement, any Restricted Stock Units and DERs that have not vested as of the date of Retirement shall remain outstanding and shall vest in accordance with Section I.C., as if the Grantee were continuing to provide services to the Company or a Subsidiary, as applicable; provided, however, that the Committee may determine, in its sole discretion, that some or all of such Restricted Stock Units and DERs held by the Grantee as of the date of Retirement shall vest.

E. Distributions. The Company shall issue to Grantee (or, if applicable, the Grantee's estate or personal representative) Shares with respect to the Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, upon the earliest of (i) the date provided in Section I.C(i) hereof, (ii) the date of the occurrence of a Section 409A Change in Control (as defined below), (iii) the date of the Grantee's death or (iv) the date the Grantee is determined to be Disabled, provided that such Disability also constitutes being "disabled" within the meaning of Section 409A of the Code. 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 the 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, at the Grantee's election, 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. If, however, Grantee is eligible for Retirement (as defined in the Plan) as of the date hereof, or becomes eligible for Retirement before the vesting of this award, federal employment taxes may be required by law to be collected by the Company immediately upon grant, or immediately upon the day the Grantee becomes eligible for Retirement, as applicable.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT

A. Agreement Not To Compete. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee shall not, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, engage in business with, be employed by, or render any consultation or business advice or other services with respect to, any business which provides or offers products or services which compete with any Company Business, in any geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

B. Agreement Not To Solicit. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, shall not:

1. Interfere with the relationship of the Company and/or any of its affiliates and any of its employees, agents, representatives, consultants or advisors.

2. Divert, or attempt to cause the diversion from the Company and/or any of its affiliates, any Company Business, nor interfere with relationships of the Company and/or any of its affiliates with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers.

3. Solicit, recruit or otherwise induce or influence any employee of the Company and/or any of its affiliates to accept employment in any business which competes with the Company Business, in any of the geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

C. Definitions.

For purposes of Sections II.A and B, the following definitions apply.

1. “Company Business” shall mean any business related to a service or product offered by the Company and/or any of its affiliates during the two-year period immediately preceding the Grantee’s termination date that Grantee engaged in or rendered any consultation or business advice or other services with respect to, during Grantee’s employment with the Company and/or any of its affiliates.

2 “Geographic area” shall mean any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

D. Effect of Termination of Employment on Agreements Not to Compete and Not to Solicit .

1. In the event Grantee voluntarily resigns or is discharged by 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 and II.B shall remain in full force and effect.

2. In the event Grantee is discharged by Company other than with Cause prior to the vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect only if the Company, solely at its option, pays to Grantee an amount at least equal to Grantee’s then current annual base salary, whether such amount is paid pursuant to this provision or pursuant to any other severance or separation plan or other plan or agreement between Grantee and Company.

3. In the event Grantee is discharged by Company other than with Cause prior to vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.B 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 Change In Control on Agreements Not to Compete and Not to Solicit .

1. In the event of a Change in Control, 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 Grantee’s employment termination date with the Company or its successor, to the Grantee an amount at least equal to Grantee’s then current annual base salary, plus Grantee’s maximum potential bonus pursuant to any bonus plan in which Grantee participated as of the date of the Change in Control. Such sums shall be in addition to any other amounts paid or payable to Grantee with respect to other change in control agreements.

2. In the event of a Change in Control, the prohibitions on Grantee set forth in Section II.B. shall remain in full force and effect.

F. **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.

G. **Injunctive Relief; Invalidity of Any Provision**. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II hereof are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a 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 both 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 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, 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.

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 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 Section 4.6 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 as otherwise provided herein, 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 the 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. 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.

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.

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: _____
[Name]
[Title]

BY: _____
[Name]
[Title]

"Grantee"

_____
[Name]

***** Includes confidential material omitted and filed separately with the Commission.

AWARD/CONTRACT	1 THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 700) →	RATING DO-C9	PAGE OF PAGES 1 / 103
2. CONTRACT (PROC INST. IDENT.) NO HT9402-11-0003	3. EFFECTIVE DATE See Block 20C	4. REQUISITION/PURCHASE REQUEST/PROJECT NUMBER 11-T3S-0001	

5. ISSUED BY	CODE HT9402	6. ADMINISTERED BY (IF OTHER THAN ITEM 5)	CODE HT9402
DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY COD-A 16401 E CENTRETECH PARKWAY AURORA CO 80011-9066		DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY COD-A 16401 E CENTRETECH PARKWAY AURORA CO 80011-9066	

7. NAME AND ADDRESS OF CONTRACTOR (No. , Street, City, Country, State and ZIP Code)	8. DELIVERY ☐ FOB ORIGIN ☒ OTHER (see below)
HUMANA MILITARY HEALTHCARE SERVICES INC 500 W MAIN STREET PO BOX 740062 LOUISVILLE, KY 40202	9. DISCOUNT FOR PROMPT PAYMENT NET 30 10. SUBMIT INVOICES (4 COPIES UNLESS OTHERWISE SPECIFIED) TO THE ADDRESS SHOWN IN → ITEM
CODE 05050 FACILITY CODE	

11. SHIP TO/MARK FOR	CODE HT9402	12. PAYMENT WILL BE MADE BY	CODE HT9402
DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY COD-A 16401 E CENTRETECH PARKWAY AURORA CO 80011-9066		DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY COD-A 16401 E CENTRETECH PARKWAY AURORA CO 80011-9066	

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION: ☐ 10 U.S.C. 2304 (c) ( ) ☐ 41 U.S.C. 253 (c) ( )	14. ACCOUNTING AND APPROPRIATION DATA SEE SCHEDULE

15A. ITEM NO	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	CONTINUED				
				15G. TOTAL AMOUNT OF CONTRACT →	*****

16. TABLE OF CONTENTS

(X)	SEC.	DESCRIPTION	PAGE(S)	(X)	SEC.	DESCRIPTION	PAGE(S)
		PART I – THE SCHEDULE				PART II – CONTRACT CLAUSES	
X	A	SOLICITATION/CONTRACT FORM	1	X	I	CONTRACT CLAUSES	85-102
X	B	SUPPLIES OR SERVICES AND PRICES/COSTS	2-24			PART III – LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACH.	
X	C	DESCRIPTION/SPECS/WORK STATEMENT	25-37	X	J	LIST OF ATTACHMENTS	103
X	D	PACKAGING AND MARKING	38			PART IV – REPRESENTATIONS AND INSTRUCTIONS	
X	E	INSPECTION AND ACCEPTANCE	39		K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	
X	F	DELIVERIES OR PERFORMANCE	40-45				
X	G	CONTRACT ADMINISTRATION DATA	46-59		L	INSTRS., CONDS., AND NOTICES TO OFFERORS	
X	H	SPECIAL CONTRACT REQUIREMENTS	60-84		M	EVALUATION FACTORS FOR AWARD	

CONCTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. ☒ CONTRACTOR'S NEGOTIATED AGREEMENT *(Contractor is required to sign this document and return __1__ copies to issuing office.)* Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract. (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)	18. ☐ AWARD *(Contractor is not required to sign this document.)* Your offer on Solicitation Number _____, including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any condition sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.
19A. NAME AND TITLE OF SIGNER (Type or print) David J. Baker, President & CEO	20A. NAME OF CONTRACTING OFFICER Andrew C. Obermeyer 303.676.3839 *****
19B. NAME OF CONTRACTOR BY /s/ David J. Baker (SIGNATURE OF PERSON AUTHORIZED TO SIGN)	19C. DATE SIGNED 3-2-11
20B. UNITED STATES OF AMERICA BY /s/ Andrew C. Obermeyer (SIGNATURE OF THE Contracting Officer)	20C. DATE SIGNED 3 Mar 11

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STANDARD FORM 26 (Rev. 4/2008)
Prescribed by GSA
FAR (48 CFR) 53.214 (a)

CONFIDENTIAL TREATMENT REQUESTED.
Confidential portions of this document have been redacted and have been filed separately with the Commission.

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Duns Number 805349198 **Base Period CLIN 001**				
001	**Transition In** **Obligated Amount: ***** **Accounting Info:** **9711110130.1889.102000 (FY11)** **Funded: ***** **OPTION PERIOD 1**				*****
1001	**Underwritten Health Care Cost for Contractor Network Prime Enrollees** **(Cost plus fixed fee)** **(Estimated Cost)** **Informational SLINs to identify multiple Accounting classifications:**				*****
100101	**FY12** **(Qty:0 and Amt: $0.00)**				
100102	**FY13** **(Qty:0 and Amt: $0.00)**				
1002	**Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees** **(Cost plus fixed fee)** **(Estimated Cost)** **Informational SLINs to Identify multiple Accounting classifications:**				*****
100201	**FY12** **(Qty:0 and Amt: $0.00)**				
100202	**FY13** **Continued…**				

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Qty: 0 and Amt: $0.00)				
1003	**Fixed Fee for CLIN 1001** **(Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple Accounting classifications:				
100301	**FY12** **(Qty: 0 and Amt: $0.00)**				
100302	**FY13** **(Qty: 0 and Amt: $0.00)**				
1004	**Fixed Fee for CLIN 1002** **(Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple Accounting classifications:				
100401	**FY12** **(Qty: 0 and Amt: $0.00)**				
100402	**FY13** **(Qty: 0 and Amt: $0.00)**				
1005	**Disease Management Cost** **(Cost plus fixed Fee)** **(Estimated Cost)**				*********
	Informational SLINs to identify multiple Accounting classifications:				
100501	**FY12** **(Qty: 0 and Amt: $0.00)**				
100502	**FY13** **(Qty: 0 and Amt: $0.00)**				

ITEM NO (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
1006	Fixed Fee for CLIN 1005 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple Accounting classifications:				
100601	FY12 (Qty: 0 and Amt: $0.00)				
100602	FY13 (Qty: 0 and Amt: $0.00)				
1007	Electronic Claims Processing (Fixed Price) (Estimated Quantity)	20015000	EA	*****	*****
100701	FY12 (Qty: 0 and Amt: $0.00)				
100702	FY13 (Qty: 0 and Amt: $0.00)				
1008	Paper Claims Processing (Fixed Price) (Estimated Quantity)	3639000	EA	*****	*****
100801	FY12 (Qty: 0 and Amt: $0.00)				
100802	FY13 (Qty: 0 and Amt: $0.00)				
1009	Per Member Per Month (Fixed Price)				

Continued…

ITEM NO (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
1009AA	Per Member Per Month (Estimated Quantity) First Biannual Period	18359415	EA	*****	*****
	Accounting Info: Funded: $0.00				
1009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period	18359415	EA	*****	*****
	Accounting Info: Funded: $0.00				
1010	TRICARE Service Centers (Firm fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple Accounting classifications:				
101001	FY12 (Qty: 0 and Amt: $0.00)				
101002	FY13 (Qty: 0 and Amt: $0.00)				
	Award Fee Pool Not Separately Priced				
1011	Award Fee Pool First Biannual Period				*****
	Accounting Info: Funded: $ 0.00				
1011AA	Award Fee Pool Second Biannual Period				*****
1011AB	Accounting Info: Funded: $ 0.00				

Continued…

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
1012	**Performance Incentive Pool for H.2. and H.3.**				*****
	Informational SLINs to identify multiple Accounting classifications:				
101201	**FY12 (Qty: 0 and Amt: $0.00)**				
101202	**FY13 (Qty: 0 and Amt: $0.00)**				
1013	**Reports, Contract Data Requirements List (DD Form 1423) Not Separately Priced**				
1014	**Clinical Support Agreement Program**				
1015	**Service Assist Teams (Time and Material)**				
	Labor Rates – SECT J, EXHIBIT A				
	OPTION PERIOD 2				
2001	**Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost)**				*****
	Informational SLINs to identify multiple Accounting classifications:				
200101	**FY13 (Qty: 0 and Amt: $0.00)**				

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
200102	**FY14** **(Qty:0 and Amt: $0.00)**				
2002	**Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees** **(Cost plus fixed fee)** **(Estimated Cost)**				*********
	Informational SLINs to identify multiple Accounting classifications:				
200201	**FY13** **(Qty:0 and Amt: $0.00)**				
200202	**FY14** **(Qty:0 and Amt: $0.00)**				
2003	**Fixed Fee for CLIN 2001** **(Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple Accounting classifications:				
200301	**FY13** **(Qty:0 and Amt: $0.00)**				
200302	**FY14** **(Qty:0 and Amt: $0.00)**				
2004	**Fixed Fee for CLIN 2002** **(Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple Accounting classifications:				
200401	**FY13** **(Qty:0 and Amt: $0.00)**				

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
200402	**FY14** **(Qty: 0 and Amt: $0.00)**				
2005	**Disease Management Cost** **(Cost plus fixed fee)** **(Estimated Cost)**				*********
	Informational SLINS to identify multiple accounting classifications:				
200501	**FY13** **(Qty:0 and Amt: $0.00)**				
200502	**FY14** **(Qty:0 and Amt: $0.00)**				
2006	**Fixed Fee for CLIN 2005** **(Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple Accounting classifications:				
200601	**FY13** **(Qty:0 and Amt: $0.00)**				
200602	**FY14** **(Qty:0 and Amt: $0.00)**				
2007	**Electronic Claims Processing** **(Fixed Price)** **(Estimated Quantity)**	**21815000**	**EA**	*********	*********
200701	**FY13** **(Qty:0 and Amt: $0.00)**				
200702	**FY14** **(Qty:0 and Amt: $0.00)**				

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2008	**Paper Claims Processing** **(Fixed Price)** **(Estimated Quantity)**	**3595000**	**EA**	*********	*********
200801	**FY13** **(Qty:0 and Amt: $0.00)**				
200802	**FY14** **(Qty:0 and Amt: $0.00)**				
2009	**Per Member Per Month** **(Fixed Price)**				
2009AA	**Per Member Per Month** **(Estimated Quantity)** **First Biannual Period**	**18351064**	**EA**	*********	*********
	Account Info: **Funded: $0.00**				
2009AB	**Per Member Per Month** **(Estimated Quantity)** **Second Biannual Period**	**18351064**	**EA**	*********	*********
	Account Info: **Funded: $0.00**				
2010	**TRICARE Service Centers** **(Firm Fixed Price)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple accounting classifications				
201001	**FY13** **(Qty:0 and Amt: $0.00)**				
201002	**FY14** **(Qty:0 and Amt: $0.00)**				

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

CONTINUATION SHEET	REFERENCE NO. OF DOCUMENT BEING CONTINUED HT9402-11-C-0003	PAGE of 10 / 103

NAME OF OFFEROR OR CONTRACTOR
HUMANA MILITARY HEALTHCARE SERVICES INC

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2011	**Award Fee Pool** **Not Separately Priced**				
2011AA	**Award Fee Pool** **First Biannual Period**				*********
	Accounting Info: **Funded $0.00**				
2011AB	**Award Fee Pool** **Second Biannual Period**				*********
	Accounting Info: **Funded $0.00**				
2012	**Performance Incentive Pool for H.2. and H.3.**				*********
	Informational SLINs to identify multiple accounting classifications:				
201201	**FY13** **(Qty: 0 and Amt: $0.00)**				
201202	**FY14** **(Qty:0 and Amt: $0.00)**				
2013	**Reports, Contract Data Requirements List (DD form 1423)** **Not Separately Priced**				
2014	**Clinical Support Agreement Program**				
2015	**Service Assist Team** **(Time and Material)**				
	Labor Rates – SECT J, EXHIBIT A				
	Continued …				

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	OPTION PERIOD 3				
3001	**Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost)**				*********
	Informational SLINs to identify multiple accounting classification				
300101	**FY14 (Qty:0 and Amt: $0.00)**				
300102	**FY15 (Qty: 0 and Amt: $0.00)**				
3002	**Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus Fixed) (Estimated Cost)**				*********
	Informational SLINs to identify multiple accounting classifications:				
300201	**FY14 (Qty:0 and Amt: $0.00)**				
300202	**FY15 (Qty: 0 and Amt: $0.00)**				
3003	**Fixed Fee for CLIN 3001 (Cost plus fixed fee)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple accounting classifications:				

Continued …

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
300301	FY14 (Qty:0 and Amt: $0.00)				
300302	FY15 (Qty: 0 and Amt: $0.00)				
3004	Fixed Fee for CLIN 3002 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
300401	FY14 (Qty:0 and Amt: $0.00)				
300402	FY15 (Qty: 0 and Amt: $0.00)				
3005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost)				*****
	Informational SLINs to identify multiple accounting classifications:				
300501	FY14 (Qty:0 and Amt: $0.00)				
300502	FY15 (Qty: 0 and Amt: $0.00)				
3006	Fixed Fee for CLIN 3005 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
300601	FY14				

Continued…

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Qty:0 and Amt: $0.00)				
300602	**FY15** **(Qty:0 and Amt: $0.00)**				
3007	**Electronic Claims Processing** **(Fixed Price)** **(Estimated Quantity)**	**23774000**	**EA**	*****	*****
300701	**FY14** **(Qty:0 and Amt: $0.00)**				
300702	**FY15** **(Qty: 0 and Amt: $0.00)**				
3008	**Paper Claims Processing** **(Fixed Price)** **(Estimated Quantity)**	**3522000**	**EA**	*****	*****
300801	**FY14** **(Qty:0 and Amt: $0.00)**				
300802	**FY15** **(Qty: 0 and Amt: $0.00)**				
3009	**Per member Per Month** **(Fixed Price)**				
3009AA	**Per Member Per Month** **(Estimated Quantity)** **First Biannual Period**	**18335511**	**EA**	*****	*****
	Accounting Info: **Funded: $0.00**				
3009AB	**Per Member Per Month** **(Estimated Quantity)** **Second Biannual Period**	**18335511**	**EA**	*****	*****

Continued

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: **Funded: $0.00**				
3010	**TRICARE Service Centers** **(Firm fixed price)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple accounting classification				
301001	**FY14** **(Qty:0 and Amt: $0.00)**				
301002	**FY15** **(Qty: 0 and Amt: $0.00)**				
3011	**Award Fee Pool** **Not Separately Priced**				
3011AA	**Award Fee Pool** **First Biannual Period**				*********
	Accounting Info: **Funded: $0.00**				
3011AB	**Award Fee Pool** **Second Biannual Period**				*********
	Accounting Info: **Funded: $0.00**				
3012	**Performance Incentive Pool for H.2. and H.3.**				*********
	Informational SLINs to identify multiple accounting classifications:				
301201	**FY14** **(Qty:0 and Amt: $0.00)**				

Continued …

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
301202	**FY15** **(Qty:0 and Amt: $0.00)**				
3013	**Reports, Contract Data Requirements List (DD Form 1423)** **Not Separately Priced**				
3014	**Clinical Support Agreement Program**				
3015	**Service Assist Teams** **(Time and Material)**				
	Labor Rates – SECT J, EXHIBIT A				
	Option Period 4				
4001	**Underwritten health Care Cost for Contractor Network Prime Enrollees** **(Cost Plus Fixed fee)** **(Estimated Cost)**				*****
	Informational SLINs to identify multiple accounting classifications:				
400101	**FY15** **(Qty:0 and AMT $0.00)**				
400102	**FY16** **(Qty:0 and Amt: $0.00)**				
4002	**Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees** **(Cost plus fixed fee)** **(Estimated Cost)**				*****
	Informational SLINs to identify multiple accounting classifications:				

Continued…

ITEM NO (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
400201	FY15 (Qty:0 and AMT $0.00)				
400202	FY16 (Qty:0 and Amt: $0.00)				
4003	Fixed Fee for CLIN 4001 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
400301	FY15 (Qty:0 and AMT $0.00)				
400302	FY16 (Qty:0 and Amt: $0.00)				
4004	Fixed Fee for CLIN 4002 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
400401	FY15 (Qty:0 and AMT $0.00)				
400402	FY16 (Qty:0 and Amt: $0.00)				
4005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost)				*****
	Informational SLINs to identify multiple accounting classifications:				

Continued…

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
400501	FY15 (Qty:0 and AMT $0.00)				
400502	FY16 (Qty:0 and Amt: $0.00)				
4006	Fixed Fee for CLIN 4005 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
400601	FY15 (Qty:0 and AMT $0.00)				
400602	FY16 (Qty:0 and Amt: $0.00)				
4007	Electronic Claims Processing (Fixed Price) (Estimated Quantity)	25906000	EA	*****	*****
400701	FY15 (Qty:0 and AMT $0.00)				
400702	FY16 (Qty:0 and Amt: $0.00)				
4008	Paper Claims Processing (Fixed Price) (Estimated Quantity)	3416000	EA	*****	*****
400801	FY15 (Qty:0 and AMT $0.00)				

Continued

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
400802	**FY16** **(Qty:0 and Amt: $0.00)**				
4009	**Per Member Per Month** **(Fixed Price)**				
4009AA	**Per Member Per Month** **(Estimated Quantity)** **First Biannual Period**	**18321657**	**EA**	*****	*****
	Accounting Info: **Funded: $0.00**				
4009AB	**Per Member Per Month** **(Estimated Quantity)** **Second Biannual Period**	**18321657**	**EA**	*****	*****
	Accounting Info: **Funded: $0.00**				
4010	**TRICARE Service Centers** **(Firm fixed price)**	**12**	**MO**	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
401001	**FY15** **(Qty:0 and Amt: $0.00)**				
401002	**FY16** **(Qty: 0 and Amt: $0.00)**				
4011	**Award Fee Pool** **Not Separately Priced**				
4011AA	**Award Fee Pool** **First Biannual Period**				*****
	Accounting Info: **Funded $0.00**				

Continued…

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
4011AB	**Award Fee Pool** **Second Biannual Period**				*****
	Accounting Info: **Funded: $0.00**				
4012	**Performance Incentive Pool for H.2 and H.3.**				*****
	Informational SLINs to identify multiple accounting classifications:				
401201	**FY15** **(Qty:0 and Amt: $0.00)**				
401202	**FY16** **(Qty: 0 and Amt: $0.00)**				
4013	**Reports, Contract Data Requirements List (DD Form 1423)** **Not Separately Priced**				
4014	**Clinical Support Agreement Program**				
4015	**Service Assist Teams** **(Time and Materials)**				
	Labor Rates – SECT J, EXHIBIT A				
	OPTION PERIOD 5				
5001	**Underwritten Health Care Cost for Contractor Network Prime Enrollees** **(Cost plus fixed fee)** **(Estimated Cost)**				*****
	Informational SLINs to identify multiple accounting classifications:				
	Continued…				

ITEM NO (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
500101	FY16 (Qty:0 and Amt: $0.00)				
500102	FY17 (Qty:0 and Amt: $0.00)				
5002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries (Cost plus fixed fee) (Estimated Cost)				*****
	Informational SLINs to identify multiple accounting classifications:				
500201	FY16 (Qty:0 and Amt: $0.00)				
500202	FY17 (Qty:0 and Amt: $0.00)				
5003	Fixed Fee for CLIN 5001 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple accounting classifications:				
500301	FY16 (Qty:0 and Amt: $0.00)				
500302	FY17 (Qty:0 and Amt: $0.00)				
5004	Fixed Fee for CLIN 5002 (Cost plus fixed fee)	12	MO	*****	*****
	Informational SLINs to identify multiple				

Continued…

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	accounting classifications:				
500401	**FY16** **(Qty:0 and Amt: $0.00)**				
500402	**FY17** **(Qty:0 and Amt: $0.00)**				
5005	**Disease Management Cost** **(Cost plus fixed fee)** **(Estimated Cost)**				*****
500501	**Informational SLINs to identify multiple accounting classifications:**				
500502	**FY16** **(Qty:0 and Amt: $0.00)**				
5006	**FY17** **(Qty:0 and Amt: $0.00)**				
500601	**Fixed Fee for CLIN 5005** **(Cost plus fixed fee)**	**12**	**MO**	*****	*****
500602	**Informational SLINs to identify multiple accounting classifications:**				
5007	**FY16** **(Qty:0 and Amt: $0.00)**				
	FY17 **(Qty:0 and Amt: $0.00)**				
	Electronic Claims Processing **(Fixed Price)** **(Estimated Quantity)**	**28027000**	**EA**	*****	*****

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

ITEM NO A	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
500701	**FY16** **(Qty:0 and Amt: $0.00)**				
500702	**FY17** **(Qty:0 and Amt: $0.00)**				
5008	**Paper Claims Processing** **(Fixed Price)** **(Estimated Quantity)**	**3472000**	**EA**	*********	*********
500801	**FY16** **(Qty:0 and Amt: $0.00)**				
500802	**FY17** **(Qty:0 and Amt: $0.00)**				
5009	**Per Member Per Month** **(Fixed Price)**				
5009AA	**Per Member Per Month** **(Estimated Quantity)** **First Biannual Period**	**18315880**	**EA**	*********	*********
	Accounting Info: **Funded: $0.00**				
5009AB	**Per Member Per Month** **(Estimated Quantity)** **Second Biannual Period**	**18315880**	**EA**	*********	*********
	Accounting Info: **Funded: $0.00**				
5010	**TRICARE Service Centers** **(Firm fixed price)**	**12**	**MO**	*********	*********
	Informational SLINs to identify multiple accounting classifications:				

Continued…

ITEM NO	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
501001	FY16 (Qty:0 and Amt: $0.00)				
501002	FY17 (Qty:0 and Amt: $0.00)				
5011	Award Fee Pool Not Separately Priced				
5011AA	Award Fee Pool First Biannual Period				*****
	Accounting Info: Funded $0.00				
5011AB	Award Fee Pool Second Biannual Period				*****
	Accounting Info: Funded $0.00				
5012	Performance Incentive Pool for H.2. and H.3.				*****
	Informational SLINs to identify multiple accounting classifications:				
501201	FY16 (Qty:0 and Amt: $0.00)				
501202	FY17 (Qty:0 and Amt: $0.00)				
5013	Reports, Contract Data Requirements List (DD Form 1423) Not Separately Priced				
5014	Clinical Support Agreement Program				

Continued…

******* Includes confidential material omitted and filed separately with the Commission.**

CONTINUATION SHEET	REFERENCE NO. OF DOCUMENT BEING CONTINUED HT9402-11-C-0003	PAGE of 24 / 103

NAME OF OFFEROR OR CONTRACTOR
HUMANA MILITARY HEALTHCARE SERVICES INC

ITEM NO	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5015	**Service Assist Teams** **(Time and Material)**				
	Labor Rates – SECT J, EXHIBIT A				
9001	**Transition Out** **(Cost Plus Fixed Fee)** **Option Periods 1-5 (As needed)**				*********
	Accounting Info: **Funded: $0.00**				
9002	**Fixed Fee for CLIN 9001** **(Cost Plus Fixed Fee)**				*********
	Accounting Info: **Funded: $0.00**				

Section C—Description/Specifications/Work Statement

1.0 GENERAL. Section C includes two categories of outcome based statements: Objectives and Technical Requirements. The "Objectives" represent the outcomes for this contract and are supported by technical requirements. These requirements represent specific tasks, outcomes, and/or standards that, at a minimum, shall be achieved. The purpose of this contract is to provide Managed Care Support (MCS) to the Department of Defense (DoD) TRICARE program. The MCS Contractor shall assist the Military Health System in operating an integrated health care delivery system combining resources of the military's direct medical care system and the Contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

2.0 DOCUMENTS. The following documents, including the changes identified below, are hereby incorporated by reference and made a part of the contract.

These documents form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text.

Title 10, United States Code, Chapter 55
32 Code of Federal Regulations, Part 199

TRICARE Policy Manual (TPM) 6010.57-M dated February 1, 2008 with change 4.
TRICARE Reimbursement Manual (TRM) 6010.58-M dated February 1, 2008 with change 4.
TRICARE Systems Manual (TSM) 7950.2-M dated February 1, 2008 with change 4.
TRICARE Operations Manual (TOM) 6010.56-M dated February 1, 2008 with change 4.

The TRICARE Manuals provide instruction, guidance and responsibilities in addition to the requirements set forth in the incorporated federal statutes and regulations and may not be interpreted in contradiction thereto. Among the Manuals the TRICARE Policy Manual takes precedence over the other three TRICARE Manuals. The TRICARE Reimbursement Manual takes precedence over the TRICARE Systems Manual and the TRICARE Operations Manual. The TRICARE Systems Manual takes precedence over the TRICARE Operations Manual.

3.0 DEFINITIONS. Definitions are included in the TRICARE Operations Manual, Appendix B.

4.0 GOVERNMENT FURNISHED PROPERTY. At certain Military Treatment Facilities (MTFs), facilities and Government Furnished Equipment may be provided for the TRICARE Service Center (TSC). FAR 52.245-1, Government Furnished Property (GFP) describes the Contractor's management responsibilities and use of GFP. The GFP is provided in an "as-is" condition and subject to terms discussed in the referenced FAR clause. The GFP inventory will be identified in the MTF/Regional Director MOU prepared by the Contractor during the transition phase of the contract.

5.0 OBJECTIVES. The following are the objectives of this contract.

Objective 1—In partnership with the Military Health System (MHS), optimize the delivery of health care services in the direct care system (see the definition of Military Treatment Facility Optimization in the TRICARE Operations Manual, Appendix B) for all MRS beneficiaries (active duty personnel, MTF enrollees, civilian network enrollees, and non-enrollees).

Objective 2—Beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiaries must be completely satisfied with each and every service provided by the Contractor during each and every contact.

Objective 3—Attain "best value health care" (See TRICARE Operations Manual, Appendix B) services in support of the MRS mission utilizing commercial practices when practical.

Objective 4—Fully operational services and systems at the start of health care delivery and minimal disruption to beneficiaries and MTFs.

Objective 5—Full and real time access to Contractor maintained data to support the DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

6.0 REQUIREMENTS. The Contractor must fulfill the following requirements, which are supplemented via the documents incorporated at paragraph 2.0.

PROVIDER NETWORKS

N.1. The Contractor shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers which supplements the clinical services provided to MHS beneficiaries in MTFs and promotes access, quality, beneficiary satisfaction, and "best value health care" for the Government. (See the TOM, Appendix B for the definition of "best value health care.") The network, or networks, shall be sufficient in number, mix, and geographic distribution of fully qualified providers to provide the full scope of benefits for which all Prime enrollees are eligible under this contract, as described in 32 CFR 199.4, 199.5, and 199. I 7. The Contractor shall provide copies of network provider agreements when requested by the Contracting Officer or Contracting Officer's Representative (COR).

N.2. The Contractor shall establish provider networks for the delivery of Prime and Extra services to ensure that all access standards (see 32 CFR I99.17(p)(5)) are met at the start of health care delivery and continuously maintained in all Prime Service Areas (PSAs) in the region. PSAs (i.e., areas in which the Contractor offers enrollment in TRICARE Prime in compliance with the travel time access standard) shall encompass the entire area of all the zip codes lying within or intersected by the 40 mile radius around MTFs (both hospitals and clinics) and Base Realignment and Closure (BRAC) sites. For BRAC sites, the 40 mile radius shall be determined based on the former location of the MTF, if known. If the former MTF location is not known, the 40 mile radius shall be determined from the geographic center of the BRAC site zip code as of the date of contract award. The Contractor must provide PSAs at all MTF locations as listed in Attachment J- I, Government Required MTF Prime Service Areas, and at all sites listed in Attachment J-2, Government Required BRAC Site Prime Service Areas. The Contractor may propose additional or expanded PSAs. If necessary, to ensure provision of specialty medical services, the Contractor may establish specialty networks outside the PSA. Using the ESRI ArcView 9.2 mapping software program, or a mapping program producing results that can be electronically exported to the ESRI ArcView 9.2 mapping software for display, the Contractor shall identify a one-hour travel time contour around each MTF listed in Attachment I . The MTF will have right of first refusal for provision of specialty care to TRICARE Prime enrollees who reside within the contour. All network providers must be Medicare participating providers unless they are not eligible to be participating providers under Medicare. The network must include providers in sufficient quantity and diversity to meet the access standards of 32 CFR 199.17(p)(5) for the MHS Medicare population residing in the Prime Service Area.

N.3. The Contractor's network and utilization management, and case management programs shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery and be maintained in all geographic areas covered by this contract and shall be maintained throughout the contract and all exercised options. When this contract and the accrediting body have differing standards for the same activity, the higher standard shall apply.

N.4. Network inadequacy is defined as any failure to provide health care services within the network within the access standards and one of the measures for network adequacy will be the percentage of claims submitted by network providers after excluding claims for emergency room, Point of Service, out-of-region, and Other Health Insurance. After assisting the beneficiary with accessing the needed care within access standards, the Contractor shall inform the Government in a monthly report of any instances of network inadequacy relative to the Prime and/or Extra service areas (see Section F). The Contractor will submit a corrective action plan for instances of network inadequacy that are significant (ex., the only specialist in a certain specialty leaves the network, a major hospital or system leaves the network) and/or any inadequacy that is likely to persist more than 30 days. The Contractor shall respond to any inquiries of the Government concerning any aspect of network inadequacy from a Contracting Officer, or a COR. The response shall be accomplished within two business days from receipt of a request.

N.4.1. The Contractor shall ensure that the following minimum percentages of numbers of claims for Prime enrollees region-wide are from network providers, (excluding claims for emergency room, Point of Service, out-of region, and Other Health Insurance and TRICARE Prime Remote members). The percent for the number of claims from network providers will increase ***** each option period. For example, the South Option Period 1 standard of ***** shall be increased by one percentage point to ***** for Option Period 2.

	Option Period I
South	*****

N.5. The Contractor shall adjust provider networks and services as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including those resulting from short-notice unanticipated facility expansion, MTF provider deployment, downsizing and/or closures. Changes in MTF capabilities and capacities may occur frequently over the life of the contract without prior notice. The Contractor shall ensure that all eligible beneficiaries who live in PSAs have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless of such changes. The Contractor shall ensure that MTF enrollees residing outside PSAs have the opportunity to add additional family members or remain enrolled in the Prime program regardless of such changes.

N.6. To coincide with the beginning of Option Period I, the Government will automatically disenroll any enrolled beneficiary residing outside a T-3 PSA. The Contractor shall ensure the network has the capability and capacity to permit each beneficiary enrolled in Prime to a civilian Primary Care Manager (PCM) prior to the beginning of Option Period 1 and residing outside of PSAs under this contract to enroll to a PSA PCM at the beginning of Option Period I, provided the beneficiary resides less than 100 miles from an available network primary care manager in the PSA, submits a new request for enrollment, and waives both primary and specialty care travel time standards. Beneficiaries enrolled in Prime to a civilian PCM prior to the beginning of Option Period 1 who reside outside of PSAs under this contract and are 100 miles or more from an available PCM in the PSA network shall not be granted a new enrollment. The Contractor shall refund the unused portion (based on a monthly proration) of either a quarterly or annual enrollment fee payment for any beneficiary who must be disenrolled because they reside outside a PSA at the start of Option Period I. If a beneficiary pays on a monthly basis, no monthly payment(s) shall be received for these beneficiaries.

N.7. The Contractor will not be required to establish a network with the capability and capacity to grant new enrollments to beneficiaries who reside outside a PSA. The Contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network primary care manager to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

N.8. The Contractor shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17(p)(S) are met for beneficiaries residing in TRICARE PSAs. These standards shall be met in a manner which achieves beneficiary satisfaction with access to network providers and services as set forth in the contract. The Contractor shall define metrics, and collect data about them, that give insight to the degree to which the access standards are being met.

N.9. The Contractor shall have an active provider education program designed to enhance the provider's awareness of TRICARE requirements, to include emphasis on achieving the leading health care indicators of Healthy People program, and encourage participation in the program.

N.10. The Contractor shall inform network providers, through network provider agreements, that they agree to being reported to the Department of Veterans Affairs (VA) as a TRICARE network provider. The Contractor shall request non-institutional network providers to accept requests from VA to provide care to veterans. The agreement will give VA the right to directly contact the provider and request that he/she provide care to VA patients on a case by case

basis. The Contractor shall require network providers (individual, home health care, free-standing laboratories, and free-standing radiology only) who accept VA patients to serve as a participating provider and accept assignment with the VA. If seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Those providers who express a willingness to receive VA queries as to availability shall be clearly identified with readily discernable markings on all public network provider listings. (Note: Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire. A direct contract relationship between a provider and the VA takes precedence over the requirements of this section.)

N.10.1. The Contractor shall inform network providers, through network provider agreements, that they agree to being reported to Civilian Health and Medical Program of the Department of Veteran's Administration (CHAMPVA) as a TRICARE network provider. The Contractor shall require network providers (individual, home health care, free-standing laboratories, and free-standing radiology only) who accept CHAMPVA patients to serve as a participating provider and accept assignment with the VA. The Contractor shall provide to the provider the CHAMPVA furnished claims processing instructions (Attachment J-4, CHAMPVA Fact Sheet 01-16 dated Aug 06) on how to submit CHAMPVA claims to the VA Health Administration Center P.O. Box 65024, Denver, CO 802069024 for payment. For any published network provider listing, the provider shall be clearly identified with readily discernable markings which accept CHAMPVA assignment on claims.

N.10.2. The Contractor shall request marketing and educational information on the VA and CHAMPVA through the VA Health Administration Center in sufficient quantities to provide the information to providers who agree to be listed as VA or CHAMPVA providers. [The Contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The Contractor may brief these materials to VA and CHAMPVA accepting providers.

N.11. The Contractor shall maintain an accurate, up-to-date list of network providers including their specialty, subspecialty, gender, work address, work fax number, and work telephone number for each service area, and whether or not they are accepting new beneficiaries. The Contractor shall provide easy access to this list, to include making it available upon request, for all beneficiaries, providers, and Government representatives. For the purposes of this requirement, "up-to-date" means the information contained on all electronic lists shall be current within the last 30 calendar days.

REFERRAL MANAGEMENT

RM.1. In TRICARE PSAs that include an MTF, the MTF has the right of first refusal for all referrals. Medical care and ancillary capabilities for which this right is claimed by the MTF shall be specifically addressed in the MTF/MCSC Memorandum of Understanding (MOU). For referrals to the MTF for specialty care, travel time shall not exceed one hour under normal circumstances. Right of first refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the medical care and ancillary services previously identified in the MTF/MCSC MOD. All referrals shall be processed in accordance with TRICARE Operations Manual Chapter 8, Section 5.

RM.2. A minimum of ninety-six percent of referrals for Prime enrollees, who reside in TRICARE PSAs and Prime enrollees who reside outside TRICARE PSAs and have waived the travel-time access standards shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual. All referrals, except the following, will be included to determine compliance with the standard: (1) referrals that are unknown to the Contractor before the visit (specifically ER visits, retroactively authorized referrals), (2) self-referrals and referrals of beneficiaries who use other health insurance as first payer, (3) MTF directed referrals to non-network providers when network providers are available and 4) the eight mental health self-referrals. All other referrals are included in the standard without exception.

RM.2.1. The Contractor shall ensure that TRICARE Prime beneficiaries have no liability for amounts billed, except for the appropriate co-payment, for referred care, including ancillary services from a non-network provider as a result of a medical emergency or as a result of the TRICARE Prime beneficiary being referred to a non-network/non-

participating provider by the Contractor. (For example, this requirement applies when a beneficiary is referred for surgery from a network surgeon in a network hospital, but the anesthesiologist is a non-network provider.) For these beneficiaries, amounts paid by the Contractor in excess of TRICARE allowable amounts (e.g., CHAMPUS Maximum Allowable Charge (CMACs), Diagnosis Related Groups (DRGs), Outpatient Prospective Payment System (OPPS), other prospective payment systems, or prevailing charges) to non-network/nonparticipating providers shall not be reported or used as underwritten health care costs.

RM.3. MTFs will refer their TRICARE Prime enrollees to a non-network civilian provider only when it is clearly in the best interest of the Government and the beneficiary, either clinically or financially. Such cases are expected to be rare. Federal health care systems (for example Veterans Administration and Indian Health Service) are excluded from this Government policy.

RM.4. The Contractor's referral management processes shall ensure an evaluation of the referred service is conducted to determine if the type of service is a TRICARE benefit and shall inform the beneficiary prior to the visit in the event the requested service is not a TRICARE benefit. This does not apply to referrals for active duty service members. This shall not be a preauthorization review. Rather, this process shall be a customer service/provider relations function providing an administrative coverage review. This service shall be accomplished for every referral received by the Contractor regardless of whether it was generated by an MTF provider, network provider or non-network provider.

RM.5. The Contractor shall meet with the Regional Director and each MTF in a collaborative and partnering manner to ensure balanced specialty workloads using the Contractor's referral protocols with the MTF as the first referral site. The Contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral. The Contractor will not be required to track individual consultation reports. The referral information provided, and the methods of communicating the information, will be addressed in the MTF/MCSC MOU.

MEDICAL MANAGEMENT

MM.1. The Contractor shall ensure that care it provides, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The Contractor shall use its best practices in managing, reviewing and authorizing health care services, and shall comply with the provisions of 32 CFR 199.4, 32 CFR 199.5 and the TRICARE Policy Manual when reviewing and approving medical care and establishing medical management programs to carry out this activity to the extent authorized by law.

MM.2. The Contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract and shall follow all standards, rules, and procedures as defined in 32 CFR 199.15. The Contractor, using its authority as a PRO, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a civilian setting consistent with MTF referral instructions. The Contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made.

MM.3. The Contractor shall comply with the Clinical Quality Management requirements of the TRICARE Operations Manual, Chapter 7.

MM.4. The Contractor shall operate a medical management program for all MHS eligible beneficiaries receiving care in the civilian sector that achieves the objectives of this contract. The Contractor's medical management program must fully support the services available within the MTF.

MM.4.1. The Contractor shall operate case management programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which evidenced based clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199 and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. These programs shall exclude Medicare dual eligible beneficiaries. When care occurs outside an MTF, the Contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The Contractor shall propose medical management programs and patient selection criteria for review and concurrence of the Contracting Officer prior to implementation and annually thereafter.

MM.4.1.2. The Contractor shall maintain open communication with the DoD dental Contractors in discussions to improve disease surveillance, disease management and appropriate patient education and research.

MM.4.2. The Contractor shall operate a Disease Management Program. Disease management conditions will be Asthma, Congestive Heart Failure (CHF), Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Cancer Screening, Depression and Anxiety Disorder. The Government will identify the population, and risk-stratify beneficiaries for inclusion in the Contractor's Disease Management Program. The Contractor shall make telephone contact and conduct a baseline assessment with at least 50% of the beneficiaries enrolled in the program for each disease condition at all risk levels within 12 months of identification by the Government. The Contractor shall submit a Disease Management Program Plan, required under Section F.5.1.7, which demonstrates implementation of the disease management intervention(s) that use the VA/DoD clinical practice guidelines, when available. The Contractor's Disease Management Programs shall meet national accreditation standards for disease management and chronic care management within 18 months of the start of healthcare delivery. The Contractor's plan shall include program information that will be provided to the Government, which when combined with other Government generated data will allow for effective evaluation of the Disease Management Program in accordance with the Government provided disease management outcome metrics. In order for the Government to be able to evaluate the Contractor's Disease Management Program, the Contractor shall include a Disease Management Program Plan for accounting and reporting on the cost and performance of all disease management programs, plus provide the specific guidelines and protocols they will utilize. The plan and cost estimate are subject to review and concurrence by the Contracting Officer prior to implementation and annually thereafter. The parties agree the fee as stated in the Disease Management CLINs will not change if the Government changes the diseases or stratification.

MM.5. In cooperation with the MTF, the Contractor shall, during normal business hours, in accordance with the MCSC/MTF MOU, coordinate the care and transfer of stabilized patients who require a transfer from one location to another. This function shall include coordination with the primary clinician at the losing and gaining sites, the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients. Transportation will be coordinated using Government resources when appropriate and available.

ENROLLMENT

E.1. The Contractor shall perform all enrollments, re-enrollments, disenrollments, transfer enrollments, correct enrollment discrepancies, and assign or change the PCM in accordance with the provisions of the TRICARE Operations Manual, the TRICARE Policy Manual, and the TRICARE Systems Manual. The Contractor shall accomplish primary care manager by name assignment in accordance with the TRICARE Systems Manual. For beneficiaries returning from or transferring to OCONUS, the Contractor shall follow the requirements of the TRICARE Operations Manual.

E.2. Beneficiaries residing within the travel time access standard for primary care from the MTF and required to enroll in TRICARE Prime or choosing to do so shall be enrolled to the MTF, according to the MTF Commander's enrollment priorities and guidelines as stated in the Memorandum of Understanding, on a first come, first served basis, until the enrollment capacity established by the MTF Commander is reached. The Contractor shall ensure that MTF capacity, as determined by the MTF Commander, is reached before beneficiaries may be enrolled to the Contractor's network.

E.3. A beneficiary enrolled in Prime to a civilian PCM prior to the beginning of Option Period I and residing outside of PSAs under this contract may enroll to a PSA PCM at the beginning of Option Period 1, provided the beneficiary resides less than 100 miles from an available network primary care manager in the PSA, submits a new request for enrollment and waives both primary and specialty care travel time standards. Beneficiaries enrolled in Prime to a civilian PCM prior to the beginning of Option Period 1 who reside outside of PSAs under this contract and are 100 miles or more from an available PCM in the PSA network shall not be permitted to continue their enrollment.

E.4. The Contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network primary care manager to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

E.5. The MTF Commander may grant exceptions to the requirement to enroll all beneficiaries to the MTF prior to enrollment to the Contractor's network. Such instances should be rare and should be based on valid clinical capability to meet the individual health care needs of the patient.

E.6. The Contractor shall provide commercial payment methods for Prime enrollment fees that best meet the needs of beneficiaries, while conforming to TRICARE policy requirements. The Contractor shall accept payment of fees by payroll allotment from the member's retired military pay, electronic funds transfer (EFT) from a financial institution or credit card. The only instance where a check may be used to pay enrollment fees is for the initial payment, unless administrative issues arise in the processing of an automated method, in which case the Contractor may, at their discretion, accept payment by check in order to preserve the beneficiary's prime enrollment status. Emphasis should be placed on allotments or EFT to the fullest extent possible to minimize beneficiary risk of involuntary disenrollment due to non-payment. The Contractor shall not require beneficiaries to pay an administrative fee of any kind for use of a particular payment option offered by the Contractor, but may assess the account holder a charge of up to $20.00 in the event there are insufficient funds to process an enrollment fee payment. The Contractor shall accept payment of enrollment fees on a monthly, quarterly, or annual basis. The Contractor shall provide beneficiaries with written notice of a payment due and when beneficiaries are delinquent in accordance with the TRICARE Operations Manual.

E.7. The Contractor shall ensure that enrollment during transition phase-in and transfers of enrollment, i.e., portability, as described in the TRICARE Operations Manual are accomplished in a way that ensures uninterrupted coverage for the TRICARE Prime enrollee. During transition, the incoming Contractor shall enroll all TRICARE Prime beneficiaries to their assigned PCM, and maintain the beneficiary's enrollment periods from the preceding Contractor. If a beneficiary's civilian PCM remains in the Contractor's network, the beneficiary may retain their PCM. If the beneficiary must change PCMs, all enrollments shall be to the MTF for enrollees residing within drive time standards until MTF capacity is reached, as determined by the MTF Commander.

CUSTOMER SERVICE

CS.1. The Contractor shall provide comprehensive, readily accessible customer services that includes multiple, contemporary avenues of access (for example, e-mail, World Wide Web, telephone, and facsimile) for the MRS beneficiary. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

CS.2. The Contractor shall meet with and establish a MOU with TMA Communications and Customer Service Directorate (C&CS) in accordance with the TRICARE Operations Manual, Chapter 11. The MOU shall address all interface requirements necessary to effectively administer the program. The Contractor shall partner and collaborate with C&CS on the identification and development of education materials required to support the accomplishment of the Education Plan submitted in accordance with Section F.

CS.2.1. The Contractor shall use the Government's national suite of TRICARE educational materials pertaining to specific aspects of the TRICARE benefit and programs. The Contractor shall use the Government's mandatory formats to ensure the one look and feel of all regional educational material. The Contractor will produce regional provider education material in accordance with the TRICARE Operations Manual, Chapter 11 that must be reviewed by the TRO and concurred with by the Contracting Officer.

CS.3. The Contractor shall use best commercial practices and technology that meet the needs of the MRS beneficiary in establishing a customer service presence in accordance with TRICARE Operations Manual, Chapter 11, for all MHS eligible beneficiaries at each MTF in Attachment J-3, Mandatory TSC Locations, either within the MTF or on the

base. These sites shall be named TRICARE Service Centers (TSCs) regardless of the extent of services offered. Attachment J-3 describes any space that an MTF has available to the Contractor. Where the space is insufficient to support all TSC activities, the Contractor shall establish those customer service activities not available on site in a manner that is convenient to beneficiaries and provides the highest service levels. The Contractor shall maintain a sufficient supply of TRICARE education materials at each TSC to adequately support information requests. The Contractor shall request educational information on the VA and CHAMPVA through the VA Health Administration Center in sufficient quantities to support TSC operations. [The Contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The Contractor shall provide TSC services during periods when access to the TSC physical space is limited or terminated as a result of weather, war, security, or MTF /Installation Commander's decision.

CS.3.1. The Contractor shall deploy mobile Service Assist Team (SATs) necessary to perform customer service functions to disaster areas, Active Component and Reserve Component troop mobilization areas, BRAC areas, or to any area deemed necessary and requested by the Regional Director (RD). A task order will be issued by the Contracting Officer defining the requirement for each SAT. SATs shall be deployed on an as needed basis for a finite period of time as defined in the task order. Within seven calendar days notice, the Contractor shall deploy one or more teams. Service Assist Teams shall provide services similar to those offered at a TRICARE Service Center and, at a minimum, will provide assistance with beneficiary enrollment, assistance with access to and referral for care, and providing TRICARE program information.

CS.4. The Contractor shall provide customer service support equal to forty person-hours per month for each MTF listed in Attachment J- I, Government Required MTF PRIME Service Areas, to be used at the discretion of and for the purpose specified by each MTF Commander. Examples of possible uses of this time include in-processing briefings/enrollments, TRICARE briefings, and specialty briefings on specific components of TRICARE or focused to a specific subset of TRICARE beneficiaries. This is in addition to the requirements for briefings and attendance at meetings specified in the TRICARE Operations Manual, Chapter I I. The Contractor shall provide customer service support equal to forty person-hours per month to be used at the discretion of and for the purpose specified by the Regional Director. The forty person-hours for each MTF Commander and each Regional Director may be used at various locations and outside normal business hours. Unused hours from one month will not be carried over to subsequent months.

CS.5. The Contractor shall provide assistance in accessing information about other Department of Defense programs and applicable community/state/federal health care and related resources for all MRS eligible beneficiaries who require benefits and services beyond *TRICARE.* The Contractor shall maintain Resource Guides that describe DoD programs and applicable community, state and federal health care which shall be available to TSC personnel to provide to beneficiaries. These resource guides will be updated quarterly.

CS.6. The Contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff that results in highly satisfied beneficiaries.

CLAIMS PROCESSING

CP.1. The Contractor shall establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner, and meet the functional system requirements as set forth in the TRICARE Operations Manual and the TRICARE Systems Manual. The claims processing system shall be a single data base and be HIPAA compliant.

CP.2. The Contractor shall ensure that TRICARE claims (including adjustments) are timely and accurately adjudicated for all care provided to beneficiaries in accordance with the timeliness and quality standards of the TRICARE Operations Manual, Chapter I, Section 3.

CP.3. The Contractor shall, as one means of electronic claims submission, establish and operate a system for two way, real time interactive Internet Based Claims Processing (IBCP) by providing web based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. This IBCP system shall provide immediate eligibility verification by connectivity to Defense Enrollment Eligibility Reporting System (DEERS) and provide current deductible, Catastrophic Cap, and cost share/co-payment information to the

provider online by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. The IBCP system shall comply with Department of Defense Information Assurance Certification and Accreditation Process (DIACAP) and encryption requirements. At no additional cost to the Government, the Contractor shall regularly update the IBCP system to utilize newer encryption security protocols. The IBCP must be available for benchmark testing (see the TOM, Chapter I, Section 7).

CP.4. The following percentage of all claims shall be submitted electronically after the specified percentage of claims has been excluded. For the South Region ***** of paper claims will be excluded each option period from the total number of paper claims processed.

ELECTRONIC CLAIMS PROCESSING STANDARDS

Option Period	South
1	*****
2	*****
3	*****
4	*****
5	*****

CP.5. The Contractor's claims processing system shall interface with and accurately determine eligibility and enrollment status based on the DEERS in accordance with the TRICARE Systems Manual.

CP.6. The Contractor's claims processing system shall accurately process claims in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, the TRICARE Policy Manual, and TRICARE Reimbursement Manual. The Contractor's claims processing system shall correctly apply deductible, copay/coinsurance, cost shares, catastrophic cap, authorization requirements, and point-of-service provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, 199.17 and 199.18, the TRICARE Policy Manual, and TRICARE Reimbursement Manual. The Contractor's claims processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled as required by 32 CFR 199.8, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

CP.7. Claims requiring additional information shall be returned or developed for the missing information. The Contractor shall ensure that all required information is requested with the initial return or development action and that no claim is returned/developed for information that could have been obtained internally or from DEERS. The Contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims.

CP.8. The Contractor shall ensure non-network/non-participating claims received more than 12 months after the date of service are denied unless the requirements contained in 32 CFR 199.7 are met. Timely filing requirements for network providers shall be governed by the network provider agreement, but shall not exceed 12 months from date of service (or discharge).

CP.9. The South Region Contractor shall manage enrollments, collect premiums, accurately identify and adjudicate claims and perform all requirements involving Continued Health Care Benefit Program according to the TRICARE Policy Manual.

CP.10. The Contractor shall accurately reimburse network and non-network provider claims in accordance with applicable statutory (United States Code, Chapter 55, Title 10) and regulatory provisions (32 CFR 199.14) and with the TRICARE Policy Manual and TRICARE Reimbursement Manual. The Contractor will reimburse network providers in accordance with the payment provisions contained in the provider agreement/contract. The Contractor's reimbursement to network providers shall not exceed the amount which would have been reimbursed using the TRICARE payment methodologies and limits contained in 32 CFR 199.14, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

CP.11. The Contractor shall provide an Explanation of Benefits (EOB) to each beneficiary and provider as described in the TRICARE Operations Manual, Chapter 8. The EOB must clearly describe the action taken on the claim or

on the deductible and catastrophic cap status following processing and sufficient information to allow a beneficiary to file a claim with a supplemental insurance carrier. HIPAA-compliant electronic remittance advices shall be returned to providers who submit claims via HIPAA-compliant standard electronic transactions.

CP.12. The Contractor shall accurately capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the provisions of the TRICARE Systems Manual and shall ensure the standards contained in this contract are achieved according to the TRICARE Operations Manual. All TED records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TRICARE Operations Manual.

CP.12.1. The Contractor shall submit information on all providers authorized by the Contractor, to the TRICARE Management Activity centralized TRICARE Encounter Provider Record system in accordance with the provisions of the TRICARE Systems Manual.

CP.13. The Contractor shall furnish to any TMA designated site(s) and all Health Benefits Advisors, Beneficiary Counseling and Assistance Coordinators, and Debt Collection Assistance Officers located in each region (approximately 1,000 accounts per region) with read only access to claims data. The Contractor shall provide training and ongoing customer support for this access.

CP.14. The Contractor shall process claims for pharmaceuticals to beneficiaries in a health care setting where the pharmaceuticals are not obtained from a retail pharmacy. Pharmaceuticals obtained by a beneficiary from a retail pharmacy, the TRICARE Mail Order Pharmacy, or from specialized pharmacies as a component of the consolidated retail pharmacy benefit are not the responsibility of the Contractor. See TRICARE Operations Manual, Chapter 8, Section 2, for additional claims jurisdiction information.

MANAGEMENT

MGT.1. The Contractor shall establish and maintain experienced and qualified key personnel and sufficient staffing and management support to meet the requirements of this contract.

MGT.2. The Contractor shall establish and continuously operate an internal quality management/quality improvement program covering every aspect of the Contractor's operation, both clinically and administratively. The Contractor shall provide a quarterly briefing in person or via video teleconference to the COR and TMA staff on the Contractor's ongoing internal quality improvement program. The Contractor shall also comply with the vulnerability assessment requirements of the TRICARE Operations Manual, Chapter 1.

MGT.3. The Contractor shall ensure that all network providers, TRICARE-authorized providers and their support staffs in the region gain a sufficient understanding of applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner which promotes beneficiary satisfaction. The Contractor shall have the responsibility for delivering necessary information to network providers in their region. The Contractor shall determine the requirements for printed products for network providers and will develop and deliver these products upon review by the TRO and concurrence of Contracting Officer. The information in these products will be determined by the Contractor based on their understanding of the needs of their providers in their region. The Government may measure provider satisfaction with Contractor provided information by conducting random satisfaction surveys of select network providers in accordance with TRICARE Operations Manual, Chapter II. The Contractor shall use the "one look and feel" format provided by the Government and shall submit all educational material to the Contracting Officer for review and concurrence prior to printing and provider distribution.

MGT.4. The Contractor shall collaborate with the Regional Director and MTF Commanders to ensure the most efficient mix of health care delivery between the direct care system and the Contractor's network within their region. Collaboration includes, but is not limited to, right of first refusal for referrals for all or designated specialty care, including ancillary services and coordinated preventive health care. The Memorandum of Understanding (drafted by the Contractor) between each Regional Director, MTF Commander, and the Contractor shall be in writing and must be approved by the Contracting Officer. The Contractor shall initiate discussions related to and prepare the MOU. (See the TRICARE Operations Manual, Chapter 15).

MGT.5. The Contractor shall ensure that all Contractor personnel working in DoD MTFs meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Blood Borne Pathogens (BBP) Program requirements. This includes any MTF required training for Contractor personnel.

MGT.6. The Contractor shall develop and implement, in conjunction with each MTF and the Regional Director, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, and natural disasters. The draft contingency program plan shall be provided to the Government for approval 120 days prior to the start of health care delivery and the documented contingency program shall be provided to the Government 60 days prior to the start of health care delivery and updated annually thereafter.

MGT.6.1. The Contractor shall implement the contingency program at any and all affected locations within forty-eight (48) hours of being notified by the Contracting Officer or Regional Director that a contingency exists.

MGT.6.2. The Contractor shall participate in each MTF's Installation Level Contingency Exercise twice each calendar year. The purpose of the exercise is to test the contingency program under a variety of situations and to provide information from which the Contractor's contingency program shall be updated. The Contractor shall also participate in Regionally Coordinated Table Top Contingency Exercises twice each year.

MGT.7. The Contractor shall participate, in person, in round table meetings/summits with the Government, all other Managed Care Support Contractors, and any other participants that the Government determines are necessary twice each calendar year. The round table meetings/summits requires high level managerial participation from the Contractors (CEOs, Medical Directors, Operations) and participation, in person, by the Contractor's technical and cost experts as determined by the agenda. The round table meetings/summit participants are tasked with reviewing current policies and procedures to determine where proven best practices from the participants' Government and private sector operations can be implemented in the administration of TRICARE to continue TRICARE's leading role as a world-class health care delivery system.

MGT.8. The Contractor shall locate a senior executive with the authority to obligate the Contractor's resources within the scope of this contract within a fifteen-minute drive of the TRICARE Regional Office.

MGT.9. The Contractor shall implement processes and procedures that ensure full compliance with the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities. (See http://www.hcqualitycommission.gov/.)

MGT.10. At midnight Pacific Time on the last day of health care delivery under this contract, the Contractor shall assign its rights to the telephone number serving the region to the incoming MCS Contractor.

MGT11. The Contractor shall encourage all acute-care medical/surgical hospitals in the Contractor's provider networks to become members of the National Disaster Medical System (NDMS).

MGT.12. The Contractor shall provide to authorized Government personnel (as determined by the Contracting Officer) access to ALL data at the beneficiary, non-institutional and institutional level, with immediate access to the Contractor's full set of data associated with TRICARE. Minimum access shall include two authorizations at each MTF, two authorizations at each Multi-Service Market Office, two authorizations at each Surgeon General's Office, two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Northern Virginia, two authorizations at TMA-Aurora, and authorization for each on-site Government representative. The Contractor shall make available an additional 15 authorizations to be assigned at the discretion of the Government. The Contractor shall provide training and ongoing customer support for this access. The data shall include, at a minimum, data concerning the provider network, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data. All data must be current, accurate, complete and accessible immediately. Complete information includes all data pertaining to the execution of Prime, Extra and Standard benefits both inside and outside Prime service areas. Ad hoc reports must satisfy the user's requirement within the time frames agreed upon by the Government and the Contractor. Search capabilities

must be built into systems and must be user friendly. Web based training is acceptable; however it must be updated as system changes occur and must be on-going. The data shall be, at a minimum, available for queries on a Regional, MTF Prime Service Area, and standard geographic area (State, County, and Zip Code) basis. The data access interface will be mutually agreed upon by the TRO and MCS Contractor and available by start of health care delivery.

MGT.13. The Contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TRICARE Systems Manual and the MHS Enterprise Architecture (See http://www.ha.osd.mil/mhscio/ea_reference _docs.htm).

MGT.14. The Contractor shall enter into a Data Use Agreement (DUA) for data obtained from DoD Systems and applications and comply with DoD 6025.l8-R, DoD Health Information Privacy Regulation, HIPAA Privacy Rule, and DoD 5400.ll-R DoD Privacy Program, by submitting a DUA to the Privacy Office annually or until its contract is no longer in effect, as required in the TRICARE Systems Manual and TRICARE Operations Manual.

MGT.15. The Contractor shall ensure its subcontractors and/or their agents who require the use of or access to individually identifiable information or protected health information under the provisions of this contract comply with DoD regulations and the TRICARE Systems Manual.

MGT.16. Personnel Security. The Contractor shall coordinate with the Government to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TRICARE Systems Manual, Chapter I. The Contractor shall initiate and document all activities necessary to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TRICARE Systems Manual, Chapter I. The Contractor shall also ensure all personnel, to include subcontractors and/or their agents, comply with all system access requirements including initial and refresher training at intervals designated by the Government.

MGT.16.1. System Security. The Contractor shall acquire, develop and maintain the DoD Information Assurance Certification and Accreditation Process (DIACAP) documentation to ensure both initial and continued DIACAP Certification and Accreditation (C&A) for all Contractor/subcontractor systems/networks processing or accessing Government sensitive information (SI) as required by TSM, Chapter 1. The Contractor shall cooperate with and assist the Government's (MHS) DIACAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DIACAP C&A team schedule. The Contractor shall also put in place processes that meet the requirements of the TSM, Chapter 1 to ensure at least a Mission Assurance Category III (MAC III) Sensitive level of security protection for systems/networks that process MHS SI under this contract. DIACAP certification generally takes 6 to 9 months to achieve and the Contractor shall plan the certification activity that results, at a minimum, in an Interim Authority To Operate (IATO) prior to accessing DoD data or interconnectivity with the Government systems and testing. (See DoD 8500.2 (Information Assurance Implementation) and DoD 8510.01.)

MGT.16.2. The Contractor shall comply with DoD Information Assurance (DoD Directive 8500.1), MAC III, Sensitive Requirements found in DoD Information Assurance Implementation (DoD Instruction 8500.2), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R) and the MHS AIS Security Policy Manual. The Contractor shall also comply with OMB M-06-l6, Protection of Sensitive Agency Information. The Contractor shall comply with DoD Minimum Security Requirements as outlined in the TSM, Chapter 1.

MGT.16.3. The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy Regulation (DoD 6025.18- R) the Health Insurance Portability and Accountability Act Security Compliance Memorandum (Health Affairs Policy 06-010), the Security Standards for the Protection of Electronic Protected Health Information and the requirements in the TOM, Chapter 19, and the TSM, Chapter 1.

MGT.16.4. The Contractor shall ensure that all electronic transactions comply with HIPAA rules and regulations and TMA requirements in the TSM, Chapter 1 and the TOM, Chapter 19.

MGT.16.5. Pursuant to FAR Part 24 the requirements of the Privacy Act (5 U.S.C. 552a) and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the Contractor on behalf of the TMA. These systems of records are found at 65 Federal Register 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 Federal Register 43775 (USTF Managed Care System), 69 Federal Register 50171 and 71 Federal Register 16127 (Military Health Information System), and 64 Federal Register 22837 (Health Affairs Survey Data Base). The records systems operated and maintained by the Contractor are records systems operated and maintained by a DoD Component (TMA). (See TOM, Chapter 1, Section 5, Chapter 2, Section 1, and Chapter 2, Section 2).

MGT.17. The Contractor may enter into Clinical Support Agreements (CSAs) in order to optimize the MTF (reference the TOM, Chapter 15, Section 3). The Contracting Officer will incorporate CSAs by modification to the contract.

MGT.18. The MCSC and the TRICARE Pharmacy Contractor shall establish a Memorandum of Understanding (MOU) for the purpose of addressing necessary cooperation, exchange of information, and points of contact for such things as pharmacy utilization data, program integrity issues, case management (including coordination of care for patients who are enrolled in specialty pharmacy services), third-party liability, and claims jurisdiction issues. The MOU will specifically address the frequency and format of pharmacy utilization data which will be provided to the MSCS by the TRICARE Pharmacy Contractor.

Section D—Packaging and Marking

D.1. PACKAGING

Preservation, packaging, and packing for shipment or mailing of all work delivered hereunder, by other than electronic means, shall be in accordance with good commercial practice and adequate to insure acceptance by common carrier and safe transportation at the most economical rate(s). The Contractor shall not utilize certified or registered mail or private parcel delivery service for the distribution of reports under this contract without the advance approval of the Contracting Officer. CD-ROMs (or other electronic media) shall be packed in labeled cartons in accordance with the best commercial practices that meet the packing requirements of the carrier and ensure safe delivery at the destination.

D.2. MARKING

Each package, report or other deliverable shall be accompanied by a letter or other document which:

D.2.1. Identifies the contract by number under which the item is being delivered.

D.2.2. Identifies the deliverable Item Number or Report Requirement which requires the delivered item(s).

D.2.3. Indicates whether the Contractor considers the delivered item to be a partial or full satisfaction of the requirement.

Section E—Inspection and Acceptance

E.1 52.246-4 Inspection of Services—Fixed-Price. (AUG 1996)

E.2 52.246-5 Inspection of Services—Cost-Reimbursement. (APR 1984)

E.3 52.246-6 Inspection—Time-and-Material and Labor-Hour. (MAY 2001)

E.4 252.246-7000 Material Inspection and Receiving Report. (MAR 2008)

E.5. INSPECTION LOCATIONS

Inspections may be conducted electronically or by physical inspection. Inspections will be performed at the TRICARE Management Activity (TMA), the Contractor's and/or subcontractor's facilities, or any other locations at which work is performed. Inspection of services provided hereunder will be accomplished by the Contracting Officer or his/her designee(s).

E.6. ACCEPTANCE

E.6.1. Claim Processing (paper & Electronic): The Contractor shall submit a TED record for each health care claim processed. The inspection process of claims processing services will begin at the TEDs batch header level by the TMA TED system through the individual TED record level. Acceptance will be accomplished by individual TED record. Payment of the claims processing fees for a TED record demonstrates formal acceptance.

E.6.2. Transition-In and Transition-Out: The Contractor shall submit one DD250, Material Inspection and Receiving Report after accomplishing the required Transition-In and Transition-Out requirements, respectively. The DD250 shall be sent to the Contracting Officer's Representative with a copy provided to the Contracting Officer.

E.6.3. Formal acceptance or rejection of all other services provided under the terms and conditions of this contract will be accomplished by the Contracting Officer or Contracting Officer's Representative on an annual basis after each option period using a DD250, Material Inspection and Receiving Report. The Contractor shall submit a DD250 after accomplishing all required services in each respective option period. The DD250s shall be sent to the Contracting Officer's Representative with copies provided to the Contracting Officer.

Section F—Deliveries or Performance

F.1 52.242-15 Stop-Work Order. (AUG 1989)

F.2 52.242-15 Stop-Work Order. (AUG 1989)—Alternate I (APR 1984)

F.3. PERIOD OF PERFORMANCE

F.3.1. Base Period is approximately 10 calendar months /Tom the start of work to the start of health care delivery. The Contractor shall begin transition-in activities and complete specific activities by the timelines specified in the TRICARE Operations Manual (TOM) Chapter 1, Section 7. All transition-in activities shall be completed by the date specified in the Contractor's Start-Up/Transition Plan.

F.3.2. Option Periods 1 through 5, if exercised are as follows:

Option Period 1: April 1, 2012 to March 31, 2013

Transition-Out Option (if applicable)

Option Period 2: April 1, 2013 to March 31, 2014

Transition-Out Option (if applicable)

Option Period 3: April 1,2014 to March 31, 2015

Transition-Out Option (if applicable)

Option Period 4: April 1,2015 to March 31,2016

Transition-Out Option (if applicable)

Option Period 5: April 1, 2016 to March 31, 2017

Transition-Out Option (if applicable)

F.3.3. The option periods identified herein are hereby defined as the period in which health care is delivered to TRICARE beneficiaries. The start of health care delivery is the first day of Option Period I. In order to meet the requirements of the contract for health care delivered for a given period, the Contractor will be performing incidental administrative tasks associated with the given health care delivery period beyond that period.

F.3.4. The transition-out period may be exercised during anyone of the health care delivery periods specified above. The Contractor will begin transition-out activities upon transition-out option exercise and complete the timelines as specified in TOM Chapter I, Section 7. All transition-out activities shall be accomplished no later than 270 days after the start of health care delivery for the incoming Contractor(s).

F.4. GEOGRAPHIC AREA OF COVERAGE

F.4.1. RESERVED.

F.4.2. South Contract: The contract shall be referred to as the South Region Contract. It will require development, implementation and operation of a health care delivery and support system for TRICARE and other MHS beneficiaries residing in the states of Alabama, Arkansas, Florida, Georgia, Kentucky (the Fort Campbell area only, see F.4.4.2.), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding areas of Western Texas, see F.4.4.4.). These geographic areas are hereinafter referred to as the South Region Contract. The South Region Contractor shall be responsible for administering and complying with all Continued Health Care Benefit Program (CHCBP) requirements in all geographic areas.

F.4.3. RESERVED.

F.4.4. For the states identified above that cross regional boundaries, the following zip codes define which portion of the state belongs to which region.

F.4.4.1. RESERVED.

F.4.4.2. The state of Kentucky is in the North Region except for the following zip codes (Ft. Campbell area) which are in the South Region:

42020	42076	42223	42274	42332	42413
42025	42134	42232	42276	42337	42431
42029	42135	42234	42280	42339	4236
42036	42170	42236	42283	42344	42440
42038	42202	42240	42286	42345	42441
42040	42204	42241	42320	42350	42442
42044	42206	42254	42321	42354	42445
42045	42211	42256	42323	42367	42450
42048	42215	42261	42324	42369	42453
42049	42216	42262	42325	42372	42464
42054	42217	42265	42326	42408	
42055	42220	42266	42328	42410	
42071	422221	42273	42330	42411	

F.4.4.3. RESERVED.

F.4.4.4. The state of Texas is in the South Region except for the following zip codes (western portions of the state) which are in the West Region:

79009	79855	79931	79978	88531	88562
79035	79901	79932	79980	88532	88563
79053	79902	79934	79990	88533	88565
79325	79903	79935	79995	88534	88566
79344	79904	79936	79996	88535	88567
79347	79905	79937	79997	88536	88568
79718	79906	79938	79998	88538	88569
79767	79907	79940	79999	88539	88570
79754	79908	79941	88510	88540	88571
79770	79910	79942	88511	88541	88571
79772	79911	79943	88512	88542	88573
79780	79912	79944	88513	88543	88574
79785	79913	79945	88514	88544	88575
79786	79914	79946	88515	88545	88576
79821	79915	79947	88516	88546	88577
79835	79916	79948	88517	88547	88578
79836	79917	79949	88518	88548	88579
79837	79918	79950	88519	88549	88580
79838	79920	79951	88520	88550	88581
79839	79922	79952	88521	88553	88582

79843	79923	79953	88523	88554	88583
79845	79924	79954	88524	88555	88584
79846	79925	79955	88525	88556	88585
79847	79926	79958	88526	88557	88586
79849	79927	79960	88527	88558	88587
79851	79928	79961	88528	88559	88589
79853	79929	79968	88529	88560	88590
79854	79930	79976	88530	88561	88595

F.5. REPORTS AND PLANS

Unless otherwise specified, the Contractor shall electronically submit all Contract Data Requirements List items (CDRL) (contract plans, reports, etc.) in the specified format using Microsoft Office Excel, Word, PDF, or other specified software. If no format is specified, the Contractor may use its own format. Unless otherwise specified, all CDRL items shall be submitted to the Government via the E-commerce Extranet (https://tma-ecomextranet.ha.osd.mil/logon/logon.cfm). (See the TOM, Chapter 14, Section 2, for report submission requirements.)

F.5.1. The Contractor shall provide all reports and plans that are specified in this Section. The Contractor is accountable for assuring that reports contain accurate and complete data. The Contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The Contractor shall submit a negative report if there is no data to report. Required reports include:

F.5.1.1. Daily Reports

D010 Non-Financially Underwritten Contractor Payment/Check Issue Report
D020 Financially Underwritten Contractor Payment/Check Issue Report

F.5.1.2. Weekly Reports

W010 Claims Aging Report by Status/Location
W020 Incoming Contractor Weekly Status Report
W030 Outgoing Contractor Weekly Status Report
W040 Supplemental Health Care Program (SHCP) Aging Claims Report
W050 Claims Processing Statistics Report
W060 Purchased Care Active Duty Inpatient Census Report

F.5.1.3. Monthly Reports

M010 Toll-Free Telephone Report
M020 Enrollment Plan Implementation Report
M030 TRICARE Quality Monitoring Contract (TQMC) Findings Response Report
M040 Clinical Quality Management (CQM) Monthly Quality Issues Report
M050 Right of First Refusal Referrals Report
M060 Customer Satisfaction Report
M070 Education Presentation Report
M080 Debt Collection Assistance Officer Program Collection Report
M090 Clinical Support Agreement Reports
M100 HIPAA Privacy Disclosure Report
M110 TRICARE Reserve Select (TRS) Premium Activity Report
M120 CHCBP Adjusted Premiums Report (South Contract Region only)
M130 CHCBP Enrollment Report (South Contract Region only)
M140 CHCBP Monthly Enrollee Premium Report (South Contract Region only)
M150 CHCBP Monthly Premiums Summary Report (South Contract Region only)
M160 CHCBP Workload Report (South Contract Region only)
M170 Beneficiary Services Report

M180 Case Management/Disease Management Report
M190 Cycle Time/Aging Report
M200 Workload Report
M210 Medical Management Report
M220 Network Adequacy Report
M230 Network Inadequacy Report
M240 Non-Financially Underwritten Accounts Receivable Report including Supplemental Reports
M250 Non-Financially Underwritten Bank Account Reconciliation Report
M260 Non-Financially Underwritten Bank Cleared Payment Report
M270 Financially Underwritten Bank Cleared Payment Report
M280 Non-Financially Underwritten Bank Account Statement Report
M290-Autism Services Demonstration Report
M300 TQMC Monthly Validation Report
M301 POA Indicators and HACs Monthly Report

F.5.1.4. Quarterly Reports

QO10 Claims Audit Report
Q020 Retrospective Review Requirements for Other than Diagnostic Related Group (DRG) Validation Report
Q030 Beneficiary Access Assistance Report
Q040 Congressional and Health Benefits Advisor (HBA) Relations Report
Q050 Procedure Code Unbundling Report
Q060 Prepayment Pre-encounter Screens Report
Q070 Fraud and Abuse Summary Report
Q080 Utilization Management Report
Q090 Management of Myelomeningocele Study Report
Q100 Evolving Practices Report
Q110 Network Directory Report
Q120 Appeals Quality Assessment Report
Q130 Grievances Quality Assessment Report
Q140 Written Correspondence Quality Assessment Report
Q150 Telephonic Responses Quality Assessment Report
Q160 Behavioral Health Provider Location and Assistance
Q170 Quarterly Autism Services Demonstration Report

F.5.1.5. Semiannual Reports

S010 DoD Cancer Clinical Trial Report
S020 Semiannual Autism Services Demonstration Report

F.5.1.6. Annual Reports

A010 Clinical Quality Management Report
A020 Third Party Recoveries for Region Fiscal Year Report
A030 Fraud Prevention Savings Report
A050 Mental Health Rates Report
A060 Indirect Medical Education (IDME) Ratios for Children’s Hospitals Report
A070 Listing of High Volume Providers Report
A080 Listing of Prime Service Area (PSA) Zip Codes
C020 Statement on Auditing Standards (SAS) No. 70

F.5.1.7. Annual Plans

P020 Enrollment Plan
P030 Utilization Management Plan
P040 Clinical Quality Management Program (CQMP) Plan

P050 Education Plan
P060 External Resource Sharing Plan
P090 Contingency Program Plan
P100 Disease Management Program Plan
P110 Internal Quality Management/Improvement (QM/QI) Program Plan

F.5.1.8. As Required Plans/Reports

R010 Start-Up Plan
R011 Network Implementation Plan
R020 Serious Reportable Events
R030 CHCBP Ad Hoc Reports
R040 Accreditation Reports and Documentation
R050 Service Assist Team After Action Report

F.6. CONTRACT PHASE-IN DELIVERABLES

No later than 30 calendar days after contract award, the Contractor shall forward one copy of a Freedom of Information Act (FOIA) releasable contract to the TMA-Aurora FOIA Officer at the following address: TMA, Attention: FOIA Officer, 16401 East CentreTech Parkway, Aurora, CO 80011-9066. The Contractor shall line through all information in the contract which the Contractor considers as not releasable under FOIA. The Contractor will also include a legal analysis which supports the Contractor's consideration regarding the non-releasable portions of the contract.

The following deliverables are due during the base period of the contract (reference TOM, Chapter 1, Section 7):

F.6.1. The Transition Plan is due no later than 10 calendar days following contract award.

F.6.2. The Revised Transition Plan is due no later than 15 calendar days following the transition interface meetings.

F.6.3. Executed MOUs with all Military Treatment Facility (MTF) Commanders no later than 60 calendar days prior to the start of health care delivery.

F.6.4. Executed MOU with TMA C&CS within 30 days of the C&CS MOU meeting.

F.6.5. Public Notification/Congressional Mailing to TMA for review no later than 90 calendar days prior to the start of health care delivery.

F.6.6. Demonstration of web-based services and applications no later than 15 days prior to the start of health care delivery.

F.6.7. Commencement of benchmark testing no later than 120 days prior to the start of health care delivery.

F.6.8. Benchmark TRICARE Encounter Data (TED) submissions no later than seven days following the last day of the benchmark test.

F.6.9. Demonstration of call center and TSC staff competency no later than 15 days prior to the start of health care delivery.

F.6.10. Claims Processor Data shall be provided, to include the data described in paragraphs F.6.10.2 through F.6.10.4. The Government will make the data available to the external claims audit Contractor.

F.6.10.1. Description of data elements by field position in family history file printout and field definitions for pricing, OHI, authorization, or referral screens.

F.6.10.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions.

F.6.10.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing.

F.6.10.4. Specifications for submission of the provider file, as described in the TRICARE System Manual, Chapter 2, Section 1.2.

F.7. CONTRACT PHASE-OUT DELIVERABLES

The following items shall be provided to the incoming Contractor during the transition-out of the contract.

F.7.1. Transfer electronic file specifications no later than three calendar days following award of a successor contract (reference TOM, Chapter 1, Section 7).

F.7.2. Transfer electronic Automated Data Processing (ADP) files no later than 15 calendar days fol1owing the Outgoing Transition Specifications Meeting (reference TOM, Chapter 1, Section 7).

F.7.3. Weekly shipments of beneficiary history files beginning 120 days prior to the start of health care delivery for the successor contract (reference TOM, Chapter 1, Section 7).

F.7.4. Transfer Case Management and Disease Management Files no later than 60 days prior to the start of health care delivery for the successor contract (reference TOM, Chapter 1, Section 7).

F.7.5. Provide copies of MTF MOUs no later than 30 days following the award of a successor contract (TOM, Chapter 1, Section 7).

F.7.6. Transfer Program Integrity Files no later than 30 calendar days prior to the start of health care delivery for the successor contract (reference TOM, Chapter I, Section 7).

F.7.7. Transfer Provider Certification Files no later than 30 calendar days fol1owing the award of a successor contract (TOM, Chapter 1, Section 7).

Section G—Contract Administration Data

G.1. 252.204-7006 BILLING INSTRUCTIONS (OCT 2005)

When submitting a request for payment, the Contractor shall—

(a) Identify the contract line item(s) on the payment request that reasonably reflect contract work performance; and

(b) Separately identify a payment amount for each contract line item included in the payment request. (End of Clause)

G.2.A. 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS AND RECEIVING REPORTS (MAR 2008) Applicable to ALL CLLNs (except for Health Care Cost and Claims Processing CLLNs)

As prescribed in 232.7004, use the following clause:

(a) *Definitions.* As used in this clause—

(1) "Contract financing payment" and "invoice payment" have the meanings given in section 32.001 of the Federal Acquisition Regulation.

(2) "Electronic form" means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using Wide Area WorkFlow (WAWF) or another electronic form authorized by the Contracting Officer.

(3) "Payment request" means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.

(b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests and receiving reports using WAWF, in one of the following electronic formats that WAWF accepts: Electronic Data Interchange, Secure File Transfer Protocol, or World Wide Web input. Information regarding WAWF is available on the Internet at https://wawf.eb.mil/.

(c) The Contractor may submit a payment request and receiving report using other than WAWF only when-

(1) The Contracting Officer authorizes use of another electronic form. With such an authorization, the Contractor and the Contracting Officer shall agree to a plan, which shall include a timeline, specifying when the Contractor will transfer to WAWF;

(2) DoD is unable to receive a payment request or provide acceptance in electronic form;

(3) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer's determination with each request for payment; or

(4) DoD makes payment for commercial transportation services provided under a Government rate tender or a contract for transportation services using a DoD-approved electronic third party payment system or other exempted vendor payment/invoicing system (e.g., PowerTrack, Transportation Financial Management System, and Cargo and Billing System).

(d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.

(e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payment requests.

(End of clause)

G.2.B. 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS AND RECEIVING REPORTS (DEVIATION) (MARCH 2008) Applicable to Health Care Cost and Claims Processing CLLNs 1001, 1002, 1007, 1008;2001,2002,2007,2008;3001,3002,3007,3008;4001,4002,4007,4008; and 5001, 5002, 5007, and 5008.

(a) Definitions. As used in this clause—

(I) "Contract financing payment" and "invoice payment" have the meanings given in section 32.001 of the Federal Acquisition Regulation.

(2) "Electronic form" means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of electronic payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using TRICARE Encounter Data System (TEDS).

(3) “Payment request” means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.

(b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests and receiving reports using TEDS. Information regarding TEDS is available on the Internet at http://manuals.tricare.osd.mil/.

(c) The Contractor may submit a payment request and receiving report using other than TEDS; only when—

(I) The Contracting Officer authorizes use of another electronic form. With such an authorization, the Contractor and the Contracting Officer shall agree to a plan, which shall include a timeline, specifying when the Contractor will transfer to TEDS;

(2) DoD is unable to receive a payment request or provide acceptance in electronic form;

(3) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer’s determination with each request for payment; or

(4) DoD makes payment for commercial transportation services provided under a Government rate tender or a contract for transportation services using a DoD-approved electronic third party payment system or other exempted vendor payment/invoicing system (e.g., PowerTrack, Transportation Financial Management System, and Cargo and Billing System).

(d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.

(e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payment requests.

(End of clause)

G.3. CONTRACT ADMINISTRATION

G.3.1. The Procuring Contracting Officer (PCO) is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government. Unless specified otherwise within this contract, the PCO is referred to as the Contracting Officer. The Contacting Officer for this contract is:

Contracting Officer
Department of Defense
TRICARE Management Activity/COD-A
1640 I E. Centretech Parkway
Aurora, CO 80011-9066

G.3.2. Administrative Contracting Officer (ACO):

Defense Contract Management Agency (DCMA) ACO. The Contracting Officer will delegate a limited number of functions listed in FAR 42 to the DCMA ACO. The Contractor will be provided copies of all delegation letters.

Defense Contract Management Agency
DCMA Ohio River Valley, Team ACOB
Federal Office Building
550 Main Street, Suite 10-504
Cincinnati, OH 45202-3252
Telephone: (513) 684-3925
FAX Phone: (513) 684-3991

G.3.3. Defense Contract Audit Agency (DCAA) will provide certain audit functions in support of the Contracting Officer and ACO.

DCAA Indianapolis Branch Office
8899 E. 56th Street, Column 116-AA
Indianapolis, IN 46249-4900
Telephone: (317) 510-10 II
FAX Phone: (317) 510-1012

or the DCAA office locator at http://apps.dtic.millwobin/WebObjects/DCAAzipcode

G.3.4. Contracting Officer's Representative (COR):

(SEE Section I, DFARS Clause 252.201.7000 for definition)

South Region Contracting Officer Representative
Department of Defense
TRICARE Management Activity
16401 E. Centretech Parkway
Aurora, CO 80011-9066

G.3.5. Contractor Points of Contact personnel:

The names and addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

***** *****

G.3.6. Paying office:

Department of Defense
TRICARE Management Activity
ATTN: Contract Resource ManagementlCRM
16401 E. Centretech Parkway
Aurora, CO 80011-9066

G.3.6.1. RESERVED.

G.4. RESERVED.

G.5. RESERVED.

G.6. PAYMENT INSTRUCTIONS FOR MULTIPLE ACCOUNTING CLASSIFICATION CITATIONS

In accordance with DFARS PGI 204.7108, this subsection provides instructions to the paying office:

G.6.1. Accounting & appropriation citations: When obligated, any multiple accounting and appropriation citations will be identified in Section B as informational subline items.

G.6.2. Each CLIN is a separate contract type. Payments will be applied at the CLIN or SubLine Item (SLIN) level. The paying office will assign payments to the accounting classification citation(s) based on the anticipated work performance under each CLIN as follows:

G.6.2.1. Where there is a single line of accounting under a CLIN, the payment office will make payments with the funds established for that CLIN. If there is more than one line of accounting within a CLIN, the payment office will determine the appropriate line of accounting to use based on period of performance.

G.7. OTHER INSTRUCTIONS TO PAYING OFFICE

G.7.1. The paying office will follow paying instructions included in any contract modification, including change order definitizations and performance incentive payment modifications.

G.7.2. The due date for making invoice payments to the Contractor is specified in the Prompt Payment clause, FAR 52.232-25, included in this contract (i.e.: 30th day from receipt of proper invoice or acceptance). The Prompt Payment clause with its Alternate I apply to Underwritten Health Care Cost and Disease Management CLINs. For all line items except for Underwritten Health Care Cost, the paying office will make invoice payments on or before the due date, but not earlier than 7 calendar days prior to the due date. For Underwritten Health Care Cost, the paying office should make invoice payments on the 7th calendar day from receipt or acceptance of a proper invoice/voucher. As specified in Alternate I of the Prompt Payment clause, the payment office will use the due date (30th day after receipt of a proper invoice or acceptance) for computing any late payment interest penalties that may apply. For the Underwritten Health Care Cost and Claims Processing CLINs processed using TED system, the completion of the batch TRICARE Encounter Data (TED) submission (end date/time) is sent to TMA will be used to determine the date of receipt. In the event that the payment office is informed of an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, or there are disagreements on the payment amounts, the payment office is not compelled to make payment by the above dates.

G.7.3. Revisions to payment instructions may be made as circumstances require. This may be accomplished by correspondence between the contracting office and the paying office.

G.8. PMPM MILITARY HEALTH SYSTEM (MHS) ELIGIBLE BENEFICIARIES

G.8.1. For the purpose of this CLIN, counts of MHS eligible beneficiaries under the PMPM includes all MHS eligible beneficiaries, underwritten and non-underwritten, with the exception of those covered under Uniformed Services Family Health Plan (USFHP). The contract region's count of MHS eligible beneficiaries under the PMPM CLINs is based on the eligible beneficiary's address as contained in Defense Enrollment Eligibility Reporting System (DEERS). This includes Prime enrollees who may be enrolled in a different region. The count is taken from the MHS Data Repository (MDR) Point-in-Time Extract (PITE). The MDR PITE is derived monthly from the DEERS PITE, which is a snapshot of the DEERS database reflecting beneficiary status and address at the end of each month.

G.8.2. The Government will unilaterally determine the number of MHS eligible beneficiaries prospectively two times for each option period under each PMPM CLIN (including option period 1), once for the first six month period and once for the seventh through twelfth month. This number will be based on an average of six of the seven previous months of eligible beneficiaries as reported above. Using the number of MHS eligible beneficiaries, the Government will calculate the PMPM quantity for the next bi-annual period as follows: The number of MHS eligible beneficiaries multiplied by the number of months (6) equals the number of member months (the quantity). The number of member months is then multiplied by the fixed unit price equals the extended amount for the period.

G.9. INVOICE AND PAYMENT—NON-TEDS

Non-TEDs invoice and vouchers shall be submitted electronically in accordance with G.2 above. A proper invoice must include the elements identified at FAR 32.905, except for interim payments on the Disease Management CLINs.

G.9.1. Transition-In: The Contractor may invoice for interim payment of 50% of the transition-in price upon the start of health care delivery. The Contractor may submit a final invoice (DO 250) for the balance following completion of all transition requirements.

G.9.2. Underwritten Health Care—Fixed Fee: Submit voucher (Le. SFI034) no more frequently than monthly and only after completion of the given month.

G.9.3. Disease Management: Interim cost reimbursement vouchers (Le. SFI034) shall be submitted no more frequently than monthly, and only after completion of the given month, to the cognizant Defense Contract Audit

Agency (DCAA) office for approval with a copy provided to the Contracting Officer. A final adjustment voucher shall be submitted for each option period to the Contracting Officer upon settlement of incurred cost audit and final indirect rates of the respective option period's final cost.

G.9.4. Disease Management—Fixed Fee: Vouchers (i.e. SF 1034) shall be submitted no more frequently than monthly to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer only after completion of a given month.

G.9.5. PMPM: Submit invoice no more frequently than monthly and only after completion of the given month for no more than one-sixth (rounded to the nearest dollar) of the extended CLIN amount.

G.9.6. TRICARE Service Centers: Submit invoice no more frequently than monthly and only after completion of the given month.

G.9.7. Award Fee: The Contractor shall invoice as instructed by the Contracting Officer following determination of any award fee.

G.9.8. Performance Incentive Pool: The Contractor shall invoice as instructed by the Contracting Officer following determination of any performance incentive amounts.

G.9.9. Transition-Out: Interim cost reimbursement vouchers (i.e. SF 1034) shall be submitted no more frequently than monthly, and only after completion of the given month, to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer.

G.9.9.1. Transition-Out Fixed Fee: The contractor may submit a voucher (Le. SFI 034) to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer for the fixed fee upon completion of all transition-out requirements.

G.9.10. Modifications: The Contractor may invoice for change order definitizations, Clinical Support Agreements, Service Assist Teams, or other modifications after the Contracting Officer provides instructions and authorization to invoice via modification.

G.10. INVOICE AND PAYMENT—CLAIMS PROCESSING CLINs

G.10.1. Invoice and payment procedures for claims processing fee are the same for paper and electronic claims. Submission of a TED record header to TMA is considered submittal of an invoice. For purposes of determining the due date for payment under the Prompt Payment Clause, the header "end date/time" TRlCARE Encounter Data (TED) submission is sent to TMA will be used to determine the date of receipt.

G.10.2. Claim Quantity: The Contractor is paid the unit price for each initial submission TED record (as defined under TSM Chapter 2, Section 1.1) that passes all TED edits as specified in the TSM and validated by the TMA TED record edit system, plus the Contractor's first adjustment TED record accepted under this contract that was initially submitted by a predecessor contractor.

G.10.3. Unit Price and Performance Period: The Contractor is paid the claims processing unit price identified in Section B for the contract period in which the Contractor submits the initial TED record. The Batch/Voucher date in the voucher header is used to determine the contract period and applicable unit price.

G.10.3.1. Payments for claims the Contractor receives within 120 calendar days following the cessation of health care delivery (for services rendered during the health care delivery period) are made based on the claim processing fee unit price in effect during the health care delivery period immediately preceding transition-out. In order for the Contractor to receive payment of a claims processing fee, the TED record must be accepted by TMA no later than 210 days following the end of health care delivery.

G.10.4. Invoice Instructions: The Contractor shall submit batch/vouchers under the correct "Header type Indicator" as specified in the TRlCARE Systems Manual (TSM), Chapter 2, Section 2.3.

G.10.5. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor may submit invoices outside of the TED system to the Contracting Officer. The invoice shall list the number of claims processed by CLIN. This may be submitted daily or grouped by no more than 5 days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

G.10.6. Retraction, or collection, of claim processing fee previously paid to the Contractor occurs if 'Header Type Indicator' of '5' or '0' is used. Proper use of 'Header Type Indicator' is defined below:

G.10.6.1. Ineligible TED Records: If the TED record submitted is not eligible to receive payment under the claims processing CLIN (the contract terms/conditions do not authorize payment of the claims processing fee on a TED record), the contractor shall submit the TED record to the TRICARE Management Activity (TMA) using a Header Type Indicator of '0' or' 5'. No payment under the claims processing CLIN can occur on any TED record grouped in a Batch/Voucher with Header Type Indicator of '0' or '5'. Only no-pay and credits can be processed under these header types.

G.10.6.2. Eligible TED Records: If the TED record is eligible to receive payment under the claims processing CLIN, then the TED record (with the exception of Type of Submission 'C'—complete cancellation to TED record data) shall be submitted by the Contractor to TMA using a Header Type Indicator of '6' or '9' (even if the TED record has already received payment under the claims processing CLIN).

G.10.6.3. Cancelled TED Records: For a TED record submitted with a Type of Submission 'C' by the Contractor, the Contractor shall determine if the TED record is still eligible to receive payment under the claims processing CLIN. The following criteria shall be used to determine if a TED record is still eligible for payment:

G.10.6.3.1. A TED record cancelled for any of the following reasons is eligible to retain the claims processing fee previously paid and shall be submitted with Header Type Indicator '6' or '9':

- Cancellation was at Government direction.
- Government data error.
- Stale dated/voided checks.
- New initial TED record is required by the Government.
- Incorrect DEERS response.
- Check is returned in undeliverable mail.
- Beneficiary or provider requests stop payment due to non-receipt of check prior to stale date time period.
- Beneficiary or provider returns check because payment has been received from other health insurance carrier whose responsibility was previously unknown to contractor.
- Provider returns check because beneficiary has erroneously paid the provider and believes that the TRICARE benefit check is a duplicate payment.
- Claim processed in good faith by the contractor but later identified as an error due to additional information received or learned.
- Claim processed by multiple contractors resulting in duplicate processing.
- TQMC case resolutions resulting in an error.
- Program Integrity cases that are recouped retrospectively after investigation.
- Provider requested claims to be reissued to a new provider Tax Identifier.

G.10.6.3.2. A TED record cancelled for any of the following reasons is not eligible to retain the claims processing fee previously paid and shall be submitted with Header Type Indicator '0' or '5':

- Cancellation where a new initial TED record is required to correct a contractor error.
- Cancellation due to contractor error or an inability to adjust.
- Cancellation of a claim that was not TMA's responsibility so should not have been paid.
- Any other cancellations for a reason not identified in paragraph G. 10.6.3.1 above.

If the Contractor cannot determine the reason for the TED record cancellation, then the TED record submitted is not eligible to retain the claims processing fee previously paid. The cancellation of the cancelled TED record shall be submitted under Header Type Indicator' 0' or '5'.

G.11. TEDS SUBMITTAL INSTRUCTIONS (UNDERWRITTEN AND NON-UNDERWRITTEN HEALTH CARE):

G.11.1. TEDS shall be submitted per TSM requirements which include separate groupings of underwritten and non-underwritten claims by CLIN for underwritten and the Automated Standard Application for Payment(ASAP) System ID for non-underwritten. Adjustments and cancellations may be included with initial submissions.

G.11.2. Voucher Transmission Requirements: Underwritten Batch/Vouchers shall be transmitted by 10 A.M. Eastern Time to be considered for that day's business. Non-underwritten Batch/Vouchers received after 10:00 AM Eastern Time shall be considered received the next business day for payment and check release authorization purposes. Batch/Vouchers must pass all TED header edits as specified in the TSM. If all header edits are not passed, the Batch/Voucher will be rejected and returned to the Contractor.

G.11.3. **Voucher Integrity**: Voucher header and detail amounts transmitted by the Contractor become "fixed" data elements in the finance and accounting system for purposes of control and integrity. Corrections or adjustments to reported (payment) amounts must be accomplished on separate voucher transmissions. Voucher submissions (non-underwritten payments) later determined to be underwritten benefits shall be corrected using the voucher process to reverse the submission and resubmitted under the batch process and vice versa (see TSM, Chapter 2, Section 1.1, paragraph 3.5.).

G.11.4. Payment Suspension and TED Processing During Partial Funding Shortages:

G.11.4.1. Some of the funding TMA receives may be restricted in use to a specific federal agency, military department and/or to a particular health care program. Funding for these special purpose programs may run out before funding for other TMA programs. Therefore, the Contractor shall have the ability to suspend claims payment and the associated submission of institutional TEDS records or non-institutional TED line item(s) to TMA based on values contained in the following TED record fields:

- Service Branch Classification Code (Sponsor), SBCC—As specified in the TSM, Chapter 2, Section 2.8.
- Enrollment/Health Plan Code (E/HPC)—As specified in the TSM, Chapter 2, Section 2.5.
- Special Processing Code (SP)—As specified in the TSM, Chapter 2, Section 2.8.
- Health Care Delivery Program Coverage Code—As specified in the TSM, Chapter 2, Addendum M.

G.11.4.2. The suspension of claims payment and TED records may be based on a single value (e.g., SBCC=A) or a combination of values (e.g., SBCC=A & E/HPC=SR). Suspension of TED records (institutional) or TED line items (non-institutional) containing specific values shall be implemented by the Contractor within five workdays after receiving notification from the Contracting Officer. On the sixth workday, TMA/CRM will implement immediate payment offset against Contractor invoices of any amounts paid by the Contractor from their non-underwritten bank account(s) for institutional TED records or non-institutional TED line items containing suspended value(s). The Contractor shall not, without prior Contracting Officer approval, initiate payment offset against any provider or beneficiary for payments made against suspended transactions and offset by TMA/CRM on Contractor invoices.

G.11.4.3. For all suspended transactions, the Contractor shall hold the claim information until receiving instructions from the Contracting Officer to do otherwise. The Contractor shall not reject the claims or return any information to the providers or beneficiaries unless instructed by the Contracting Officer. Once the Contracting Officer lifts the TED data submission restriction, the Contractor may submit all withheld TED data on the next appropriate (batch/voucher) data submission. TMA/CRM will reimburse the Contractor (without interest) for any invoice payment offsets done for TED suspended transaction that have not been recouped by the Contractor.

G.11.5. Federal Fiscal Year-end Processing:

G.11.5.1. All TEDS data must be received no later than 10:00 AM EDT, (8:00 AM MDT; 7:00 AM PDT) on

September 28. Any Batch/Voucher received after 10:00 AM EDT will be rejected by TMA and must be resubmitted by the Contractor using next fiscal year Batch/Voucher CLIN/ASAP Account Numbers. The Contractor should not submit batch/vouchers with dates of September 29 and September 30. Any payment processed after September 28th , must use the next fiscal year Batch/Voucher CLIN/ASAP Account Numbers and must utilize the new fiscal year check stock, as applicable. The Contractor shall not submit Batch/Vouchers to TMA between September 28, 10:00 AM Eastern Time or before October 1,12:01 AM Eastern Time. Transmission Files (TD Files) sent on September 28th cannot exceed 300,000 records.

G.11.5.2. All payments not included in the Contractor's final fiscal year data submission on September 28 must have a Batch/Voucher Date on or after October 1. Contractors will be able to test their new fiscal year's transactions in benchmark starting September 1. Like production, benchmark data must be received at TMA by 1OAM EDT on September 28. After 1OAM EDT on September 28 until October 1, 12:01 AM Eastern Time no benchmark data can be transmitted to TMA.

G.12. UNDERWRITTEN HEALTH CARE (COST REIMBURSEMENT) – TEDS

G.12.1. Underwritten claims are reimbursed upon all TED records within a TED header clearing edits and each record clearing validity edits. TMA/CRM will disburse payment to the Contractor based on the automated TED report. If the TED records are credits, which will result in a payment to the Government, collection will be made based on the same terms as payment for that respective CLIN. Credits must be applied back to the same sub-CLIN from which it came. Credits do not have to pass all TRlCARE System Manual edits, TMA/CRM will collect all underwritten credits back within seven calendar days of receipt.

G.12.2. Underwritten Under Payment (See TOM Chapter 11): When the Contractor makes an additional payment due to a prior underpayment, these payments shall be reported as an adjustment to the original TED record, but in the current fiscal year and the Contractor shall use the Begin Date of Care to determine the appropriate CLIN/ASAP ID. This would normally be the same CLIN (first six positions of CLIN/ASAP ID) used to make the original payment.

G.12.3. TED Credit Adjustment Procedures: When the Contractor submits a credit TED Record under an active underwritten CLIN, the contractor shall cite the current fiscal year underwritten CLIN/ASAP Account Number associated with the CLIN from which the Contractor originally submitted it under.

G.12.4. TED Underwritten Data Submissions for Inactive CLINs: TMA will administratively set an underwritten CLIN to an 'inactive' status when the health care cost audit process is initiated, so TED records accepted under the CLIN at that time are segregated for audit. TMA will notify the contractor at least 30 days before an underwritten CLIN is set to an 'inactive' status. When the CLIN is set to an 'inactive' status, the CLIN is closed for all TED processing. After CLIN closure, the contractor is required to submit TED records previously accepted under the closed CLIN (the audit population) using the Batch TED data submission process underG.12.4.2. below.

G.12.4.1. At the same time an underwritten CLIN is inactivated, the Contracting Officer will administratively establish a new underwritten CLIN for continued reimbursement of initial and resubmission TED records for those actions occurring after the health care audit process is initiated (i.e., after the initial CLIN is closed). This CLIN will remain active as long as the Contractor submits TED records for care rendered with a begin date of care during the option period.

- For all Batch/Voucher submissions that are in a resubmission status (Batch/Voucher Resubmission Number greater than 00, TSM Chapter 2, Section 2.3) at the time the CLIN is set to inactive, the contractor shall replace the existing CLIN type Batch/Voucher CLIN/ASAP Account Number in the header with the new CLIN type Batch/Voucher CLIN/ASAP Account Number (TSM Chapter 2, Section 1.1, paragraph 6.1) assigned to them by TMA, CRM. The contractor shall continue to resubmit the Batch/Voucher until clearing all TED edits. The resubmission number shall not change at the time of conversion (TSM Chapter 2, Section 2.3).

G.12.4.2. Upon CLIN closeout, corrections/overpayments to TED records previously accepted under the inactive CLIN shall be submitted to TMA using a Batch type (all zero's) Batch/Voucher CLIN/ASAP Account Number (TSM Chapter 2, Section 1.1, paragraph 6.1)

G.12.5. Fiscal Year Start-up: The October 1st TED and subsequent data submissions must cite the new fiscal year "Batch/Voucher CLIN/ASAP Account Number" assigned by TMA/CRM to report all new fiscal year TED data. Any previously unreported TED data citing the prior fiscal years "Batch/Voucher CLIN/ASAP Account Numbers" will not be accepted. New "Batch/Voucher CLIN/ASAP Account Numbers" used for Underwritten healthcare costs shall reflect as follows: the first six positions equal to the SLIN (zero fill positions 5 & 6 if not used), position 7 shall equal the federal fiscal year and position 8 shall equal the Contractor's region (N = North, S = South & W = West).

G.12.6. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor may submit electronic vouchers (i.e. SFI034) outside of the TED system to the Contracting Officer for underwritten healthcare costs. The invoice shall identify the underwritten health care paid and the number of claims processed by CLIN. This may be submitted daily or grouped by no more than five days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

G.13. NON-UNDERWRITTEN HEALTH CARE (Pass Through) – TEDS

G.13.1. The Contractor acts as a Fiscal Intermediary for the Government to distribute, or pass-through, Government funds for certain non-underwritten health care benefits. These are not costs to the Contractor and are not reimbursed by the Government, so the Contractor shall not collect or hold non-underwritten benefit funds before dissemination to the beneficiary or provider and the Contractor shall immediately return any collections to the Government.

G.13.1.1. Non-underwritten benefit payments by the Contractor on behalf of the Government will be facilitated by allowing the Contractor (through the Contractor's financial institution) to draw money from the designated Federal Reserve Bank (FRB). These draws may only be done for benefit payments that have previously been submitted on TEDs or as a non-TED, non-underwritten voucher and approved for release by TMA/CRM and are clearing the Contractor's financial institution on the day the draw is being accomplished. Advance payments are not allowed. No bank fees or other bank charges shall be paid from this account and no money should be drawn from the FRB for these charges.

G.13.1.2. All payments for non-underwritten claims processed by the Contractor must be approved by the TMA/CRM Budget Office before the Contractor may make payments to the beneficiary or provider. Unapproved draws and payments by the Contractor will be immediately collected and subject the Contractor to interest and penalties.

G.13.2. Establishment of Non-Underwritten Bank Accounts:

G.13.2.1. The Department of Treasury's Automated Standard Application for Payment System (ASAP), along with FEDWIRE, provide a mechanism for disbursement of Government funds for health care services received by TRICARE beneficiaries that are not underwritten by the Contractor. After authorization by TMA/CRM, these systems allow the Contractor to draw cash directly from the FRB to cover payments as they clear the Contractor's bank account. ASAP is used by the Treasury, the FRB and TMA/CRM to verify the authorization to make draws and to track transactions made by the Contractor's bank. FEDWIRE is used by the Contractor's bank to actually draw funds from the FRB.

G.13.2.2. The Contractor shall establish bank account(s) for non-underwriting transactions with a commercial bank that has FEDWIRE capability following Treasury requirements. The Contractor shall submit bank information to TMA/CRM not later than 60 calendar days prior to the beginning of processing claims on a new account. The information shall include:

- Name of Bank
- Overnight mail address
- American Banking Association (ABA) routing number
- Taxpayer Identification Number (TIN) (must be the same TIN used for payment)

- Contractor's bank account number (if separate checking and deposit accounts are used, both need to be provided)
- Individual point of contact at the bank and an alternate, including their phone numbers, fax numbers and email addresses
- Individual point of contact at the Contractor and an alternate, including their phone numbers, fax numbers and e-mail addresses

G.13.2.3. TMA/CRM will establish the bank account(s) on ASAP with the Treasury Department. TMA/CRM will notify the bank and the Contractor once the bank account(s) have been established and provide codes or other information necessary for the bank to make draws against the FRB using FEDWIRE. Currently, ASAP has a requirement to identify a total dollar amount that may be drawn on the FRB. This dollar limit, established by TMA/CRM, only represents an administrative ceiling at the FRB, and does not constitute any authority to draw funds. Accounts will also have daily limits for the amount that can be drawn. The Contractor will be notified of these limits by TMA/CRM. TMA/CRM will be able to increase these limits as needed.

G.13.3. Authorization to Release Non-Underwritten Payments:

G.13.3.1. TED data submissions for non-underwritten benefit payments shall be grouped into TED Vouchers by the "Batch/Voucher CLIN/ASAP Account Number" field (defined in TSM, Chapter 2, Section 2.2). The Contractor shall not release non-underwritten benefit payments without prior authorization from the TMA/CRM Budget Office. Authorization from TMA/CRM to release payments will be sent to the Contractor via fax or e-mail no later than 5:00 PM Eastern Time the day of receipt. Authorization will specify contract number, ASAP Account ID#, initial transmission received date, and total dollar amount of funds that may be released based on information contained in the Batch/Voucher header. Approval for funds release will be given provided the following criteria are met:

- Voucher submissions must pass all header edits as specified in TSM, Chapter 2, Section 2.3.
- TMA/CRM Budget Officer has confirmed that funding is available to cover payments.

G.13.3.2. Benefit payments shall be released/mailed no later than two workdays after TMA/CRM has approved the release of payments.

G.13.3.3. Authorization to release payments does not constitute TMA's acceptance that all payments are valid and/or correct. Detailed records will be audited for financial compliance. All transactions in these bank accounts must be valid and justified. Any unreported/unauthorized disbursements identified by TMA will be subject to immediate payment offset against any payments being made to the Contractor. All disputed amounts will remain in the possession of the Government until no longer in dispute.

G.13.3.4. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor will send an email or fax with a listing of specific vouchers to TMA/CRM to request release of payments. This may be done daily. TMA/CRM will return to the Contractor a signed release so the Contractor can pay the providers and beneficiaries without delay. The Contractor must not release payments until this approval is received. Upon notification by the Contracting Officer that the TED Record processing system is operating again, this process can be discontinued and the Contractor shall have 30 days to clear all vouchers where payments have been released thru the TED header edits (as specified in the TRICARE Systems Manual, Chapter 2). Failure to clear all header edits for any vouchers where the Contractor was authorized under this contingency process to release payments shall result in the Government collecting back the rejected voucher header totals via payment offset. When the vouchers clear the header edits, the monies collected via payment offset shall be refunded to the Contractor (without interest or penalty). The Contractor requests will include the following Header information for each voucher (See TRICARE Systems Manual, Chapter 2, Section 2.2):

ELN Element Name

0-001 Header Type Indicator
0-005 Contract Identifier
0-010 Contract Number
0-015 Batch/Voucher Identifier

0-020 Batch/Voucher Number
0-025 Batch/Voucher ASAP Account Number
0-030 Batch/Voucher Date YYYYDDD
0-035 Batch/Voucher Sequence Number
0-040 Batch/Voucher Resubmission Number
0-045 Total Number of Records
0-050 Total Amount Paid

G.13.4. Draws on the Federal Reserve:

G.13.4.1. The Contractor shall ensure that cash draw downs do not exceed the payments authorized, as they clear the bank on a given day, less deposits. The Contractor shall ensure that any excess draws are immediately returned to the FRB. Interest and a penalty will be charged beginning the day after the overdraw and will continue until the overdraw amount is returned. Interest will accrue daily and is based on the Treasury Current Value of Funds Rate. The penalty will accrue daily and is based on the penalty rates in the Code of Federal Regulations, Title 31, Volume I, PART 5, Subpart B Sec.5.5. TMA/CRM may initiate immediate payment offset against any payments to the Contractor involved for the interest, penalties and/or the overdrawn amount.

G.13.4.2. Contractors with more than one bank account shall ensure transactions are properly accounted for to prevent the commingling of funds. Failure to properly associate transactions with the correct bank account could result in the over-execution of TMA/CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except for correcting deposits that are in the wrong account. Any transactions reported under one bank account and erroneously charged against a different bank account shall be reported immediately to TMA/CRM when identified. TMA/CRM will instruct the Contractor as to what action to take.

G.13.4.3. The total amount of a cash draw down on the FRB is based on the daily total of benefit payments presented to the bank for payment. If estimates are needed due to timing of reports from check clearinghouses or the FRB, the draws shall be adjusted the next business day.

G.13.4.4. Computation of the amount of the draw must include any deposits of funds into the account. These deposits will reduce the amount of cash needed for the draw down on the day of the deposit.

G.13.5. Financial Editing of Detail Claims Data for Non-Underwritten Claims: The TED system allows for the categorization of claim errors based on the type or classification error failed during the edit process. TMA/CRM will use the edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1, Financial Edits, to determine the propriety of payments. TED records that fail the Financial Edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1 will be “flagged” by TMA/CRM as inadequate payment information. The Contractor shall correct the claims flagged by TMA/CRM within 90 calendar days. If not corrected in 90 days, TMA/CRM will send a demand letter requiring resolution or reimbursement for all claims identified through TEDs as edit failures. The Contractor shall respond within 30 calendar days as to why the claim(s) in question cannot be corrected. If resolution cannot be reached between TMA/CRM and the Contractor, the total amount of improper payments still in dispute will be collected by TMA/CRM. The Contractor shall take no recourse against TRICARE beneficiaries or providers under the situations described in this paragraph without prior TMA approval.

G.13.6. Fiscal Year Start-up of Non-Underwritten ASAP Accounts:

G.13.6.1. The Contractor shall establish a separate bank account for each new Government fiscal year following the procedures specified in G.13.2. “Establishment of Non-Underwritten Bank Accounts”. All payments issued for benefit payments and all refunds received shall be processed against the new account effective the first day of the new fiscal year. The Contractor shall also transfer all recoupment installment payments to the new account from the previous year’s account.

G.13.6.2. Cash draw downs against the prior fiscal year’s bank account may continue, if required, until all payments from the prior year have either cleared or have been canceled, but no longer than the end of February of the following year or five months after the last payments have been cut on an account (in the case of a contract closeout).

G.13.6.3. Bank accounts shall be closed no later than the end of February, following the fiscal year end, or one month after the last payment on an account has been made or voided. Final bank account reconciliation shall be made within 30 calendar days following the last authorized transactions. All transactions that were not previously approved by TMA/CRM shall be explained with supporting documentation on the final bank reconciliation report (Section F.5.1.3.). TMA/CRM reserves the right to not accept these transactions.

G.13.6.4. Any outstanding balance in the account shall be reimbursed to TMA no later than the required submission date of the final bank account reconciliation. This balance may be subject to interest if it includes overdrawn amounts that were required to be submitted at an earlier date.

G.13.7. Voided or Stale-dated Payments

G.13.7.1. For payments that are voided or stale-dated that are over $10, a credit voucher through TEDs must be processed in accordance with the standards detailed in TSM Chapter I, Section 3. If the check was issued as a manual voucher, the credit should be submitted as a similar manual voucher. The only exception to issuing a credit voucher would be stale-dates under $10.00.

G.13.7.2. For voided/stale-dated payments of $10.00 or less, the Contractor may elect either to:

- Affect a credit voucher for the check using automated means, or
- Instead of making a voucher transaction, a memorandum record shall be prepared and included on a listing of transactions as submitted monthly in the Non- Underwritten Funds Bank Account Reconciliation Report.

G.13.7.3. Replacement Payments:

G.13.7.3.1. Reissuance of payments will be made against the current fiscal year bank account.

G.13.7.3.2. Replacement payments may be issued upon request of the payee or authorized representative. If the check is not returned by the payee, the payee must provide a statement describing the loss or destruction of the check. Before a replacement check is issued, a stop payment order for the original check must have been issued and accepted by the bank.

G.13.7.3.3. If the claim history is not available to the Contractor, the Contractor shall submit a request for approval of check release to TMA/CRM within 10 workdays from the request by payee. Supporting documentation shall include the original check, the sponsor's SSN, a copy of the EOB, (if available) or other documentation showing the computation and payment of the original check, and the check or copy or statement as described in G.13.7.3.2. above.

G.13.7.3.4. The Contractor shall report the reissuance using the same procedure as was used to void/stale-date the original.

G.13.7.3.4.1. If no credit voucher was made in voiding/stale-dating of the check, no credit voucher is required for the reissue (i.e. if the Contractor gets a returned check and immediately reissues from the same bank account, no TED or other voucher needs to be done). If the reissuance involves a check from a prior year, a TED or other voucher will need to be done to report the reissuance from the current year.

G.13.7.3.4.2. If the amount of the stale-dated check to be reissued is $10.00 or less, the Contractor shall use the same procedure in the reissuance as was used for the stale-dating. If no credit voucher was made in the stale-dating of the check, no credit voucher is required for the reissue. The Contractor shall reissue the payment and include the amount in the Non-Underwritten Funds Bank Account Reconciliation Report.

G.13.7.3.5. Reissuance of Payments When Original Payee is Deceased: Payments issued by the Contractor shall be made payable to the legal representative of the estate of the person concerned with an additional line stating "For the estate of " Payments shall not be payable to the "estate of" a decedent, nor to a deceased person.

Payments shall be to the named payee or mailed to the payee's address of record.

G.13.8. Non-Underwritten Under Payments: When the Contractor makes an additional payment due to a prior underpayment, these payments shall be reported as an adjustment to the original TED record, but in the current fiscal year and current CLIN/ASAP ID regardless of the fiscal year or CLIN/ASAP ID of the original payment.

G.13.9. Non-Underwritten Overpayments: When reporting collections the Contractor makes (whether cash or offset), the collection shall be accomplished as a separate credit transaction as an adjustment to the original TED record. Identified debts shall be reported on the Accounts Receivable Report in accordance with Section F.5.1.3.

G.14. INVOICE AND PAYMENT NON-UNDERWRITTEN—NON-TEDS

The Contractor shall group and electronically process each type of Non-TED voucher by each non-underwritten cost category identified below as a pass-through payment.

G.14.1. Capital and Direct Medical Education Costs (CAP/DME): Are paid by the Contractor from the non-underwritten bank account to hospitals requesting reimbursement under the TRICARE/CHAMPUS DRG-Based Payment System (excludes children's hospitals) (see TRM Chapter 6, Section 8).

G.14.1.1. The Contractor shall submit a monthly CAP/DME voucher in a .csv format to TMA/CRM no later than the 20th calendar day of the month following receipt of the hospital's request for payment. Supporting documentation, including copies of the hospital's claim and the payment calculation, shall be submitted electronically using approved formats specified in TOM Chapter 2. Within two calendar days after receiving disbursement clearance from TMA/CRM, the Contractor shall complete the process by making payment to the hospital.

G.14.1.2. If the Contractor makes an underpayment, the Contractor shall determine the amount and pay any amount due to the hospital with the next group of payments made. If the Contractor overpays a hospital, the Contractor shall recoup this amount and document as follows:

a. Offset funds shall be included as credits on the monthly CAPIDME voucher for the month the credits were processed.

b. Collections shall be included as credits indicating the month the collection was deposited (normally the prior month).

c. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report.

G.14.1.3. Federal Fiscal Year-end Processing of Non-TED Vouchers: September CAP/DME vouchers that are submitted in the month of October shall utilize the October new fiscal year check stock.

G.14.2. Bonus Payments (HPSA/PSA): Bonus payments are an addition to the amount normally paid under the allowable charge methodology in order to provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. On a quarterly basis, the Contractor shall submit the voucher electronically as a pass-through payment. Supporting documentation including lists of doctors, their addresses, and the calculation of the payment, shall also be sent electronically based on approved formats as specified in the TOM, Chapter 2. The Contractor shall process and make payment within 2 business days after receipt of clearance from TMA/CRM.

G.14.2.1. Vouchers shall contain the following:

a. Format for Vouchers
Period Covered (Quarter)
Physician Name
Physician Address
Physician Provider Number
Amount Paid/Collected for Bonus Total Bonus Paid [5 and/or 10 percent of the above bullet]

Total of all Bonuses being paid

b. Sort for Vouchers
By Contract
By Automated Standard Application for Payment System (ASAP) ill (Fiscal Year) of Bank Account
By Type (e.g., standard or active duty)
By Coverage (Prime, Extra, Standard)
By State
By Physician
By Physician Number
By Specialty
By Address & Zip
By Participating & Non-Participating
By Contracted (Network) and Not Contracted (Non-network)
By Modifier (“QB”, “QU” or “AR”)

G.14.2.2. Federal Fiscal Year-end Processing: September HPSA vouchers that are submitted in the month of October shall utilize the October new fiscal year check stock.

G.14.3. Demonstrations: These are trial programs and they may vary in many ways from TRlCARE benefits. TEDs will be used if possible but if the data associated with demonstrations is incompatible with TED data formats, the Contractor shall submit a separate voucher to TMA/CRM no more frequently than monthly to obtain clearance to make non-underwritten bank account transactions.

G.14.4. Other Payments: Other adjustments are rare situations where a payment needs to be made but does not fall into routine processing such as TEDs, etc. For example, these payments may be the result of a very old case or legal settlements that don’t apply to a given individual. These must be submitted to the Contracting Officer and to TMA/CRM with supporting documentation explaining the issues that don’t allow a TED record along with the claim, computation, and other applicable documents. After release approval by TMA/CRM, the Contractor shall make payment within 2 working days. The Contractor shall report these payments on the Bank Reconciliation Report under TMA approved manual transactions.

G.15. TRICARE RESERVE SELECT PREMIUMS:

The Contractor shall establish separate non-interest bearing account for the collection and disbursement of TRS premiums. The Contractor shall make daily deposits of premium collections to the established account. The Contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified Government account as directed by TMA/CRM Finance and Accounting Office. The Government will provide the Contractor with information for this Government account. The Contractor shall notify the TMA/CRM by e-mail within one business day of the deposit specifying the date and amount of the deposit. The Contractor shall submit a monthly TRS report with premium activity supporting the wire transfer of dollars, including premium billings, collections, and enrollments (Section F).

G.16. CONTINUING HEALTH CARE BENEFIT PROGRAM PREMIUMS:

The South Region Contractor shall establish a separate non-interest bearing account for the collection and disbursement of CHCBP premiums. The Contractor shall make daily deposits of premium collections to the established account. The Contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified Government account as directed by TMA/CRM Finance and Accounting Office. The Government will provide the Contractor with information for this Government account. The Contractor shall notify TMA/CRM by email within one business day of the deposit specifying the date and amount of the deposit. The Contractor shall submit a monthly CHCBP report with premium activity supporting the wire transfer of dollars, including premium billings, collections, and enrollments (Section F).

Section H—Special Contract Requirements

H.1.1. The Managed Care Support (MCS) Contractor shall underwrite the cost of civilian health care services (also referred to as "purchased care" which is defined as care rendered outside the Direct Care System) provided to all CHAMPUS-eligible beneficiaries who are enrolled in the contract region, or for non-enrollees who reside in the contract region, except for the following non-underwritten categories:

-Outpatient retail and mail order pharmacy services (on separate contract)

-Active Duty Service Members including TRICARE Prime Remote for Active Duty Service Members (Active Duty Family Members are underwritten)

-Continued Health Care Benefits Program (CHCBP)

-Foreign/OCONUS beneficiaries and CONUS-based beneficiaries who receive care OCONUS (on separate contract)

-Medicare dual-eligible TRICARE CHAMPUS beneficiaries (on separate contract)

-Cancer prevention and treatment Clinical Trials demonstration (for those beneficiaries enrolled in the demonstration on or before March 31, 2008)

-State of Alaska (care for beneficiaries who are enrolled in the state of Alaska and care for non-enrollees who reside in the state of Alaska)

-In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration

-Bonus Payments in Medically Underserved Areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]

-Capital and Direct Medical Education (Cap/DME)

-TRICARE Reserve Select

-Custodial Care Transitional Program (CCTP)

-Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)

-Residual Claims (date of service prior to the start of health care delivery under the contract)

-Autism Services Demonstration

* CHAMPUS-eligible beneficiaries are defined as those beneficiaries that meet the requirements in Title 10, United States Code, Chapter 55.

H.1.2. In this contract, these underwritten beneficiaries may be referred to as "underwritten beneficiaries" or "non-TRICARE/Medicare dual-eligible CHAMPUS eligible beneficiaries". In this contract, the health care costs the Contractor underwrites may be referred to as "health care cost" or "underwritten health care cost".

H.1.3. Other supplemental details regarding underwritten health care follow:

H.1.3.1. Beneficiaries may enroll in TRICARE Prime with an MTF Primary Care Manager (PCM). Even though they may have an MTF PCM, Prime enrolled non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries' costs outside of the MHS direct care system are underwritten by the Contractor, except for ADSMs.

H.1.3.2. The health care costs for beneficiaries enrolled in Prime are underwritten by the Contractor in whose region the beneficiary is enrolled, regardless of the address or location of the beneficiary.

H.1.3.3. Enrollment fees collected by the Contractor are not considered health care costs. These fees are considered as a part of the PMPM price of the contract and are retained by the Contractor.

H.1.3.4. The costs of medical management activities, such as case management, disease management and utilization management, are not considered underwritten health care costs. Cost under separate Clinical Support Agreements, if issued, are not considered underwritten health care costs.

H.1.3.5. Capitation arrangements are prohibited.

H.1.4. Underwritten health care is cost-reimbursable. These costs are reimbursed with obligated funds that are dispersed under this contract. The associated underwritten fixed fee in Section B of the contract is considered the underwriting fee, or underwriting premium.

H.1.4.1. For administrative purposes, underwritten health care cost is broken down into two main Contractor underwriting risk categories:

H.1.4.1.1. Contractor Network Prime Enrollees: These are TRICARE Prime enrollees with network PCMs. The Contractor underwrites TRICARE healthcare services provided to Prime enrollees with network PCMs (exclusive of TRICARE Prime Remote [TPR] beneficiaries).

H.1.4.1.2. Non-Prime Beneficiaries and MTF Prime Enrollees: This category includes health care services provided to all other underwritten beneficiaries, including:

-Non-Prime enrolled, non-TRICARE/Medicare dual-eligible beneficiaries

-TRICARE Standard,

- TRICARE Extra

-TPR-ADFM Enrollees

- MTF Prime Enrollees (Prime Enrollees with MTF PCMs)

H.2. HEALTH CARE UNDERWRITING INCENTIVES

H.2.1. Introduction and Administration: This section addresses the administration of the positive and negative incentives that are part of the underwriting mechanism of the contract. The Contractor may earn a performance incentive by either exceeding a minimum standard, or for performance above a fully satisfactory level in areas that reduce health care cost and are measurable as defined in this section for each respective option period. The financial administration of the incentives' assessment for a given option period will be conducted after completion of the option period. When performance exceeds the standard, or exceeds the fully satisfactory level specified in the paragraphs below, the Government administratively obligates funding equal to, or greater than, the stated incentive amount into the applicable Performance Incentive Funding contract line item in Section B. After the Government has completed measurement and any administrative funding action(s), and the Contracting Officer notifies the Contractor of the incentive earned (if any), the Contractor may invoice and receive payment for the amount authorized by the Contracting Officer. The Government will obligate funds at any time on the performance incentive funding contract line item as the Contracting Officer determines necessary to ensure sufficient funds are available to pay the Contractor any earned incentive amount. If the Contractor fails to meet the fully satisfactory levels described below and earns a negative incentive, the funded amount on the performance incentive contract line item may be netted, or the payments from the performance incentive contract line item are offset by the negative incentive amount. If the offset amount is greater than any earned incentive (if any), or the Contractor only earns a negative incentive, the Contracting Officer will deduct that amount from the next payment from any administrative contract line item of this contract.

H.2.1.2. For purposes of administering underwriting incentives, the underwritten population will be divided into two separate underwriting risk groups, which are identified as two separate CLINs in Section B:

-Contractor Network Prime Enrollees

-Non-Prime Beneficiaries and MTF Prime Enrollees

H.2.2. Dollar Limits of Underwriting Incentives: There is no ceiling limit on the net positive incentives that may be earned in a given option period. There is a maximum limit on the net negative incentives that may be assessed for the three underwriting incentives combined (these incentives are described in Section H.2.3). This amount is equal to the underwriting fixed fee amount for each option period identified in Section B, plus the amount identified below for each option period and underwriting category. This means the maximum negative net incentive will exceed the underwriting fixed fee paid to the Contractor by the amounts listed below.

H.2.2.1. SOUTH REGION Network Prime enrollees:

—OP 1: *****
—OP 2: *****
—OP 3: *****
—OP 4: *****
—OP 5: *****

H.2.2.2. SOUTH REGION MTF Prime enrollees and non-Prime beneficiaries:

—OP 1 *****
—OP 2: *****
—OP 3: *****
—OP 4: *****
—OP 5: *****

H.2.2.3. The negative incentive dollar limit identified in H.2.2 above are independent of the results of the annual healthcare cost audits for overpayments to providers (i.e., the limits on the underwriting incentives do not limit the Contractor's financial liability for claims overpayments as determined by audit). The assessment, including recovery from the Contractor, of any negative incentive dollar amount is conducted separately from the underwriting fixed-fee payments for each option period.

H.2.3. Incentives. The administration of the Network Discount Incentive, the Network Usage Incentive, and the National Cost Trend Incentive described herein is assessed before any cost audit that determines allowable and unallowable health care costs. The Contractor will be assessed the following positive and negative incentives, based on performance:

H.2.3.1. Network Discount Incentive. The purpose of this incentive is to encourage Contractors to proactively negotiate discounts with network providers and thereby reduce underwritten health care costs. The incentive will be calculated separately for two different categories of beneficiaries. The first category includes all Contractor Prime network enrollees and the second category consists of all MTF Prime enrollees and non-enrolled beneficiaries.

H.2.3.1.1. This incentive will be calculated as ***** of the average value of discounts from TRICARE allowable charges for care provided by civilian network providers to Contractor Prime network enrollees, and MTF Prime enrollees and non-enrolled beneficiaries that exceed a minimum average discount level for each option period as follows:

Contractor Prime Enrollees	*****	*****	*****	*****	*****
MTF Prime Enrollees plus Non-Enrolled Beneficiaries	*****	*****	*****	*****	*****

(The incentive will be calculated once for care provided to Contractor Prime network enrollees and once again for care provided to MTF Prime enrollees and non-enrollees.) For example (using a minimum average discount level of *****, if the calculated total value of discounts obtained in a given option period is ***** and this represents a ***** average discount, the incentive amount would be ***** of the amount above the ***** minimum average discount level. Since the ***** minimum in this case represents *****, the average value of discounts obtained above the minimum threshold equals *****. The incentive payment would be, therefore, *****. If the estimated network discounts obtained for the option period do not exceed the average value of discounts identified above, no incentive payment will be made.

H.2.3.1.1.1. The TED record must reflect the actual dollar amount of network discount, excluding other health insurance (OHI) claims. The dollar amount of the network discount is the difference between the network provider's negotiated rate and what TRICARE reimbursement methodology would have allowed in the absence of the negotiated discount rate. See the TRICARE Systems Manual, Chapter 2 for the TED record requirements for correctly coding the provider network discount.

H.2.3.1.1.2. The network discount incentive will be calculated after the end of the option period based on TED records accepted during that option period (excluding OHI claims) for each of the above two categories of beneficiaries for care provided by Contractor network providers. The percent of discounts will be determined by dividing the total value of discounts reported by the total allowable costs, specifically: the total amount of network discounts achieved during the period will be the numerator; the denominator will be the sum of the amounts that were allowed prior to applying the network discount. The total value of discounts will be the sum of all dollar amounts reported on TED records in the field "Amount Network Provider Discount." For care provided by Contractor network providers (excluding OID claims), the total allowable cost will be the sum of all dollar amounts reported on TED records for all amount allowed fields and all amount of network provider discount fields.

H.2.3.2. Network Usage Incentive. The purpose of this incentive is to promote a higher percent of usage of network providers by all prime enrollees, thereby reducing the enrollees' out-of-pocket costs and potentially reducing underwritten health care costs.

H.2.3.2.1. Network Usage by Prime Enrollees (Combined MTF enrollees and Contractor network enrollees). This incentive can only result in either no payment or a negative incentive. It will be measured based on the number of civilian network provider claims for Prime Enrollees compared with the total number of civilian claims for these beneficiaries, after excluding claims with other health insurance (OID), Prime Point-of-Service (POS) claims, claims for care provided out-of-region, TRICARE Prime Remote, and claims for emergency care. The exclusion applies if any line item on the claim meets the exclusion criteria. If the percentage of network versus total claims meets or exceeds the minimum standard for a given month, no negative incentive will be applied. If the network percentage falls below that standard, a negative incentive will be assessed on a per-claim basis for the calculated number of non-network claims that fall below the standard. This will be done according to a series of percentage corridors, with larger negative incentives applied for successively larger discrepancies between the standard and the actual level of performance.

South Region:	Option Period *****
	Option Period *****
	Option Period *****
	Option Period *****

H.2.3.2.2. No incentive will be applied for Option Period 1. Beginning with Option Period 2 for each month that the minimum claims percentage is not met, a negative incentive shall apply. The network usage incentive will be calculated after the end of the option period based on TED records accepted during each month of the option period. The Government will apply an incentive for every claim that falls below the minimum standard. The amount assessed per claim is based on the percentage below the standard as follows:

South Region, Option Period Two:
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** = ***** per claim

South Region, Option Period Three:
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** = *****per claim

South Region, Option Period Four:
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** = ***** per claim

South Region, Option Period Five:
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** and more than or equal to ***** = ***** per claim
If less than ***** = ***** per claim

H.2.3.2.3. For example, in month 2 of Option Period 2, South Region, if the actual percent of Prime enrollee claims with a network provider is ***** then a negative performance incentive equal to *****of the claims will be assessed *****

represents the difference between the actual number of claims for care provided by a network provider and the standard). If ***** equates to ***** claims not meeting the standard, the performance incentive assessment for that month will be *****, or ***** times *****. In determining the performance incentive, the applicable amount will be determined based on the Contractor's actual performance. For instance, in the example above, the Contractor's actual performance was *****, so the performance incentive will equal ***** for every claim falling below the minimum performance standard of *****. In other words, the highest per claim amount will be applied to all claims failing the standard. The Government will not stratify the performance incentive based on the variable per claim amounts.

H.2.3.2.4. The percentage standards above, and the claims volumes used to calculate performance against those standards, will reflect claims for both MTF Prime enrollees and Contractor Network Prime enrollees combined. In the event a negative incentive amount is assessed, the resulting dollar amount will then be administratively allocated to MTF Prime enrollees and Contractor Network Prime enrollees based on their respective percentage shares of the overall network plus non-network claims volume used in the incentive measurement (after the exclusions of OHI claims, POS claims, etc.). As an example of this allocation approach, if the composite network usage standard were not met and a ***** negative incentive result were assessed, and if MTF Prime enrollees comprised ***** of the network plus non-network claims considered in this incentive measurement and Contractor Network Prime enrollees comprised ***** of the claims, then ***** of the incentive result would be allocated to MTF Prime enrollees and ***** would be allocated to Contractor Network Prime enrollees.

H.2.3.3. National Cost Trend Incentive. The purpose of this incentive is to motivate cost-control efforts by the Contractor for Contractor Network Prime enrollees, by comparing the observed annual trend in the underwritten costs of Contractor Network Prime enrollees in the contract region as a whole to an external national standard, a level of performance the Contractor is expected to achieve. The observed trend will be adjusted for changes in the percentage of care provided in the Contractor network versus at Military Treatment Facilities (MTFs), for changes in enrollment levels, and for change orders affecting underwritten health care costs. This incentive calculation is described below, and a detailed hypothetical example is presented in Attachment J-6, Hypothetical Example of the External Trend Incentive Calculation.

H.2.3.3.1. For this incentive, the national external trend used as a standard of comparison will be a sub-set of the National Health Expenditures (NHE) trends reported annually by the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS). Specifically, the national external trend standard will be the portion of the NHE trend for Personal Health Care Costs Per Capita represented by Hospital Care, Professional Services (for Physician and Clinical Services and for Other Professional Services only), and Durable Medical Equipment. Other categories of Personal Health Care Costs are excluded from the national external trend standard either because they are not representative of the underwritten care under this contract (such as dental care and most prescription drugs) or because they are disproportionately represented in the NHE projections relative to the underwritten costs of this contract (such as home health care and nursing home care). The per capita NHE national trend data is used as the basis of the external national trend standard for the following reasons:

a) the NHE data reflect the broad national health care sector (employer health plans, Medicare, etc.), rather than a small sample of health plans;

b) the data are collected and reported by a Government entity;

c) the NHE trends are widely cited;

d) the NHE data are readily available by the categories and sub-categories described above; and

e) CMS provides both projections of the NHE trends and subsequent actual trends.

Further information on the NHE data can be found at http://www.cms.hhs.govlNationalHealthExpendData

H.2.3.3.2. The NHE data are reported on a calendar year basis. For purposes of this incentive, the trend for the calendar year that overlaps the first 9 months of a given option period will be used as the comparison trend for that option period (e.g., the CY1O CMS NHE trend will be used as the standard for the incentive result for Option Period 1).

H.2.3.3.3. The actual CMS NHE data for a given calendar year are available approximately 15 months after the end of that calendar year (e.g., actual data for CY06 are expected to be available by March 2008). The Government will

perform the calculation of this incentive result after the actual data are available. For the incentive calculation, to be performed at a minimum of 17 months after the end of each option period, the actual NHE trend reported by CMS for the relevant calendar year will be used based on the NHE data available at the time the final incentive calculation is performed.

H.2.3.3.4. Prior to comparing the observed trend experienced for the underwritten cost for Contractor Network Prime enrollees to the national external standard (the NHE per capita trend described above), the actual underwritten cost for the region trend will be adjusted for the approximate effects of three potential factors: I) changes in the Contractor network share of MHS workload for this population; 2) changes in the number of Contractor Network Prime enrollees; and 3) contract change orders.

H.2.3.3.5. To adjust for changes in the Contractor network share of MHS workload, the Government will calculate, retrospectively, the Contractor network and MTF percentages of MHS workload for Contractor Network Prime enrollees in the option period being measured and in the preceding option period. TEDs data will be used to tabulate the number of Contractor network inpatient admissions and outpatient visits; MTF Standard Inpatient Data Records (SIDRs) will be used to tabulate the number of MTF inpatient dispositions; and MTF Standard Ambulatory Data Records (SADRs) will be used to tabulate the number of MTF outpatient encounters. The trend in the Contractor network share of MHS workload, per Contractor Network Prime enrollee, will be calculated as the ratio of the percentage of Contractor network care in the option period being measured to the corresponding percentage in the preceding option period and will be netted from the overall trend in underwritten cost per Contractor Network Prime enrollee. More details and an example of this calculation are provided in Attachment J-6, Hypothetical Example of the External Trend Incentive Calculation.

H.2.3.3.6. The actual trend can also be affected by a change in the share of Active Duty Dependents (ADDs) or Non-Active Duty Dependents (NADDs) in the Contractor Network Prime population. To normalize the observed trend in TRICARE underwritten health care costs for changes in the number of ADFM and/or NADFM Contractor Network Prime enrollees, relative to the prior year, the cost trend per enrollee, after being normalized for changes in the Contractor network share of workload, will be multiplied by the prior year's underwritten costs, separately for Active Duty Family Members (ADFMs) and Non-Active Duty Family Members (NADFMs). More details and an example of this calculation are provided in Attachment J-6.

H.2.3.3.7. Benefit changes unique to TRICARE can also affect the actual trend in cost per Contractor Network Prime enrollee. The impact of contract change orders on underwritten costs for Contractor Network Prime enrollees will also be netted from the underwritten cost trend prior to comparison to the CMS NHE standard. This will be done independently by the Government based on the best estimates and information available to the Government at the time this incentive calculation is performed. For the purpose of calculating this incentive, the Contracting Officer will have sole discretion to determine the cost impacts of change orders. More details and an example of this calculation are provided in Attachment J-6.

H.2.3.3.8. Once the underwritten cost trend per Contractor Network Prime enrollee has been normalized for these three factors cited under H.2.3.3.4. above, the normalized trend will be compared to the NHE cost trend described above. The normalized underwritten trend will be subtracted from the NHE trend, and the Contractor's incentive result will be ***** of the difference between the two trends. If the normalized underwritten trend is lower than the NHE trend described above, there will be a positive trend differential and the Contractor will receive a positive incentive result. If the normalized underwritten trend is higher than the NHE trend, there will be a negative trend differential and the Contractor will receive a negative incentive result. For example, if the normalized underwritten trend is ***** and the NHE trend is *****, the Contractor will receive a negative ***** incentive result. If the normalized underwritten trend is ***** and the NHE trend is *****, the Contractor will receive a positive incentive of *****. To convert the incentive result into a dollar amount, the percentage result will be multiplied by the normalized underwritten cost for Contractor Network Prime enrollees that is calculated in Step 7 of this trend methodology (see Attachment J6 for the detailed steps in calculating this incentive).

H.2.3.3.9. This incentive will be calculated for each option period of the contract based on the begin date of care. For the Option Period I calculation, the prior year's data used as part of the calculation will reflect the data from the last year of the succeeded contract. Thus, the incoming Contractor's incentive result for Option Period 1 will reflect the trend in underwritten costs for Contractor Network Prime enrollees from the last year of the succeeded contract to the first option period of this contract, subject to the adjustments and external trend comparison described above.

H.2.3.3.10. For purposes of this incentive calculation, the underwritten costs tabulated from TED data will not be adjusted for the results of the allowable cost audits, for three reasons. First, this simplifies administration of this incentive. Second, not adjusting for the audit in this trend measurement gives the Contractor an additional incentive to improve claims processing accuracy. Third, the audit results may not be stratified specific to Contractor Network Prime enrollee claims.

H.3. PERFORMANCE INCENTIVES

H.3.1. Introduction: Monetary performance incentives are available to the Contractor. The Contractor may receive a positive performance incentive payment by either exceeding a minimum standard, or for performance above a fully satisfactory level in any of three areas: clinical quality; program integrity; and electronic claims as defined in this section for each respective option period. If the Contractor fails to meet the minimum standard for electronic claims processing, a negative incentive is applied.

H.3.1.1. Incentive Administration: Contractor performance for a given option period will be measured after completion of each option period. When performance exceeds the standard, or exceeds the fully satisfactory level described below, the Government administratively obligates funding on the applicable performance incentive contract line item in Section B. If the Contractor fails to meet the minimum standard for electronic claims processing, the funding level on the performance incentive contract line item may be netted, or the payments from the performance incentive contract line item offset by the applicable negative incentive amount described in this section. If the offset amount is greater than any earned incentive (if any), the Contracting Officer will deduct that amount from the next payment from any administrative line item to the Contractor under this contract. After the Government has completed measurement, and the Contracting Officer notifies the Contractor, the Contractor may invoice the net amount authorized by the Contracting Officer. The Government may obligate funds into the performance incentive pool at any time as the Contracting Officer determines necessary to ensure sufficient funds are available to pay performance incentives under H.2 and H.3 to the Contractor after the option period is completed.

H.3.2. Clinical Quality Incentive: Clinical quality will be measured on a region-wide basis using seven performance metrics which are similar to Healthcare Effectiveness Data and Information Set (HEDIS®) “Effectiveness of Care” measures.

1. Cervical Cancer Screening
2. Breast Cancer Screening
3. Asthma Use of Medication
4. Colorectal Screening
5. Diabetes Management A1c testing
6. Diabetes Management Lipid testing
7. Diabetes Management Retinal Screening

These seven HEDIS® -like measures will be calculated by the Government from administrative data using current technical specifications for all Prime Network enrolled patients in the relevant region. A description of and technical information on the performance metrics are at Attachment J-5, Clinical Quality Incentive Performance Metrics. The Government calculated HEDIS® -like measures will be provided to the Contractor at the beginning and end of each 12 month evaluation period. The Contractor may earn an incentive based on the Government’s measurement of performance improvement over each one-year option period. The regional performance on each measure for the last 12 months preceding the start of health care delivery will serve as the baseline for the first option year following onset of delivery of health services under new contracts. The annual incentive award, if any, is final upon notification by the Contracting Officer.

H.3.2.1. The monetary incentive will be based on improvement (expressed as a percentage) in each measure over each one-year option period. Beneficiaries with other health insurance will be excluded from the baseline measurement and re-measurement. Independent monetary awards may be earned annually for each measure as follows:

Measure	≥ 1% improvement	≥ 3% improvement	≥ 5% Improvement
Cervical Screening	*****	*****	*****
Breast Cancer Screening	*****	*****	*****
Asthma Medication	*****	*****	*****
Colorectal Screening	*****	*****	*****
Diabetes A1C testing	*****	*****	*****
Diabetes Lipid testing	*****	*****	*****
Diabetes Retinal Exam	*****	*****	*****

(Example: OPI Colectoral Screening = *****
OP2 = *****

H.3.2.2. The Government may unilaterally add additional administrative HEDIS ® "Effectiveness of Care" measures in future option periods. If additional measures are added, the total monetary amount available under this incentive (shown in H.3.2.1 above) will be redistributed among all measures.

H.3.3. Program Integrity Incentive: The Government will evaluate the referral of fraud and abuse cases referred during each respective option period and determine if the Contractor satisfactorily met all minimum requirements contained in each of the following sections of TRICARE Operations Manual (TOM) Chapter 14:

Section 1 Contractor's Responsibility in Program Integrity
Section 2 Case Development and Action
Section 3 Prevention and Detection
Section 4 Evaluation
Section 5 Reporting
Section 6 Provider Exclusions, Suspensions and Terminations
Section 7 Provider Reinstatements
Section 8 Threats against Contractors

H.3.3.1. The Contractor will earn a performance incentive if performance results in referral of over 10 complete cases to the TMA Office of Program Integrity during each option period that are rated "5" on a quality scale.

H.3.3.2. The monetary incentive amount applied to the performance incentive pool will be as follows:

11-15 cases referred with a "5" rating assigned: *****
16-20 cases referred with a "5" rating assigned: *****
21 or more cases referred with a "5" rating assigned: *****

H.3.3.2.1. Rating criteria: The rating of the individual cases will be based on the Government's analysis of the case referral as follows: does the case identify a pattern of fraud or abuse; have the allegations been substantiated; how has TRICARE been affected (monetarily, patient harm, etc.); is the case referral complete (thoroughly documented with evidentiary data); was appropriate back-up information included (audit files, provider files, correspondence, etc.); and was the applicable TRICARE regulation and/or policy cited and included in the package. The PI "Case

Referral Evaluation" sheet will be used to rate each referral and can be found at TOM Chapter 14, Addendum A. All case ratings will be determined by the Government solely based on the information within the initial case submittal. Any information, rebuttals, or arguments provided by the Contractor subsequent to the initial submittal of a case will not be considered for the rating determination. Any case prepared, dated, or submitted prior to the start date of the delivery of care under this contract will not be considered for this incentive. If, in the opinion of the Contracting Officer, a newly referred case should reasonably have been referred under a separate contract, that case will not be considered for an incentive. The rating assignment by the Contracting Officer is final and un-appealable.

H.3.4. Electronic Claim Submission Positive Incentive: The minimum electronic claims EMC submission performance standard is specified in Section C, paragraph CP.4.

H.3.4.1. After the appropriate paper claim exclusion percentage has been applied, if the Contractor exceeds the minimum performance standard, the amount of the incentive will be applied as follows:

H.3.4.1.1. For Option Period 1: ***** for every EMC claim which exceeds the minimum performance standard so long as the difference between the Contractor's EMC rate and paper claim rate is ***** or greater. If the difference in the EMC and paper claim rate is less than *****, then the incentive amount will be ***** of such difference for every EMC claim which exceeds the minimum performance standard.

H.3.4.1.2. For Option Periods 2 through 5: ***** for every EMC claim which exceeds the minimum performance standard so long as the difference between the Contractor's EMC rate and paper claim rate is ***** or greater. If the difference in the EMC and paper claim rate is less than *****, then the incentive amount will be ***** of such difference for every EMC claim which exceeds the minimum performance standard.

H.3.4.2. Electronic Claim Submission Negative Incentive: If the Contractor does not meet the minimum standard, positive and negative incentives will be netted, or any payment offset by the amount equal to the difference between the EMC claim rate and the paper claim rate for every claim that is below the minimum performance standard. (For example, if the Contractor is two percentage points below the minimum standard, the monetary negative incentive will be applied to two percent of the total claims not including those claims that were excluded as part of the paper claims percentage exclusion.)

H.3.4.3. The EMC submission performance rate will be determined based on data in the TEDs data base at the conclusion of an option period for claims that passed all TEDs edits during that option period regardless of the date of service or when the Contractor submits the TED record. The calculation will include initial TED records (TED type of submission equal to I, R, 0 or D) and will exclude any TED record with a provider in a foreign country or in the State of Alaska.

H.4. PERFORMANCE GUARANTEES

H.4.1 The performance guarantee described in this Section is the Contractor's guarantee that the Contractor's performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee Section are in addition to all other rights and remedies of the Government. Specifically, the Government reserves the rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4,52.246-5) and the Default clause (FAR 52.249-8, 52.249-6).

H.4.2. The Contractor guarantees that performance will meet or exceed the standards in this Section. For each occurrence the Contractor fails to meet each guaranteed standard, the Government will withhold from the Contractor the amount listed for each standard below. The total performance guarantee amount that can be assessed per option period is shown below. The total option period amount will be divided equally among the six performance guarantees. Assessments for a specific performance guarantee will continue until the guarantee amount for the respective guarantee (i.e., one-sixth of the total option period amount) is depleted. For administrative purposes, the Contractor will be notified of performance guarantee withholds on a quarterly basis via a unilateral modification in accordance with FAR 43.1 03(b)(3) with this section as the cited authority for the modification. Withholds will be made from the next available contract payment under an administrative line item. The amount of the performance guarantee will not change after contract award.

H.4.3. Performance Guarantee Amounts:

Option Period 1	*****
Option Period 2	*****
Option Period 3	*****
Option Period 4	*****
Option Period 5	*****

H.4.4. Telephone Service (Telephone Answering Speed)

H.4.4.1. Standard: When a telephone call is transferred to/answered by an individual, ***** of all calls shall be answered by an individual (not an answering machine/automated voice unit) within 30 seconds.

H.4.4.2. For each month the minimum telephone answering speed is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee of ***** per telephone call not meeting the standard. For example, if the actual percent of calls answered within 30 seconds is *****, then a performance guarantee equal to ***** of the calls will be assessed (***** represents the difference between the actual number of calls not answered within 30 seconds and the standard). If ***** equates to 1000 calls not meeting the standard, the performance guarantee withhold will be *****, or 1000 calls times *****.

H.4.4.3. All calls is defined as any call to any Contractor operated TRICARE customer service telephone number. Customer service shall be interpreted in the broadest terms including, but not limited to, calls from beneficiaries, providers, Government representatives, and interested parties about general program information, network providers, enrollment, eligibility, benefits, referrals, preauthorization's/authorizations, claims, complaints, processes and procedures.

H.4.5. Telephone Service (Initial Call Resolution Rate).

H.4.5.1. Standard: ***** of all inquiries shall be fully and completely answered during the initial telephone call. (Applies to all calls transferred to an individual.)

H.4.5.2. For each month the call resolution rate is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of ***** for each call that is not fully and completely answered during the initial telephone call that is below the ***** standard. For example, if the actual percent of calls fully and completely answered during the initial call is *****, then a performance guarantee equal to ***** of the calls not responded to will be assessed (***** represents the difference between the actual number of calls not answered during the initial call and the standard). If ***** equates to 500 calls not meeting the standard, the performance guarantee withhold will be *****, or 500 calls times *****.

H.4.6. Telephone Service (Call Resolution)

H.4.6.1. Standard: ***** of all telephone inquiries not fully and completely answered initially shall be fully and completely answered within 10 workdays.

H.4.6.2. For each month the standard is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of ***** for each call that is not fully and completely answered within 10 workdays that is below the above standard of *****. For example, if the actual percent of calls not fully and completely answered within 10 workdays is *****, then a performance guarantee equal to ***** of the calls not responded to will be assessed (***** represents the difference between the actual number of calls not answered within 10 workdays and the standard). If ***** equates to 100 calls not meeting the standard, the performance guarantee withhold will be *****, or 100 calls times *****.

Note: A performance guarantee assessment will be applied independently to each call resolution standard for telephone calls that fail to meet the minimum performance. For example, a telephone call that received a performance withhold because the ***** standard was not met, is again subject to withhold if it is not responded to within 10 workdays (and the Contractor's performance is below the minimum standard of *****).

H.4.7. Claims Processing Timeliness (30 days)

H.4.7.1. Standard: ***** of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt.

H.4.7.2. For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of ***** per retained claim in excess of the ***** standard. For example, if the actual percent of retained claims processed in 30 calendar days is *****, a performance guarantee equal to ***** of the retained claims processed that month will be assessed (***** represents the difference between the actual performance of ***** and the standard of *****). If ***** equates to 600 retained claims not processed in 30 calendar days, the performance guarantee withhold will be *****, or 600 times *****.

H.4.7.3. The Government will calculate the contractor claims processing cycle time performance utilizing TED records. Included in the monthly measurement will be TED records in initial submission batch/vouchers (Batch/Voucher Resubmission Number equals zero), and TED records in adjustment/cancellation submission batch/vouchers, which are received by TMA during the reporting period, and that have passed the TMA batch/voucher header edit(s). TED records in initial submission batch/vouchers, or TED records in adjustment/cancellation submission batch/vouchers, which fail the TMA batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor, and TEDS in resubmission batch/vouchers (Batch/Voucher Resubmission Number is greater than zero), will be excluded from the claims processing cycle time calculation. Only a single processing time will be calculated per claim. The cycle time calculation for initial submission TED records is one plus the difference between the Julian date the claim processed to completion, and the claim receipt date. The cycle time calculation for TED adjustments is one plus the difference between the Julian date the TED record was identified as an adjustment (Date Adjustment Identified not zero), and the date the adjusted record processed to completion.

H.4.8. Claim Processing Timeliness (90 Days)

H.4.8.1. Standard: ***** of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days unless the Government specifically directs the Contractor to continue pending a claim or group of claims.

H.4.8.2. For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of ***** per claim in excess of the ***** standard. For example, if the actual percent of all claims processed in 90 calendar days is *****, a performance guarantee equal to ***** of all claims processed that month will be assessed (***** represents the difference between the actual performance of ***** and the standard of *****). If ***** equates to 450 claims not processed in 90 calendar days, the performance guarantee withhold will be *****, or 450 times *****.

H.4.8.2.1. A performance guarantee assessment will be applied independently to each claim processing timeliness standard for claims that fail to meet the minimum performance. For example, a retained claim that received a performance withhold because the ***** in 30-day standard was not met, is again subject to withhold if it is not processed in 90 calendar days (and the Contractor's performance is below the minimum standard of *****).

H. 4.8.3. The Government will calculate the contractor claims processing cycle time performance utilizing TED records. Included in the monthly measurement will be TED records in initial submission batch/vouchers (Batch/Voucher Resubmission Number equals zero), and TED records in adjustment/cancellation submission batch/vouchers, which are received by TMA during the reporting period, and that have passed the TMA batch/voucher edit(s). TED records in initial submission batch/vouchers, or TED records in adjustment/cancellation submission batch/vouchers, which fail the TMA batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor, and TEDS in resubmission batch/vouchers (Batch/Voucher Resubmission Number is greater than zero), will be excluded from the claims processing cycle time calculation. Only a single processing time will be calculated per claim. The cycle time calculation for initial submission TED records is one plus the difference between the Julian date the claim processed to completion, and the claim receipt date. The cycle time calculation for TED adjustments is one plus the difference between the Julian date the TED record was identified as an adjustment (Date Adjustment Identified not zero), and the date the adjusted record processed to completion.

H.4.9. TED Edit Accuracy

H.4.9.1. Standard: The accuracy rate for TED edits shall not be less than
***** in months seven through nine;
***** in months ten through eleven
***** in months twelve through twenty-three
***** in month twenty-four through contract close.

H.4.9.2. Beginning in month seven of Option Period I, for each month that the accuracy rate for TED edits is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, if the Contractor fails to meet the standard, a performance guarantee amount of ***** for each TED record not meeting the standard will be assessed. For example, if only ***** of all TEDs pass editing in month seven, then a performance guarantee amount equal to ***** of all TEDs submitted during the month will be assessed (***** equals the difference between the Contractor's actual performance and the standard in this example). If ***** equates to 1,000 TEDs, the performance guarantee amount will be ***** or 1,000 times *****.

H.5. EVOLVING PRACTICES, DEVICES, MEDICINES, TREATMENTS AND PROCEDURES

H.5.1. Medical practices and procedures are expected to continue developing during the period of this contract: some will increase and some will decrease the cost of medical care. These changes will include practices, devices, medicines, treatments and procedures that previously were excluded from the benefits as unproven. The Contractor underwrites the cost of all drugs covered under this contract; and devices, and medical treatments or medical procedures that move from unproven to proven; and shall implement the move from unproven to proven as required at no change in contract price or underwriting fixed fee. Changes to the requirements caused by changes in the statutory definitions of the benefit or new benefits added by statute will be implemented under the Changes clause.

H.5.2. TRICARE can only cover costs only for medically necessary supplies and services. Regulatory procedures are in place at 32 C.F.R. I99.4(g)(l5) that describe the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The Contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 C.F.R. 199.2.

H.6. INTEGRATED PROCESS TEAMS

H.6.1. The Government may develop major contract and program changes through Integrated Process Teams (IPTs). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The IPT process required in this section begins the date when the Contracting Officer notifies the Contractor in writing. The Contractor will provide the appropriate personnel (as agreed to by the Contracting Officer and the Contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any proposed TRICARE program contract changes within 14 calendar days after written notification by the Contracting Officer.

H.6.2. The Contractor shall participate in all required meetings as determined by the Government team lead within the change milestones described in this section, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences). The frequency and scheduling will vary depending on the topic. The Contractor will participate with the Government team in the entire process from concept development through the final requirement. The IPT process required in this section includes developing the Government's budgetary cost estimates, identifying requirements, developing associated rough order of magnitude cost estimates, and preparing the final specification/statement of work. The IPT process required in this section will end at this point, thus this requirement does not include post-change order activities, such as implementation/coordination meetings, and definitization efforts, whose costs are allocable to the change.

H.7. AWARD FEE

The award fee will be administered two times per contract option period (semi-annually) in accordance with the

award fee plan. The award fee pool is as shown in Section B and awarded portions, if any, will be disbursed two times a contract option period. Unawarded portions of the award fee pool do not carry forward and are not available for any subsequent award fee period. The amount of the award fee pool will not change after contract award.

H.8. ASSUMPTION OF PERFORMANCE IN A SECOND TRICARE CONTRACT AREA

TRICARE is a statutory entitlement program under which there can be no lapse in program execution or interruption of services. It is the Government's duty to take all reasonable steps to ensure the ready availability of alternative contract sources to facilitate stability in delivery of this statutory entitlement program, help avoid unnecessary disruption in healthcare provider and patient relationships, and insure continuation of critical health services. Recognizing the potential that circumstances may arise under which the Government may require an alternative Contractor to assume, on an interim basis, contract performance in one of the three TRICARE contract areas, the Government will consider other options, including substituting contract performance by one or both of the other Contractors pending competitive acquisition of a successor. The Government agrees to negotiate in good faith a fair and reasonable compensation for the additional work to be performed. The Contractor retains all rights to equitable adjustments under the Changes clause in this matter.

H.9. CLAIMS PROCESSING AUDIT SAMPLING METHODOLOGY

H.9.1. Quarterly Claim Audit Sampling Methodology and Error Determinations.

H.9.1.1. Sampling Methodology: There will be three types of audit samples: one occurrence sample and two payment samples (one for non-denied claims and one for denied claims). The occurrence samples will be drawn from TEDs records which pass TMA validity edits. Records to be sampled will be "net" records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). The payment samples will be drawn from TEDs records which pass all TMA edits. Payment samples will be drawn from all records with Government payments or billed amounts greater than zero and less than $200,000, although the Government may choose to exclude certain claims strata from the sampling frame. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts or billed amounts of over $200,000. Payment samples will be stratified at multiple levels, either by payment amount, billed amount or by other claims-based parameters, such as type of care and/or type of provider. Records to be sampled for both the occurrence and payment audits will be "net" records (i.e., the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in batches/vouchers which fail TRICARE edits or which are otherwise unprocessable as submitted by the Contractor will be excluded from the sampling frame.

H.9.1.2. Required Contractor Documentation: Upon receipt of the TEDs Internal Control Number (lCN) listing and TED Detail Audit Report (TADR) from TMA the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit Contractors within forty five (45) calendar days from the date of the TMA letter transmitting the ICN and TADR listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service.

H.9.1.2.1. Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, and other telephone conversation records.

H.9.1.2.2. Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate(s), per diem rate(s), state prevailing fee(s) or fee schedule(s), DRG, OPPS, SNF, pricing information and such other documents as are required to support the action taken on the claim.

H.9.1.2.3. A copy of the Explanation of Benefits (EOB) (or EOB facsimile) for each claim selected.

H.9.1.2.4. The Contractor shall send via electronic data input the current family history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or the designated audit Contractor within forty five (45) calendar days from the date of the TMA or designated audit Contractor letter transmitting the ICN and TADR listing.

H.9.1.2.5. Payment or occurrence errors will be assessed if a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable. For TEDs which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit Contractors will return original documents upon completion of the audit process.

H.9.1.2.6. Additional data to be furnished by the Contractor.

H.9.1.2.6.1. Description of data elements by field position in family history file printout and field definitions for pricing, OHI, authorization, referral screens. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

H.9.1.2.6.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

H.9.1.2.6.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the 5th work day of the month following the change.

H.9.1.2.6.4. Specifications for submission of the provider files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

H.9.1.2.6.5. Documentation for any claim selected with adjustment transactions completed prior to the date of the sample must include the documentation to indicate both initial and adjustment processing actions to include claims EOBs, and pricing information.

H.9.1.2.6.6. Documentation to support beneficiary approved participation in any TMA demonstration programs.

H.9.2. Quarterly Payment Error and Process Error Determinations.

H.9.2.1. There are two categories of payment errors: (I) a payment error which cannot be removed by Contractor post payment processing actions and (2) a payment error which can be removed by Contractor post payment processing actions (see list of audit error codes defining payment error categories). Payment errors which can be removed by Contractor post payment actions will also be assessed a process error at audit. If Contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

H.9.2.2. Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a non-covered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed medical emergency not substantiated, medical necessity review not evident and is cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

H.9.2.3. Payment errors which may not be removed by Contractor post payment actions (see audit error categories)

are based only on the claim information available and those processing actions which occur prior to the date the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to include the action taken and the date the action was completed is submitted with audit documentation. Action determinations occurring after the date the audit sample is pulled will not be considered in the audit regardless of whether resolution of payment error exists. Adjustment transactions are not allowed on total claim denials. Therefore, subsequent reprocessing actions to a denied claim which occur prior to the date the audit sample is pulled will be considered during the audit.

H.9.2.4. All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

H.9.3. Computation of the "Total Amount Billed" for Non-Denied Institutional Claims.

H.9.3.1. For treatment encounters for which no per diem, negotiated rate or DRG-based amount applies for consideration of payment, the "total amount billed" is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG exempt services and those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid.

H9.3.2. For treatment encounters subject to the TRICARE per diem payments, negotiated rate, or the DRG reimbursement methodology, the "total amount billed" is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

H.9.3.3. If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total amount billed will be assessed. For health care services records which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total amount billed. This condition is considered to be an unsupported TED.

H.9.3.4. The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

01K-AuthorizationlPreAuthorization needed (all- except (ECHO)* and Adjunctive Dental Authorizations)
03K-Billed Amount Incorrect
04K-Cost-share / Deductible Error
07K- Duplicate Services Paid
08K- Eligibility Determination—Patient
09K- Eligibility Determination—Provider
12K- Non-Availability Statement Error
13K-OHI/TPL—Govt. Pay Miscalculated
14K-Om Payment Omitted
15K-Payee Wrong-Sponsor/Patient
16K- Payee Wrong- Provider
17K- Participating/Non-Participating Error
18K- Pricing Incorrect
19K-Procedure Code Incorrect
20K-Signature Error
22K-DRG Reimbursement Error
24K-Incorrect Benefit Determination
25K-Claim Not Provided
26K-Claim Not Auditable
27K-Incorrect MCS System

H.9.3.5. The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

01K-Authorization/Pre-Authorization Needed (ECHO* and adjunctive dental authorizations)
02K-Unsupported Benefit Determination
05K-Development Claim Denied Prematurely
06K-Development Required
10K-Medical Emergency Not Substantiated
11K-Medical Necessity/Review Not Evident
21K-Timely-Filing Error
23K-Contract Jurisdiction Error
99K-Other—This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

*ECHO Care Health Option
—Extended

H.9.4. Quarterly TED Occurrence Error Determination.

H.9.4.1. The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

H.9.4.2. Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields, or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

H.9.4.3. Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

H.9.4.4. Some TED error conditions are not attributable to anyone specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated.

H.9.4.5. The following are occurrence error categories and codes. All TED record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the TED record.

Error Categories	Errors Condition Specific to Data Field
A	Incorrect Claim Information
B	Incorrect Patient/Sponsor Information
C	Incorrect Provider Information
D	Incorrect Admission/Discharge Information (Institutional TED Records only)
E	Incorrect Diagnosis/Treatment Information (Institutional TED Records Only)
F	Incorrect Diagnosis Information (Non-Institutional TED Records Only)
G	Incorrect Financial Information
H	Incorrect Institutional Revenue Data
I	Incorrect Non-Institutional Claims/Provider/Utilization Information

Error Codes	Error Condition Specific to Claim	Number of Errors
01J	Unlike Procedures/Providers Combined (Non-institutional Record)	7 errors for each additional utilization data set*
02J	Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**

03J	Services Should Be Combined	1 error for each additional revenue code/utilization data set
04J	Missing Non-institutional Utilization Data Set	7 errors for each missing data set*
05J	Extra Non-institutional Utilization Data Set	7 errors for each extra data set*
06J	Missing Institutional Revenue Code Set	5 error for each missing revenue code set**
07J	Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
08J	Incorrect Record Type	5 errors
09J	Separate TED Record Required	1 error
10J	Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
11J	Claims Not Auditable	1 error plus 1 error for each revenue code utilization data set in TED
12J	Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in TED

H.9.4.6. The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

01P – Authorization/Pre-authorization needed (ECHO and adjunctive dental authorizations)
02P—Unsupported Benefit Determinations
05P—Development Claim Denied Prematurely
06P—Development Required
10P—Medical Emergency Not Substantiated
11P—Medical Necessity/Review Not Evident
21P—Timely Filing Error
23P—Contract Jurisdiction Error
99P – Other

H.9.5. Quarterly Payment and Occurrence Error Determination Rebuttals. Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality audit within 30 calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within 30 calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit Contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated audit Contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 30 to the Julian calendar date of the TMA or designated audit Contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit Contractor rebuttal response letter.

H.10. UNDERWRITTEN HEALTH CARE COST AUDIT
(Reference FAR Clause 52.216-25, ALLOWABLE COST AND PAYMENT (DEC 2002) (DEVIATION),

H.10.1 TRICARE Encounter Data (TED) batch/voucher payment records are utilized to determine unallowable costs based on the results of this health care cost audit. The total unallowable amount is calculated on a per record basis, using all fields used to calculate a batch/voucher header total, and for dates of service falling within a specified option period. The total amount reimbursed by the Government will be calculated using all edited TEDs batch/vouchers with resubmission number equal to zero. At the time of the audit, batch/voucher records that have not passed validity edits on the TED record, or which are otherwise unprocessable as submitted by the Contractor, will be excluded from this audit sample. The Government reserves its rights under FAR 42.80 I to disallow costs identified as unallowable through means other than the underwritten health care cost audit, when such costs are not included in the audit sample universe.

H.10.2. Sampling Methodology, Application of Results and Error Determinations.

H.10.2.1. For each option period, a stratified random sample of up to 10,000 claims from the universe of non-denied underwritten claims will be used to estimate the total overpayment amount in the claims universe. The point estimate (E) of questioned cost in the universe will be deemed the unallowable cost amount, provided that the lower bound (LB) of a one-sided ninety-percent (90%) confidence interval for E is at least 95% as large as E. Otherwise, LB will be deemed as the unallowable cost amount. All claims in the sample determined to have been underpaid will be deemed to have an overpayment amount of zero. At the discretion of the Government, the unallowable cost amount will be determined based on the estimated average overpayment per claim in the universe, the estimated ratio of overpayments to payments in the universe, or other commonly used estimation methods, in order to allow the Government to arrive at the best estimate of overpayments in the claims universe. The payment samples will be drawn from all records with Government reimbursement of greater than zero and less than $200,000, although the Government may choose to exclude certain claims strata from the sampling frame and from the claims universe. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts of over $200,000. The unallowable cost amount found in this 100% audit will be added to the unallowable costs estimated based on the sampling of claims with payment amounts of under $200,000. Payment samples will be stratified at multiple levels, either by payment amount or by other claims-based parameters, such as type of care and/or type of provider.

H.10.2.2. Samples will be drawn from underwritten TED records that have passed all TED edits and that have processed into the TEDs database through the thirteenth month following the end of the each contract option period. The audit sample will be drawn from underwritten TED records with beginning dates of service within the option period in question. Records to be sampled will be “net” records (i.e., the sum of the option-period transaction records available). The Government will provide the Contractor, at the same time the sample is requested, a complete listing of all TED records that encompass the audit universe for each respective option period. At that time, the Contractor shall identify all TED records that are from non-underwritten claims and claims that were not within the dates of service range for the option period being audited. The Contractor shall provide a list of such claims, including any supporting documentation, not later than thirty (30) calendar days after receipt of the listing.

H.10.2.2. Required Contractor Documentation.

H.10.2.2.1. Upon receipt of the TEDs Internal Control Number (lCN) listing and TED Detail Audit Report (TADR) from TMA, the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit Contractors within forty-five (45) calendar days from the date of the TMA letter transmitting the ICN listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service:

a) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, and other telephone conversation records;

b) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: I) provider name, 2) provider identification number, 3) effective and termination dates of agreements, and 4) negotiated rate(s), per diem rate(s), state prevailing fee(s) or fee schedule(s), DRG, OPPS, or SNF pricing information, and such other documents as are required to support the action taken on the claim;

c) A copy of the EOB (or EOB facsimile) for each claim selected.

d) Documentation to support beneficiary approved participation in any TMA demonstration programs.

H.10.2.2.2. The Contractor shall also send, via electronic data input, the current family history (15 to 27 months) for each selected claim.

H.10.2.2.3. Documentation for any claim selected with adjustment transactions completed prior to the date of the sample must include the documentation to indicate both initial and adjustment processing actions, to include claims EOBs, and pricing information.

H.10.2.2.4. If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, 100 percent of the payment based upon the total Government Pay Amount will be deemed unallowable. For TEDs that do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, 100 percent of the payment amount will be deemed unallowable. The payment amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or the designated audit Contractors will return original documents upon completion of the audit process.

H.10.2.3. Other Deliverables. Paragraphs F.6.1 0 through F.6.10.4 in Section F describe the Contractor's claims processing data elements, guidelines, processes, screens, criteria, instructions, etc. that are required to be submitted during the base period of the contract. The Contractor shall submit any changes to these elements/guidelines/ processes/screens/criteria/instructions as they occur.

H.10.2.4. Payment Error Determinations.

H.10.2.4.1. The audit error codes (K codes) indicated in Section H.9, above will apply to the cost audit. Payment errors are based on the claim information available and those processing actions taken up to the time the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to indicate the action taken and the date the action was completed is submitted. Actions and determinations occurring after the date the audit sample is pulled will not be considered in the audit described in this section regardless of whether resolution of a payment error exists.

H.10.2.4.2. Payment errors are the amount of overpayments on a claim, including but not limited to misapplication of the deductible, payment of non-covered service/supplies, or payment of services/supplies for which a benefit cannot be determined based on the information available at the time of processing, or a payment in the correct amount but sent to the wrong payee. The measure of the payment error is the TED record.

H.10.2.5. Cost Audit Rebuttals.

H.10.2.5.1. Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality auditor within thirty (30) calendar days of the date of the audit transmittal letters. Rebuttals not submitted within thirty (30) calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when, during the audit rebuttal process, the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit Contractor during the initial rebuttal process must be submitted within 30 calendar days of the TRICARE or designated quality review Contractor rebuttal response letter. Rebuttals to new errors not submitted within 30 calendar days from the date of the original rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 30 to the Julian calendar date of the TMA or designated audit Contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit Contractor rebuttal response letter.

H.10.2.5.2. The rebuttal for the healthcare cost audit shall be certified by a responsible official of the Contractor as to accuracy and completeness. The rebuttal submission and the rebuttal process used by the Contractor may be reviewed by the Government.

H.10.3. Upon completion of the audit process, the Contracting Officer will notify the Contractor of the disallowed amount and will either deduct that amount from current payments, or provide other instructions for the return of the disallowed amount. When the Government has recovered from any disallowed amount; the Contractor is not required to return monies it subsequently recovered from third parties on any claims/TED records that were included in the universe from which the audit sample was drawn. See TOM Chapter 3, Section 3., Paragraph 2.2.2.

H.11. EXPRESSLY UNALLOWABLE HEALTH CARE COSTS

This contract identifies certain cost categories that are not underwritten health care costs. These are known as

expressly unallowable underwritten health care costs. This includes, but is not limited to, the Contractor payments under Section C, paragraph RM.2.1. and payments over the allowed amounts specified in the TRICARE Manuals. Any payment made by the Contractor that is expressly unallowable is borne by the Contractor and shall not be reported or billed as underwritten health care costs. The Contractor must account for these payments at the individual claim level. These unallowable amounts shall be available for review by the Contracting Officer or designee.

H.12. INSURANCE LIABILITY COVERAGES

In accordance with FAR 28.306(b) and as incorporated by reference in Section I, FAR 52.228-5, INSURANCE—WORK ON A GOVERNMENT INSTALLATION (JAN 1997), the following minimum liability coverages are stated below:

(a) *Workers' compensation and employer's liability.* The Contractor is required to comply with applicable Federal and State workers' compensation and occupational disease statutes. If occupational diseases are not compensable under those statutes, they shall be covered under the employer's liability section of the insurance policy, except when contract operations are so commingled with a contractor's commercial operations that it would not be practical to require this coverage. Employer's liability coverage of at least $100,000 shall be required, except in States with exclusive or monopolistic funds that do not permit workers' compensation to be written by private carriers. (See 28.305(c) for treatment of contracts subject to the Defense Base Act.)

(b) General liability.

(1) The contractor shall be required to provide bodily injury liability insurance coverage written on the comprehensive form of policy of at least $500,000 per occurrence.

(2) Property damage liability insurance shall be required only in special circumstances as determined by the agency.

(c) *Automobile liability.* The contractor shall be required to provide automobile liability insurance written on the comprehensive form of policy. The policy shall provide for bodily injury and property damage liability covering the operation of all automobiles used in connection with performing the contract. Policies covering automobiles operated in the United States shall provide coverage of at least $200,000 per person and $500,000 per occurrence for bodily injury and $20,000 per occurrence for property damage. The amount of liability coverage on other policies shall be commensurate with any legal requirements of the locality and sufficient to meet normal and customary claims.

H.13. ADDITIONAL PERFORMANCE REQUIREMENTS

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H.13.1. *****

H.13.2. *****

H.13.3. *****

H.13.4. *****

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Section I—Contract Clauses

52.202-1 Definitions. (JUL 2004)

52.203-3 Gratuities. (APR 1984)

52.203-5 Covenant Against Contingent Fees. (APR 1984)

52.203-6 Restrictions on Subcontractor Sales to the Government. (SEP 2006)

52.203-7 Anti-Kickback Procedures. (OCT 2010)

52.203-8 Cancellation, Rescission, and Recovery of Funds for illegal or Improper Activity. (JAN 1997)

52.203-10 Price or Fee Adjustment for Illegal or Improper Activity. (JAN 1997)

52.203-12 Limitation on Payments to Influence Certain Federal Transactions. (OCT 2010)

52.203-13 Contractor Code of Business Ethics and Conduct. (APR 2010)

52.203-14 Display of Hotline Poster(s). (DEC 2007)

(a) Definition.

"United States," as used in this clause, means the 50 States, the District of Columbia, and outlying areas.

(b) Display of fraud hotline poster(s). Except as provided in paragraph (c)—

(1) During contract performance in the United States, the Contractor shall prominently display in common work areas within business segments performing work under this contract and at contract work sites—

(i) Any agency fraud hotline poster or Department of HomeIand Security (DHS) fraud hotline poster identified in paragraph (b)(3) of this clause; and

(ii) Any DHS fraud hotline poster subsequently identified by the Contracting Officer.

(2) Additionally, if the Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the poster(s) at the website.

(3) Any required posters may be obtained as follows:

Poster(s) Obtain from

(3) Any required posters may be obtained as follows:

DoD Inspector General, ATTN: Defense Hotline, 400 Army Navy Drive, Washington, DC 22202-2884.

Poster(s) Obtain by accessing the following website:

http://www.dodig.osd.mil/hotline/hotline7.htm

(c) If the Contractor has implemented a business ethics and conduct awareness program, including a reporting mechanism, such as a hotline poster, then the Contractor need not display any agency fraud hotline posters as required in paragraph (b) of this clause, other than any required DHS posters.

(d) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (d), in all subcontracts that exceed $5,000,000, except when the subcontract—

(1) Is for the acquisition of a commercial item; or

(2) Is performed entirely outside the United States.

(End of clause)

52.204-4 Printed or Copied Double-Sided on Recycled Paper. (AUG 2000)

52.204-7 Central Contractor Registration. (APR 2008)

52.204-9 Personal Identity Verification of Contractor Personnel. (JAN 2011)

52.204-10 Reporting Executive Compensation and First-Tier Subcontract Awards. (JUL 2010)

52.209-6 Protecting the Government's Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment. (DEC 2010)

52.209-9 - Updates of Publicly Available Information Regarding Responsibility Matters.

(Jan 2011)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the Central Contractor Registration database at http://www.ccr.gov .

(b)

(1) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(2) The Contractor will have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i. *e.,* for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3)

(i) Public requests for system information posted prior to April 15,2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

(ii) As required by section 3010 of Public Law 111-212, all information posted in FAPIIS on or after April IS, 2011, except past performance reviews, will be publicly available.

(End of clause)

52.211-15 Defense Priority and Allocation Requirements. (APR 2008)

52.215-2 Audit and Records—Negotiation. (OCT 2010)

52.215-8 Order of Precedence—Uniform Contract Format. (OCT 1997)

52.215-11 Price Reduction for Defective Certified Cost or Pricing Data—Modifications. (OCT 2010)

52.215-13 Subcontractor Certified Cost or Pricing Data—Modifications. (OCT 2010

52.215-15 Pension Adjustments and Asset Reversions. (OCT 2010)

52.215-18 Reversion or Adjustment of Plans for Postretirement Benefits (PRB) Other Than Pensions (JUL 2005)

52.215-19 Notification of Ownership Changes. (OCT 1997)

(a) The Contractor shall make the following notifications in writing:

(1) When the Contractor becomes aware that a change in its ownership has occurred, or is certain to occur, that could result in changes in the valuation of its capitalized assets in the accounting records, the Contractor shall notify the Administrative Contracting Officer (ACO) within 30 days.

(2) The Contractor shall also notify the ACO within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership.

(b) The Contractor shall -

(1) Maintain current, accurate, and complete inventory records of assets and their costs;

(2) Provide the ACO or designated representative ready access to the records upon request;

(3) Ensure that all individual and grouped assets, their capitalized values, accumulated depreciation or amortization, and remaining useful lives are identified accurately before and after each of the Contractor's ownership changes; and

(4) Retain and continue to maintain depreciation and amortization schedules based on the asset records maintained before each Contractor ownership change.

(c) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR l5.408(k).

(End of clause)

52.216-7 Allowable Cost and Payment. (DEC 2002)
(Applicable to all CLINs for Disease Management and Transition Out)

(a) *Invoicing.* (l) The Government will make payments to the Contractor when requested as work progresses, but (except for small business concerns) not more often than once every 2 weeks, in amounts determined to be allowable by the Contracting Officer in accordance with Federal Acquisition Regulation (FAR) subpart 31.2 in effect on the date of this contract and the terms of this contract. The Contractor may submit to an authorized representative of the Contracting Officer, in such form and reasonable detail as the representative may require, an invoice or voucher supported by a statement of the claimed allowable cost for performing this contract.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

(3) The designated payment office will make interim payments for contract financing on the 30 th day after the designated billing office receives a proper payment request.

In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) *Reimbursing costs.* (l) For the purpose of reimbursing allowable costs (except as provided in subparagraph (b)(2) of this clause, with respect to pension, deferred profit sharing, and employee stock ownership plan contributions), the term "costs" includes only-

(i) Those recorded costs that, at the time of the request for reimbursement, the Contractor has paid by cash, check, or other form of actual payment for items or services purchased directly for the contract;

(ii) When the Contractor is not delinquent in paying costs of contract performance in the ordinary course of business, costs incurred, but not necessarily paid, for –

(A) Supplies and services purchased directly for the contract and associated financing payments to subcontractors, provided payments determined due will be made-

(1) In accordance with the terms and conditions of a subcontract or invoice; and

(2) Ordinarily within 30 days of the submission of the Contractor's payment request to the Government;

(B) Materials issued from the Contractor's inventory and placed in the production process for use on the contract;

(C) Direct labor;

(D) Direct travel;

(E) Other direct in-house costs; and

(F) Properly allocable and allowable indirect costs, as shown in the records maintained by the Contractor for purposes of obtaining reimbursement under Government contracts; and

(iii) The amount of financing payments that have been paid by cash, check, or other forms of payment to subcontractors.

(2) Accrued costs of Contractor contributions under employee pension plans shall be excluded until actually paid unless –

(i) The Contractor's practice is to make contributions to the retirement fund quarterly or more frequently; and

(ii) The contribution does not remain unpaid 30 days after the end of the applicable quarter or shorter payment period (any contribution remaining unpaid shall be excluded from the Contractor's indirect costs for payment purposes).

(3) Notwithstanding the audit and adjustment of invoices or vouchers under paragraph (g) of this clause, allowable indirect costs under this contract shall be obtained by applying indirect cost rates established in accordance with paragraph (d) of this clause.

(4) Any statements in specifications or other documents incorporated in this contract by reference designating performance of services or furnishing of materials at the Contractor's expense or at no cost to the Government shall be disregarded for purposes of cost-reimbursement under this clause.

(c) *Small business concerns.* A small business concern may receive more frequent payments than every 2 weeks.

(d) *Final indirect cost rates.* (1) Final annual indirect cost rates and the appropriate bases shall be established in accordance with Subpart 42.7 of the Federal Acquisition Regulation (FAR) in effect for the period covered by the indirect cost rate proposal.

(2)(i) The Contractor shall submit an adequate final indirect cost rate proposal to the Contracting

Officer (or cognizant Federal agency official) and auditor within the 6-month period following the expiration of each of its fiscal years. Reasonable extensions, for exceptional circumstances only, may be requested in writing by the Contractor and granted in writing by the Contracting Officer. The Contractor shall support its proposal with adequate supporting data.

(ii) The proposed rates shall be based on the Contractor's actual cost experience for that period. The appropriate Government representative and the Contractor shall establish the final indirect cost rates as promptly as practical after receipt of the Contractor's proposal.

(3) The Contractor and the appropriate Government representative shall execute a written understanding setting forth the final indirect cost rates. The understanding shall specify (i) the agreed-upon final annual indirect cost rates, (ii) the bases to which the rates apply, (iii) the periods for which the rates apply, (iv) any specific indirect cost items treated as direct costs in the settlement, and (v) the affected contract and/or subcontract, identifying any with advance agreements or special terms and the applicable rates. The understanding shall not change any monetary ceiling, contract obligation, or specific cost allowance or disallowance provided for in this contract. The understanding is incorporated into this contract upon execution.

(4) Failure by the parties to agree on a final annual indirect cost rate shall be a dispute within the meaning of the Disputes clause.

(5) Within 120 days (or longer period if approved in writing by the Contracting Officer) after settlement of the final annual indirect cost rates for all years of a physically complete contract, the Contractor shall submit a completion invoice or voucher to reflect the settled amounts and rates.

(6)(i) If the Contractor fails to submit a completion invoice or voucher within the time specified in paragraph (d)(5) of this clause, the Contracting Officer may—

(A) Determine the amounts due to the Contractor under the contract; and

(B) Record this determination in a unilateral modification to the contract.

(ii) This determination constitutes the final decision of the Contracting Officer in accordance with the Disputes clause.

(e) *Billing rates.* Until final annual indirect cost rates are established for any period, the Government shall reimburse the Contractor at billing rates established by the Contracting Officer or by an authorized representative (the cognizant auditor), subject to adjustment when the final rates are established. These billing rates –

(1) Shall be the anticipated final rates; and

(2) May be prospectively or retroactively revised by mutual agreement, at either party's request, to prevent substantial overpayment or underpayment.

(f) *Quick-closeout procedures.* Quick-closeout procedures are applicable when the conditions in FAR 42.708(a) are satisfied.

(g) *Audit.* At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. Any payment may be –

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or

(2) Adjusted for prior overpayments or underpayments.

(h) *Final payment.* (1) Upon approval of a completion invoice or voucher submitted by the Contractor in

accordance with paragraph (d)(5) of this clause, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, or other amounts (including interest, if any) accruing to or received by the Contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government. Reasonable expenses incurred by the Contractor for securing refunds, rebates, credits, or other amounts shall be allowable costs if approved by the Contracting Officer. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver –

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except –

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the Contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier; and

(C) Claims for reimbursement of costs, including reasonable incidental expenses, incurred by the Contractor under the patent clauses of this contract, exclud-ing, however, any expenses arising from the Contractor's indemnification of the Government against patent liability.

(End of clause)

52.216-7 Allowable Cost and Payment. (DEC 2002) (DEVIATION)
(Applicable to CLINs for Underwritten Health Care Cost)

(a) Invoicing.

(1) The Government will make payments to the Contractor when requested, but not more often than once every Government business day, in amounts determined to be allowable by the Contracting Officer in accordance with Federal Acquisition Regulation Subpart 31.201-6 and with the terms of this contract. The submission of health care costs on a TED voucher that pass the TED edits will be considered an invoice or voucher for reimbursement of claimed allowable health care costs.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

(3) In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) Reimbursing costs. For the purpose of reimbursing allowable costs, the term "costs" includes only —

(1) Those submitted on vouchers either for direct health care costs that, at the time the request for reimbursement has passed the TED edits; and,

(2) Those recorded costs that, at the time of the request for reimbursement, the Contractor has actually paid or made the expenditure by cash, check, electronic fund transfer, or other form of actual payment for health care under this contract and,

(3) Those costs eligible for reimbursement are the direct health care costs that pass TED edits involving health care furnished to an eligible beneficiary, health care authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies. Costs reimbursed based on vouchers passing initial TED edits are subject to further payment adjustment by the Government if determined not to qualify as an allowable cost.

(d) Audit. At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits" as used in this clause, includes audits on statistically valid samples. The audit results will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine the total overpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments of, or other unallowable health care costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5). Any payment may be-

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or

(2) Adjusted for prior overpayments or underpayments.

(e) Final Payment.

(1) Upon approval of a completion invoice or voucher submitted by the Contractor, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, Contractor's claim overpayment or fraud recoveries, or other amounts (including interest, if any) accruing to or received by the contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government and not previously identified and returned to the Government as an unallowable cost. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver—

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except-

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier.

(End of Clause)

52.216-8 Fixed Fee. (MAR 1997)

(CLINs 1003, 1004, 1006; CLINs 2003, 2004, 2006; CLINs 3003, 3004, 3006; CLINs 4003, 4004, 4006; CLINs 5003,5004,5006 and 9001.)

52.216-30 Time-and-Materials/Labor-Hour Proposal Requirements—Non-Commercial Item Acquisition without Adequate Price Competition. (FEB 2007)
CLINs 1015,2015,3015,4015, and 5015.

(a) The Government contemplates award of a Time-and-Materials or Labor-Hour type of contract resulting from this solicitation.

(b) The offer or must specify separate fixed hourly rates in its offer that include wages, overhead, general and administrative expenses, and profit for each category of labor to be performed by—

(1) The offer or;

(2) Each subcontractor; and

(3) Each division, subsidiary, or affiliate of the offeror under a common control.

(c) Unless exempt under paragraph (d) of this provision, the fixed hourly rates for services transferred between divisions, subsidiaries, or affiliates of the offeror under a common control—

(1) Shall not include profit for the transferring organization; but

(2) May include profit for the prime Contractor.

(d) The fixed hourly rates for services that meet the definition of commercial item at 2.10 1 that are transferred between divisions, subsidiaries, or affiliates of the offeror under a common control may be the established catalog or market rate when it is the established practice of the transferring organization to price interorganizational transfers at other than cost for commercial work of the offeror or any division, subsidiary or affiliate of the offeror under a common control.

(End of provision)

52.217-8 Option to Extend Services. (NOV 1999)

The Government may require continued performance of any services within the limits and at the rates specified in the contract. These rates may be adjusted only as a result of revisions to prevailing labor rates provided by the Secretary of Labor. The option provision may be exercised more than once, but the total extension of performance hereunder shall not exceed 6 months. The Contracting Officer may exercise the option by written notice to the Contractor within 90 days of contract expiration.

(End of Clause)

52.217-9 Option to Extend the Term of the Contract. (MAR 2000)

(a) The Government may extend the term of this contract by written notice to the Contractor within 30 calendar days provided that the Government gives the Contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.

(b) lf the Government exercises this option, the extended contract shall be considered to include this option clause.

(c) The total duration of this contract, including the exercise of any options under this clause, shall not exceed 7 years, 5 months.

(End of clause)

52.219-4 Notice of Price Evaluation Preference for HUBZone Small Business Concerns. (JAN 2011)

(a) *Definition.* See 13 *CPR* 125.6(e) for definitions of terms used in paragraph (d).
(b) *Evaluation preference.*

(1) Offers will be evaluated by adding a factor of 10 percent to the price of all offers, except –

(i) Offers from HUBZone small business concerns that have not waived the evaluation preference; and

(ii) Otherwise successful offers from small business concerns.

(2) The factor of 10 percent shall be applied on a line item basis or to any group of items on which award may be made. Other evaluation factors described in the solicitation shall be applied before application of the factor.

(3) A concern that is both a HUBZone small business concern and a small disadvantaged business concern will receive the benefit of both the HUBZone small business price evaluation preference and the small disadvantaged business price evaluation adjustment (see FAR clause 52.219-23). Each applicable price evaluation preference or adjustment shall be calculated independently against an offeror's base offer. These individual preference amounts shall be added together to arrive at the total evaluated price for that offer.

(4) When the two highest rated offerors are a HUBZone small business concern and a large business, and the evaluated offer of the HUBZone small business concern is equal to the evaluated offer of the large business after considering the price evaluation preference, award will be made to the HUBZone small business concern.

(c) *Waiver of evaluation preference.* A HUBZone small business concern may elect to waive the evaluation preference, in which case the factor will be added to its offer for evaluation purposes. The agreements in paragraphs (d) and (e) of this clause do not apply if the offeror has waived the evaluation preference. _ Offer elects to waive the evaluation preference.

(d) *Agreement.* A HUBZone small business concern agrees that in the performance of the contract, in the case of a contract for

(1) Services (except construction), at least 50 percent of the cost of personnel for contract performance will be spent for employees of the concern or employees of other HUBZone small business concerns;

(2) Supplies (other than procurement from a nonmanufacturer of such supplies), at least 50 percent of the cost of manufacturing, excluding the cost of materials, will be performed by the concern or other HUBZone small business concerns;

(3) General construction.

(i) At least 15 percent of the cost of contract performance to be incurred for personnel will be spent on the prime contractor's employees;

(ii) At least 50 percent of the cost of the contract performance to be incurred for personnel will be spent on the prime contractor's employees or on a combination of the prime contractor's employees and employees of HUBZone small business concern subcontractors;

(iii) No more than 50 percent of the cost of contract performance to be incurred for personnel will be subcontracted to concerns that are not HUBZone small business concerns; or

(4) Construction by special trade contractors.

(i) At least 25 percent of the cost of contract performance to be incurred for personnel will be spent on the prime contractor's employees;

(ii) At least 50 percent of the cost of the contract performance to be incurred for personnel will be spent on the prime contractor's employees or on a combination of the prime contractor's employees and employees of HUBZone small business concern subcontractors;

(iii) No more than 50 percent of the cost of contract performance to be incurred for personnel will be subcontracted to concerns that are not HUBZone small business concerns.

(e) A HUBZone joint venture agrees that the aggregate of the HUBZone small business concerns to the joint venture, not each concern separately, will perform the applicable percentage of work requirements.

(f)

(1) When the total value of the contract exceeds $25,000, a HUBZone small business concern nonmanufacturer agrees to furnish in performing this contract only end items manufactured or produced by HUBZone small business concern manufacturers.

(2) When the total value of the contract is equal to or less than $25,000, a HUBZone small business concern nonmanufacturer may provide end items manufactured by other than a HUBZone small business concern manufacturer provided the end items are produced or manufactured in the United States.

(3) Paragraphs (f)(1) and (f)(2) of this section do not apply in connection with construction or service contracts.

(g) Notice. The HUBZone small business offeror acknowledges that a prospective HUBZone awardee must be a HUBZone small business concern at the time of award f this contract. The HUBZone offeror shall provide the Contracting Officer a copy of the notice required by 13 CFR 126.501 if material changes occur before contract award that could affect its HUBZone eligibility. If the apparently successful HUBZone offeror is not a HUBZone small business concern at the time of award of this contract, the Contracting Officer will proceed to award to the next otherwise successful HUBZone small business concern or other offeror.
(End of clause)

52.219-8 Utilization of Small Business Concerns. (JAN 2011)

52.219-9 Small Business Subcontracting Plan. (JAN 2011)

52.219-9 Small Business Subcontracting Plan.—Alternate II (OCT 2001)

52.219-16 Liquidated Damages—Subcontracting Plan. (JAN 1999)

52.222-1 Notice to the Government of Labor Disputes. (FEB 1997)

52.222-2 Payment for Overtime Premiums. (JUL 1990)

(a) The use of overtime is authorized under this contract if the overtime premium does not exceed Zero (0) or the overtime premium is paid for work -

(1) Necessary to cope with emergencies such as those resulting from accidents, natural disasters, breakdowns of production equipment, or occasional production bottlenecks of a sporadic nature;

(2) By indirect-labor employees such as those performing duties in connection with administration, protection, transportation, maintenance, standby plant protection, operation of utilities, or accounting;

(3) To perform tests, industrial processes, laboratory procedures, loading or unloading of transportation conveyances, and operations in flight or afloat that are continuous in nature and cannot reasonably be interrupted or completed otherwise; or

(4) That will result in lower overall costs to the Government.

(b) Any request for estimated overtime premiums that exceeds the amount specified above shall include all estimated overtime for contract completion and shall –

(1) Identify the work unit; *e.g.,* department or section in which the requested overtime will be used, together with present workload, staffing, and other data of the affected unit sufficient to permit the Contracting Officer to evaluate the necessity for the overtime;

(2) Demonstrate the effect that denial of the request will have on the contract delivery or performance schedule;

(3) Identify the extent to which approval of overtime would affect the performance or payments in connection with other Government contracts, together with identification of each affected contract; and

(4) Provide reasons why the required work cannot be performed by using multi-shift operations or by employing additional personnel.

* Insert either “zero” or the dollar amount agreed to during negotiations. The inserted figure does not apply to the exceptions in subparagraph (a)(1) through (a)(4) of the clause.

(End of clause)

52.222-3 Convict Labor. (JUN 2003)

52.222-21 Prohibition of Segregated Facilities. (FEB 1999)

52.222-26 Equal Opportunity. (MAR 2007)

52.222-35 Equal Opportunity for Veterans (SEP 2010)

52.222-36 Affirmative Action for Workers with Disabilities. (OCT 2010)

52.222-37 Employment Reports on Veterans (SEP 2010)

52.222-50 Combating Trafficking in Persons. (FEB 2009)

52.223-6 Drug-Free Workplace. (MAY 2001)

52.223-14 Toxic Chemical Release Reporting. (AUG 2003)

52.224-1 Privacy Act Notification. (APR 1984)

52.224-2 Privacy Act. (APR 1984)

52.225-13 Restrictions on Certain Foreign Purchases. (JUN 2008)

52.227-1 Authorization and Consent. (DEC 2007)

52.227-2 Notice and Assistance Regarding Patent and Copyright Infringement. (DEC 2007)

52.227-3 Patent Indemnity. (APR 1984)

52.227-14 Rights in Data—General. (DEC 2007)

52.228-5 Insurance—Work on a Government Installation. (JAN 1997)

52.228-7 Insurance—Liability to Third Persons. (MAR 1996)

52.229-3 Federal, State, and Local Taxes. (APR 2003)

52.230-2 Cost Accounting Standards. (OCT 2010)

52.230-6 Administration of Cost Accounting Standards. (JUN 2010)

52.232-1 Payments. (APR 1984)

52.232-3 Payments under Personal Services Contracts. (APR 1984)
(CLINs/Sub-CLINs for Clinical Support Agreement when determined as a personal service)

52.232-7 Payments under Time-and-Materials and Labor-Hour Contracts. (FEB 2007)

52.232-8 Discounts for Prompt Payment. (FEB 2002)

52.232-9 Limitation on Withholding of Payments. (APR 1984)

52.232-11 Extras. (APR 1984)

52.232-17 Interest. (OCT 2010)

52.232-18 Availability of Funds. (APR 1984)

52.232-19 Availability of Funds for the Next Fiscal Year. (APR 1984)

Funds are not presently available for performance under this contract beyond 30 September 2011/2012/2013/2014/2015/2016 as applicable for option periods. The Government's obligation for performance of this contract beyond that date is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal liability on the part of the Government for any payment may arise for performance under this contract beyond 30 September 2011/2012/2013/2014/2015/2016 as applicable for option periods until funds are made available to the Contracting Officer for performance and until the Contractor receives notice of availability, to be confirmed in writing by the Contracting Officer.

(End of clause)

52.232-20 Limitation of Cost. (APR 1984)

52.232-22 Limitation of Funds. (APR 1984)

52.232-23 Assignment of Claims. (JAN 1986)

52.232-25 Prompt Payment. (OCT 2008)

52.232-25 Prompt payment. — Alternate I (FEB 2002)

52.232-33 Payment by Electronic Funds Transfer—Central Contractor Registration. (OCT 2003)

52.232-37 Multiple Payment Arrangements. (MAY 1999)

52.233-1 Disputes. (JUL 2002)

52.233-1 Disputes.—Alternate I (DEC 1991)

52.233-3 Protest after Award. (AUG 1996)

52.233-3 Protest after Award.—Alternate I (JUN 1985)

52.233-4 Applicable Law for Breach of Contract Claim. (OCT 2004)

52.237-2 Protection of Government Buildings, Equipment, and Vegetation. (APR 1984)

52.237-3 Continuity of Services. (JAN 1991)

52.237-7 Indemnification and Medical Liability Insurance. (JAN 1997)
(Applies to any Non-Personal Services under CSA (CLINs 1014,2014,3014,4014,5014»

(a) It is expressly agreed and understood that this is a non-personal services contract, as defined in Federal Acquisition Regulation (FAR) 37.101, under which the professional services rendered by the Contractor are rendered in its capacity as an independent contractor. The Government may evaluate the quality of professional and administrative services provided, but retains no control over professional aspects of the services rendered, including by example, the Contractor's professional medical judgment, diagnosis, or specific medical treatments. The Contractor shall be solely liable for and expressly agrees to indemnify the Government with respect to any liability producing acts or omissions by it or by its employees or agents. The Contractor shall maintain during the term of this contract liability insurance issued by a responsible insurance carrier of not less than the following amount(s) per specialty per occurrence: As required in the state the military treatment facility is located, or the local community standard if none required by the state, or as specified by the contracting officer.

(b) An apparently successful offeror, upon request by the Contracting Officer, shall furnish prior to contract award evidence of its insurability concerning the medical liability insurance required by paragraph (a) of this clause.

(c) Liability insurance may be on either an occurrences basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided.

(d) Evidence of insurance documenting the required coverage for each health care provider who will perform under this contract shall be provided to the Contracting Officer prior to the commencement of services under this contract. If the insurance is on a claims-made basis and evidence of an extended reporting endorsement is not provided prior to the commencement of services, evidence of such endorsement shall be provided to the Contracting Officer prior to the expiration of this contract. Final payment under this contract shall be withheld until evidence of the extended reporting endorsement is provided to the Contracting Officer.

(e) The policies evidencing required insurance shall also contain an endorsement to the effect that any cancellation or material change adversely affecting the Government's interest shall not be effective until 30 days after the insurer or the Contractor gives written notice to the Contracting Officer. If, during the performance period of the contract the Contractor changes insurance providers, the Contractor must provide evidence that the Government will be indemnified to the limits specified in paragraph (a) of this clause, for the entire period of the contract, either under the new policy, or a combination of old and new policies.

(f) The Contractor shall insert the substance of this clause, including this paragraph (t), in all subcontracts under this contract for health care services and shall require such subcontractors to provide evidence of and maintain insurance in accordance with paragraph (a) of this clause. At least 5 days before the commencement of work by any subcontractor, the Contractor shall furnish to the Contracting Officer evidence of such insurance.

(End of clause)

52.237-7 Indemnification and Medical Liability Insurance (JAN 1997) DEVIATION
(Excludes CSA Sub-CLINs/CLINs)

(a) The Contractor is responsible for determining the medical malpractice coverage required in the state (including state risk pools if applicable) for each network provider (both professional and institutional), and ensuring that each network provider is in compliance with this requirement. In the absence of state law

requirement for medical malpractice insurance coverage, the Contractor is responsible for determining the local community standard for medical malpractice coverage, and the Contractor must maintain the documentation evidencing- both the standard and compliance by network providers. In no case shall a network provider not have medical malpractice coverage.

(b) The Contractor shall be solely liable for and expressly agrees to indemnify the Government for the costs of defense and any liability resulting from services provided to Military Health System (MHS) eligible beneficiaries by a network provider. As an alternate, the Contractor shall have all network provider agreements used by the Contractor contain a requirement, directly or by reference, to applicable regulations or TRICARE Management Activity policies, that the provider agrees to indemnify, defend and hold harmless the Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorney's fees, whatsoever, arising from any acts or omissions in the provision of medical services by the provider to MHS eligible beneficiaries.

(c) Each network provider agreement must indicate the required malpractice coverage. Evidence documenting the required coverage of each network provider under the contract shall be provided to the Contracting Officer upon request. The Contracting Officer, after consulting with the Contractor, retains the authority to determine whether state and/or local community standards for medical malpractice coverage have been met by a network provider and whether the Contractor has documented the required coverage.

(d) Liability insurance may be on either an occurrences basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided, or as long as standard practice in the locality or as may be required by local law or ordinance.

52.239-1 Privacy or Security Safeguards. (AUG 1996)

52.242-1 Notice of Intent to Disallow Costs. (APR 1984)

52.242-3 Penalties for Unallowable Costs. (MAY 2001)

52.242-4 Certification of Final Indirect Costs. (JAN 1997)

52.242-13 Bankruptcy. (JUL 1995)

52.243-1 Changes—Fixed-Price. (AUG 1987)

52.243-1 Changes—Fixed-Price.—Alternate I (APR 1984)

52.243-2 Changes—Cost-Reimbursement. (AUG 1987)

52.243-2 Changes—Cost-Reimbursement.—Alternate I (APR 1984)

52.243-3 Changes—Time-and-Materials or Labor-Hours. (SEP 2000)

52.243-6 Change Order Accounting. (APR 1984)

52.243-7 Notification of Changes. (APR 1984)

(a) *Definitions.* "Contracting Officer," as used in this clause, does not include any representative of the Contracting Officer.

"Specifically Authorized Representative (SAR)," as used in this clause, means any person the Contracting Officer has so designated by written notice (a copy of which shall be provided to the Contractor) which shall refer to this paragraph and shall be issued to the designated representative before the SAR exercises such authority

(b) *Notice.* The primary purpose of this clause is to obtain prompt reporting of Government conduct that the Contractor considers to constitute a change to this contract. Except for changes identified as such in writing and signed by the Contracting Officer, the Contractor shall notify the Administrative Contracting Officer in writing promptly, within 30 calendar days from the date that the Contractor identifies any Government conduct (including actions, inactions, and written or oral communications) that the Contractor regards as a change to the contract terms and conditions. On the basis of the most accurate information available to the Contractor, the notice shall state –

(1) The date, nature, and circumstances of the conduct regarded as a change;

(2) The name, function, and activity of each Government individual and Contractor official or employee involved in or knowledgeable about such conduct;

(3) The identification of any documents and the substance of any oral communication involved in such conduct;

(4) In the instance of alleged acceleration of scheduled performance or delivery, the basis upon which it arose;

(5) The particular elements of contract performance for which the Contractor may seek an equitable adjustment under this clause, including –

(i) What contract line items have been or may be affected by the alleged change;

(ii) What labor or materials or both have been or may be added, deleted, or wasted by the alleged change;

(iii) To the extent practicable, what delay and disruption in the manner and sequence of performance and effect on continued performance have been or may be caused by the alleged change;

(iv) What adjustments to contract price, delivery schedule, and other provisions affected by the alleged change are estimated; and

(6) The Contractor's estimate of the time by which the Government must respond to the Contractor's notice to minimize cost, delay or disruption of performance.

(c) *Continued performance.* Following submission of the notice required by paragraph (b) of this clause, the Contractor shall diligently continue performance of this contract to the maximum extent possible in accordance with its terms and conditions as construed by the Contractor, unless the notice reports a direction of the Contracting Officer or a communication from a SAR of the Contracting Officer, in either of which events the Contractor shall continue performance; provided, however, that if the Contractor regards the direction or communication as a change as described in paragraph (b) of this clause, notice shall be given in the manner provided. All directions, communications, interpretations, orders and similar actions of the SAR shall be reduced to writing promptly and copies furnished to the Contractor and to the Contracting Officer. The Contracting Officer shall promptly countermand any action which exceeds the authority of the SAR.

(d) *Government response.* The Contracting Officer shall promptly, within 30 calendar days after receipt of notice, respond to the notice in writing. **In** responding, the Contracting Officer shall either -

(1) Confirm that the conduct of which the Contractor gave notice constitutes a change and when necessary direct the mode of further performance;

(2) Countermand any communication regarded as a change;

(3) Deny that the conduct of which the Contractor gave notice constitutes a change and when necessary direct the mode of further performance; or

(4) In the event the Contractor's notice information is inadequate to make a decision under paragraphs (d)(l), (2), or (3) of this clause, advise the Contractor what additional information is required, and establish the date by which it should be furnished and the date thereafter by which the Government will respond.

(e) *Equitable adjustments.* (1) If the Contracting Officer confirms that Government conduct effected a change as alleged by the Contractor, and the conduct causes an increase or decrease in the Contractor's cost of, or the time required for, performance of any part of the work under this contract, whether changed or not changed by such conduct, an equitable adjustment shall be made –

(i) In the contract price or delivery schedule or both; and

(ii) In such other provisions of the contract as may be affected.

(2) The contract shall be modified in writing accordingly. In the case of drawings, designs or specifications which are defective and for which the Government is responsible, the equitable adjustment shall include the cost and time extension for delay reasonably incurred by the Contractor in attempting to comply with the defective drawings, designs or specifications before the Contractor identified, or reasonably should have identified, such defect. When the cost of property made obsolete or excess as a result of a change confirmed by the Contracting Officer under this clause is included in the equitable adjustment, the Contracting Officer shall have the right to prescribe the manner of disposition of the property. The equitable adjustment shall not include increased costs or time extensions for delay resulting from the Contractor's failure to provide notice or to continue performance as provided, respectively, in paragraphs (b) and (c) of this clause.

Note: The phrases "contract price" and "cost" wherever they appear in the clause, may be appropriately modified to apply to cost-reimbursement or incentive contracts, or to combinations thereof.

(End of clause)

52.244-2 Subcontracts. (OCT 2010)

52.244-5 Competition in Subcontracting. (DEC 1996)

52.244-6 Subcontracts for Commercial Items. (DEC 2010)

52.245-1 Government Property. (AUG 2010)

52.245-1 Government Property. — Alternate I (AUG 2010)

52.245-9 Use and Charges. (AUG 2010)

52.248-1 Value Engineering. (OCT 2010)

52.249-2 Termination for Convenience of the Government (Fixed-Price). (MAY 2004)

52.249-6 Termination (Cost-Reimbursement). (MAY 2004)

52.249-6 Termination (Cost-Reimbursement).—Alternate IV (SEP 1996)

52.249-8 Default (Fixed-Price Supply and Service). (APR 1984)

52.249-12 Termination (Personal Services). (APR 1984)
(CLINs/SubCLINs for Clinical Support Agreement when determined personal service)

52.249-14 Excusable Delays. (APR 1984)

52.252-2 Clauses Incorporated by Reference. (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es): http://farsite.hill.af.mil/

(End of clause)

52.252-6 Authorized Deviations in Clauses. (APR 1984)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the clause.

(End of clause)

52.253-1 Computer Generated Forms. (JAN 1991)

252.201-7000 Contracting Officer's Representative. (DEC 1991)

(a) "Definition. Contracting officer's representative" means an individual designated in accordance with subsection 201.602-2 of the Defense Federal Acquisition Regulation Supplement and authorized in writing by the contracting officer to perform specific technical or administrative functions.

(b) If the Contracting Officer designates a contracting officer's representative (COR), the Contractor will receive a copy of the written designation. It will specify the extent of the COR's authority to act on behalf of the contracting officer. The COR is not authorized to make any commitments or changes that will affect price, quality, quantity, delivery, or any other term or condition of the contract.

(End of clause)

252.203-7000 Requirements Relating to Compensation of Former DoD Officials. (JAN 2009)

252.203-7001 Prohibition on persons convicted of fraud or other defense-contract-related felonies. (DEC 2008)

252.203-7002 Requirement to Inform Employees of Whistleblower Rights. (JAN 2009)

252.204-7000 Disclosure of Information. (DEC 1991)

252.204-7002 Payment for Subline Items Not Separately Priced. (DEC 1991)

252.204-7003 Control of Government Personnel Work Product. (APR 1992)

252.204-7004 Alternate A, Central Contractor Registration. (SEP 2007)

252.205-7000 Provision of lnformation to Cooperative Agreement Holders. (DEC 1991)

252.209-7004 Subcontracting with Firms That Are Owned or Controlled by the Government of a Terrorist Country.(DEC 2006)

252.215-7000 Pricing Adjustments. (DEC 1991)

252.215-7002 Cost Estimating System Requirements. (DEC 2006)

252.219-7003 Small Business Subcontracting Plan (DoD contracts). (OCT 2010)

252.223-7004 Drug-Free Work Force. (SEP 1988)

252.225-7004 Report of Intended Performance Outside the United States and Canada—Submission after Award. (OCT 2010)

252.225-7006 Quarterly Reporting of Actual Contract Performance Outside the United States. (OCT 2010)

252.225-7012 Preference for Certain Domestic Commodities. (JUN 2010)

252.226-7001 Utilization of Indian Organizations, Indian-owned Economic Enterprises, and Native Hawaiian Small Business Concerns. (SEP 2004)

252.231-7000 Supplemental Cost Principles. (DEC 1991)

252.242-7004 Material Management and Accounting System. (JUL 2009)

252.243-7001 Pricing of Contract Modifications. (DEC 1991)

252.243-7002 Requests for equitable adjustment. (MAR 1998)

Section J—List of Documents, Exhibits and Other Attachments

Attachment Number	Attachment Title	Date	Number of Pages	Cross Reference Materials	Document Version
J-1	Government Required MTF Prime	Award Date	4		
J-2	Government Required BRAC Site Prime Service Area	Award Date	1		
J-3	Mandatory TRICARE Service Center Locations	Award Date	3		
J-4	CHAMPVA Fact Sheet 01-16	Award Date	1		
J-5	Clinical Quality Incentive Performance Metrics	Award Date	8		
J-6	Hypothetical Example of the External Trend Incentive Calculation	Award Date	2		
J-7	Proposed Elements Exceeding Government T-3 Requirements	Award Date	2		
J-8	Subcontracting Plan	Award Date	18		
EXHIBIT A	Proposed Service Assist Team Rates	Award Date	2		
EXHIBIT B	Contract Data Requirements List (CDRLs)	Award Date	Multiple PDF Docs		

HUMANA INC.
STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of _____ 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 _____, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors (the **"Board"**) 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 of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of $_____ 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 _____ (**"Expiration Date"**).

C. Vesting of Option. Except as otherwise set forth herein, this Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the date hereof in cumulative annual installments of one-third of the number of Shares covered hereby.

D. Effect of Termination of Employment on Option.

1. 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.

2. If the employment of Optionee is terminated for any reason other than for Cause, Retirement, death or Disability, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the date of such termination, but in no event beyond the Expiration Date.

3. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, this Option (or portion hereof) shall continue to vest and become exercisable as if the Optionee were continuing to provide services to the Company or a Subsidiary, as applicable, and this Option (or portion hereof) shall be exercisable at any time within two (2) years following the date on which this Option (or portion hereof) becomes vested and exercisable, but in no event beyond the Expiration Date.

4. In the event of death or Disability of Optionee while in the employ of the Company, this Option shall become immediately exercisable and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of the Optionee or the estate of the Optionee at any time within two (2) years after the date of such death or Disability, regardless of the Expiration Date.

5. In the event of a Change in Control, the Option granted in Section I shall become fully vested and immediately exercisable in its entirety. In addition, Optionee will be permitted to surrender for cancellation within sixty (60) days after a Change in Control, any portion of this Option to the extent not yet exercised and Optionee will be entitled to receive a payment in an amount equal to the excess, if any, of (x) the Fair Market Value on the date of surrender of the Shares subject to this Option or portion thereof surrendered, over (y) the aggregate purchase price for such Shares under this Option or portion thereof surrendered. The form of payment shall be determined by the Committee. In the event Optionee's employment with the Company is terminated other than for Cause within three (3) years following a Change in Control, each Option held by the Optionee that was exercisable as of the date of termination of the Optionee's employment or service shall remain exercisable for a period ending the earlier of the second anniversary of the termination of the Optionee's employment or the Expiration Date.

E. Exercise of Option.

1. This Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the on-line procedure to such broker-dealer as designated by the Company, by 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; or

b) By tendering to the Company shares of the Common Stock of Company owned by him/her prior to the date of exercise and having an aggregate fair market value equal to the cash exercise price applicable to his/her 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 the Grantee 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 this Option shall be paid pursuant to the Plan by Grantee prior to the delivery of any Common Stock under this Agreement. The Company shall, at the Grantee'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 the Grantee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT

A. Agreement Not To Compete. Optionee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Optionee's termination of employment with the Company, Optionee shall not, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, engage in business with, be employed by, or render any consultation or business advice or other services with respect to, any business which provides or offers products or services which compete with any Company Business, in any geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

B. Agreement Not To Solicit. Optionee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Optionee's termination of employment with the Company, Optionee, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, shall not:

1. Interfere with the relationship of the Company and/or any of its affiliates and any of its employees, agents, representatives, consultants or advisors.

2. Divert, or attempt to cause the diversion from the Company and/or any of its affiliates, any Company Business, nor interfere with relationships of the Company and/or any of its affiliates with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers.

3. Solicit, recruit or otherwise induce or influence any employee of the Company and/or any of its affiliates to accept employment in any business which competes with the Company Business, in any of the geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

C. Definitions.

For purposes of Sections II.A and B, the following definitions apply.

1. "Company Business" shall mean any business related to a service or product offered by the Company and/or any of its affiliates during the two-year period immediately preceding the Optionee's termination date that Optionee engaged in or rendered any consultation or business advice or other services with respect to, during Optionee's employment with the Company and/or any of its affiliates.

2 "Geographic area" shall mean any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

D. Effect of Termination of Employment on Agreements Not to Compete and Not to Solicit .

1. In the event Optionee voluntarily resigns or is discharged by Company with Cause at any time prior to the vesting of the Option, the prohibitions on Optionee set forth in Sections II.A and II.B shall remain in full force and effect.

2. In the event Optionee is discharged by Company other than with Cause prior to the vesting herein of the Option, the prohibitions set forth in Section II.A shall remain in full force and effect only if the Company, solely at its option, pays to Optionee an amount at least equal to Optionee's then current annual base salary, whether such amount is paid pursuant to this provision or pursuant to any other severance or separation plan or other plan or agreement between Optionee and Company.

3. In the event Optionee is discharged by Company other than with Cause prior to vesting herein of the Option, the prohibitions set forth in Section II.B above shall remain in full force and effect.

4. After the vesting of the Option, 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 Change In Control on Agreements Not to Compete and Not to Solicit .

1. In the event of a Change in Control, 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 Optionee's employment termination date with the Company or its successor, to the Optionee an amount at least equal to Optionee's then current annual base salary, plus Optionee's maximum

potential bonus pursuant to any bonus plan in which Optionee participated as of the date of the Change in Control. Such sums shall be in addition to any other amounts paid or payable to Optionee with respect to other change in control agreements.

2. In the event of a Change in Control, the prohibitions on Optionee set forth in Section II.B. shall remain in full force and effect.

F. **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.

G. **Injunctive Relief; Invalidity of Any Provision**. Optionee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II hereof are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Optionee were to breach any of such covenants, and (6) the Company's remedy at law for such a 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 both 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 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, 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.

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 Section 4.6 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.

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 the 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.

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 this Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and Company may terminate this Option as to any then unexercised shares.

H. Defined Terms. 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.

I. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the on-line 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: _____
[Name]
[Title]

BY: _____
[Name]
[Title]

"Optionee"

_____
[Name]

HUMANA INC.
INCENTIVE STOCK OPTION AGREEMENT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS STOCK OPTION AGREEMENT (**"Agreement"**) made as of _____ 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_____**,** an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors (the **"Board"**) 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, mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

1. 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 of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of $_____ per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

2. The term of the Option shall commence upon the date of grant, _____, and shall expire on _____ (**"Expiration Date"**).

3. Except as otherwise set forth herein, this Option shall be exercisable in full by Optionee or his/her personal representative on and after the first anniversary of the date hereof in cumulative annual installments of one-third of the number of shares covered hereby.

4. A. 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.

B. If the employment of Optionee is terminated for any reason other than for Cause, Retirement, death or Disability, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the date of such termination, but in no event beyond the Expiration Date.

C. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, this Option (or portion hereof) shall continue to vest and become exercisable as if the Optionee were continuing to provide services to the Company or

a Subsidiary, as applicable, and this Option (or portion hereof) shall be exercisable at any time within two (2) years following the date on which this Option (or portion hereof) becomes vested and exercisable, but in no event beyond the Expiration Date.

D. In the event of death or Disability of Optionee while in the employ of the Company, this Option shall become immediately exercisable and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of the Optionee or the estate of the Optionee at any time within two (2) years after the date of such death or Disability.

5. A. This Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices by 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 by Optionee or his/her legal representative, as applicable.

B. The purchase price shall be paid as follows:

i) In full in cash upon the exercise of the Option; or

ii) By tendering to the Company shares of the Common Stock of Company owned by him/her prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to his/her Option; or

iii) A combination of 5(B)(i) and 5(B)(ii) above.

C. 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 this Option shall be paid pursuant to the Plan by Grantee at the time such Withholding Taxes become due. The Company shall, at the Grantee'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 the Grantee's obligations hereunder.

6. 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 this Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and Company may terminate this Option as to any then unexercised shares.

7. In the event of a Change in Control, as defined in the Plan, this Option shall become fully vested and immediately exercisable in its entirety. In addition, Optionee will be permitted to surrender for cancellation within sixty (60) days after a Change in Control, any portion of this Option to the extent not yet exercised and Optionee will be entitled to receive a payment in an amount equal to the excess, if any, of (x) the Fair Market Value on the date of surrender of the Shares subject to this Option or portion thereof surrendered, over (y) the aggregate purchase price for such Shares under this Option or portion thereof surrendered. The form of payment shall be determined by the Committee.

In the event Optionee's employment with the Company is terminated other than for Cause within three (3) years following a Change in Control, each Option held by the Optionee that was exercisable as of the date of termination of the Optionee's employment or service shall remain exercisable for a period ending the earlier of the second anniversary of the termination of the Optionee's employment or the Expiration Date.

8. This Agreement shall be binding and conclusive upon each successor and assign of the Company. This Agreement may be amended only by a writing signed by each of the parties hereto. 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 Option 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 Section 4.6 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.

9. Except as to matters of federal law, this Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Delaware without giving effect to the conflicts of laws principles thereof.

10. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify the Optionee 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.

11. 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, his/her assigns, and any person or persons claiming through Optionee as to any rights hereunder.

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: _____

[Name]
[Title]

_____

[Name]
[Title]

"Optionee"

_____

[Name]

HUMANA INC.
RESTRICTED STOCK AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK AGREEMENT (**"Agreement"**) made as of_____ 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 _____, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors (the **"Board"**) and stockholders; and

WHEREAS, the Company desires to award to Grantee restricted shares of common stock of the Company in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of restricted stock to Grantee, the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK GRANT

A. Purchase and Sale of Common Stock. 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. The purchase price, if any, for the Shares shall be determined by the Committee, but shall not be less than par value of $.16 2/3 per share.

B. Restrictions on Non-Vested Shares. Until such time as the Shares purchased hereunder have become vested in accordance with Section I.C. (Shares which are not vested are referred to herein as **"Restricted Stock"**), such Restricted Stock may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock shall be subject to forfeiture in accordance with the provisions of Section I.D. Except for the restrictions provided for in this Section I.B., Grantee shall have all of the rights of a stockholder with respect to Restricted Stock including, but not limited to, the right to vote; provided that any cash or in-kind dividends paid with respect to Restricted Stock shall be withheld by the Company and shall be paid to Grantee, without interest, only when, and if, such Restricted Stock shall become vested (**"Dividends"**).

C. Vesting of Shares.

1. None of the Restricted Stock shall vest until _____, the third anniversary of the date hereof, at which time it shall vest in full.

2. Notwithstanding the foregoing, upon (i) the death or Disability of Grantee, or (ii) a Change in Control, all restrictions shall lapse and all Restricted Stock and Dividends shall thereafter be immediately transferable and non-forfeitable.

3. Upon the Restricted Stock becoming vested, such Shares shall be free of all restrictions provided for in this Section I.

D. Forfeiture. Upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock has vested pursuant to Section I.C., other than a termination in the event of Grantee's Retirement, the Restricted Stock and Dividends shall thereupon be forfeited immediately by Grantee. In the event of Grantee's Retirement, any Restricted Stock with respect to which restrictions have not lapsed as of the date of Retirement shall continue to vest in accordance with Section I.C. as if the Grantee were continuing to provide services to the Company or a Subsidiary, as applicable; provided, however, that the Committee may determine, in its sole discretion, that the restrictions on some or all of such Restricted Stock held by the Grantee as of the date of Retirement shall immediately lapse.

E. Retention of Stock Certificate. Notwithstanding that Grantee has been awarded the Restricted Stock on the date hereof, the Company has caused all Restricted Stock to be issued in book entry format or under a Certificate representing the Restricted Stock prior to vesting. If a Certificate is issued, it shall bear the following legend:

> "The Shares represented by this certificate have been issued pursuant to the terms of the Humana Inc. Amended and Restated 2003 Stock Incentive Plan and may not be sold, assigned, transferred, discounted, exchanged, pledged or otherwise encumbered or disposed of in any manner except as set forth in the terms of the agreement embodying the award of such Shares."

Upon the vesting of the Restricted Stock, Grantee shall have the right to receive a Certificate evidencing such vested stock, shall receive any Dividends and shall have the right to have the legend provided for above removed from the Certificate representing such vested Shares.

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 vesting of an Award shall be paid by Grantee prior to the issuance of a Certificate representing the shares. The Company shall, at the Grantee's election, withhold delivery of Certificates representing a number of Shares with a Fair Market Value as of the vesting date equal to the Withholding Taxes in satisfaction of the Grantee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT

A. Agreement Not To Compete. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee shall not, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, engage in business with, be employed by, or render any consultation or business advice or other services with respect to, any business which provides or offers products or services which compete with any Company Business, in any geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

B. Agreement Not To Solicit. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, shall not:

1. Interfere with the relationship of the Company and/or any of its affiliates and any of its employees, agents, representatives, consultants or advisors.

2. Divert, or attempt to cause the diversion from the Company and/or any of its affiliates, any Company Business, nor interfere with relationships of the Company and/or any of its affiliates with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers.

3. Solicit, recruit or otherwise induce or influence any employee of the Company and/or any of its affiliates to accept employment in any business which competes with the Company Business, in any of the geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

C. Definitions.

For purposes of Sections II.A and B, the following definitions apply.

1. "Company Business" shall mean any business related to a service or product offered by the Company and/or any of its affiliates during the two-year period immediately preceding the Grantee's termination date that Grantee engaged in or rendered any consultation or business advice or other services with respect to, during Grantee's employment with the Company and/or any of its affiliates.

2 “Geographic area” shall mean any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

D. Effect of Termination of Employment.

1. In the event Grantee voluntarily resigns or is discharged by Company with Cause at any time prior to the vesting of the Restricted Stock, the prohibitions on Grantee set forth in Sections II.A and II,B shall remain in full force and effect.

2. In the event Grantee is discharged by Company other than with Cause prior to the vesting herein of the Restricted Stock, the prohibitions set forth in Section II.A. shall remain in full force and effect only if the Company, solely at its option, pays to Grantee an amount at least equal to Grantee’s then current annual base salary, whether such amount is paid pursuant to this provision or pursuant to any other severance or separation plan or other plan or agreement between Grantee and Company.

3. In the event Grantee is discharged by Company other than with Cause prior to vesting herein of the Restricted Stock, the prohibitions set forth in Section II.B. above shall remain in full force and effect.

4. After the vesting of the Restricted Stock, 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 Change In Control.

1. In the event of a Change in Control, 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 Grantee’s employment termination date with the Company or its successor, to the Grantee an amount at least equal to Grantee’s then current annual base salary, plus Grantee’s maximum potential bonus pursuant to any bonus plan in which Grantee participated as of the date of the Change in Control. Such sums shall be in addition to any other amounts paid or payable to Grantee with respect to other change in control agreements.

2. In the event of a Change in Control, the prohibitions on Grantee set forth in Section II.B. shall remain in full force and effect.

F. 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.

G. **Injunctive Relief; Invalidity of Any Provision** . Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Sections II hereof are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a 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 both 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 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, 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.

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 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 Section 4.6 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 the 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. 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.

G. Execution. If Grantee shall fail to execute this Agreement within ____ days of the date hereof, 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 Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY: _____
[Name]
[Title]

BY: _____
[Name]
[Title]

"Grantee"

_____
[Name]

Exhibit 10(rr)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of _____ (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 _____, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors (the **"Board"**) 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 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 _____ Restricted Stock Units. Each Restricted Stock Unit represents the right of the Grantee to receive (i) one (1) Share on the date of distribution provided for in Section 1.E. In addition, the 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 the 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 and DERs shall vest in full on the earliest of (i) the third anniversary of the Date of Grant, (ii) the death or Disability of Grantee, or (iii) a Change in Control.

D. Forfeiture. Upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units have vested pursuant to Section I.C., other than a termination in the event of Grantee's Retirement, the Restricted Stock Units and DERs shall thereupon be forfeited immediately by Grantee. In the event of Grantee's Retirement, any Restricted Stock Units and DERs that have not vested as of the date of Retirement shall remain outstanding and shall vest in accordance with Section I.C., as if the Grantee were continuing to provide services to the Company or a Subsidiary, as applicable; provided, however, that the Committee may determine, in its sole discretion, that some or all of such Restricted Stock Units and DERs held by the Grantee as of the date of Retirement shall vest.

E. Distributions. The Company shall issue to Grantee (or, if applicable, the Grantee's estate or personal representative) Shares with respect to the Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, upon the earliest of (i) the date provided in Section I.C(i) hereof, (ii) the date of the occurrence of a Section 409A Change in Control (as defined below), (iii) the date of the Grantee's death or (iv) the date the Grantee is determined to be Disabled, provided that such Disability also constitutes being "disabled" within the meaning of Section 409A of the Code. 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 the 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, at the Grantee's election, 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. If, however, Grantee is eligible for Retirement (as defined in the Plan) as of the date hereof, or becomes eligible for Retirement before the vesting of this award, federal employment taxes may be required by law to be collected by the Company immediately upon grant, or immediately upon the day the Grantee becomes eligible for Retirement, as applicable.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT

A. Agreement Not To Compete. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee shall not, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, engage in business with, be employed by, or render any consultation or business advice or other services with respect to, any business which provides or offers products or services which compete with any Company Business, in any geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

B. Agreement Not To Solicit. Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, shall not:

1. Interfere with the relationship of the Company and/or any of its affiliates and any of its employees, agents, representatives, consultants or advisors.

2. Divert, or attempt to cause the diversion from the Company and/or any of its affiliates, any Company Business, nor interfere with relationships of the Company and/or any of its affiliates with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers.

3. Solicit, recruit or otherwise induce or influence any employee of the Company and/or any of its affiliates to accept employment in any business which competes with the Company Business, in any of the geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

C. Definitions.

For purposes of Sections II.A and B, the following definitions apply.

1. “Company Business” shall mean any business related to a service or product offered by the Company and/or any of its affiliates during the two-year period immediately preceding the Grantee’s termination date that Grantee engaged in or rendered any consultation or business advice or other services with respect to, during Grantee’s employment with the Company and/or any of its affiliates.

2 “Geographic area” shall mean any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

D. Effect of Termination of Employment on Agreements Not to Compete and Not to Solicit .

1. In the event Grantee voluntarily resigns or is discharged by 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 and II.B shall remain in full force and effect.

2. In the event Grantee is discharged by Company other than with Cause prior to the vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect only if the Company, solely at its option, pays to Grantee an amount at least equal to Grantee’s then current annual base salary, whether such amount is paid pursuant to this provision or pursuant to any other severance or separation plan or other plan or agreement between Grantee and Company.

3. In the event Grantee is discharged by Company other than with Cause prior to vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.B 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 Change In Control on Agreements Not to Compete and Not to Solicit .

1. In the event of a Change in Control, 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 Grantee’s employment termination date with the Company or its successor, to the Grantee an amount at least equal to Grantee’s then current annual base salary, plus Grantee’s maximum potential bonus pursuant to any bonus plan in which Grantee participated as of the date of the Change in Control. Such sums shall be in addition to any other amounts paid or payable to Grantee with respect to other change in control agreements.

2. In the event of a Change in Control, the prohibitions on Grantee set forth in Section II.B. shall remain in full force and effect.

F. **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.

G. **Injunctive Relief; Invalidity of Any Provision** . Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II hereof are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a 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 both 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 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, 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.

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 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 Section 4.6 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 the 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. 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.

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.

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: _____

[Name]
[Title]

BY: _____

[Name]
[Title]

"Grantee"

_____

[Name]

Exhibit 12

Humana Inc.

Computation of Ratio of Earnings to Fixed Charges

	For the year ended December 31,				
	2011	2010	2009	2008	2007
Income before income taxes	$2,235	$1,749	$1,602	$ 993	$1,289
Fixed charges	178	157	160	128	109
Total earnings	$2,413	$1,906	$1,762	$1,121	$1,398
Interest charged to expense	$ 109	$ 105	$ 106	$ 80	$ 69
One-third of rent expense	69	52	54	48	40
Total fixed charges	$ 178	$ 157	$ 160	$ 128	$ 109
Ratio of earnings to fixed charges (1)(2)	13.6x	12.1x	11.0x	8.8x	12.8x

Notes

(1) For the purposes of determining the ratio of earnings to fixed charges, earnings consist of income before income taxes and fixed charges. Fixed charges include gross interest expense, amortization of deferred financing expenses, and an amount equivalent to interest included in rental charges. One-third of rental expense represents a reasonable approximation of the interest amount.

(2) There are no shares of preferred stock outstanding.

Exhibit 21

HUMANA INC.
SUBSIDIARY LIST

ALABAMA

1. CompBenefits of Alabama, Inc.

ARIZONA

1. Managed Prescription Program

ARKANSAS

1. American Dental Providers of Arkansas, Inc. – Doing Business As:
    a. CompBenefits

CALIFORNIA

1. Humana Health Plan of California, Inc.
2. M.D. Care, Inc.

CAYMAN ISLANDS

1. OMP Insurance Company, Ltd.

DELAWARE

1. American Tax Credit Corporate Georgia Fund III, L.L.C.
2. Anvita, Inc. Doing Business As:
    a. Anvita Health (CA)
3. Auto Injury Solutions, Inc.
4. Availity, L.L.C.
5. B-Cycle, LLC
6. CompBenefits Corporation
7. CompBenefits Direct, Inc.
8. Concentra Akron, L.L.C.
9. Concentra Arkansas, L.L.C.
10. Concentra Inc.
11.0 Concentra Laboratory, L.L.C.
12. Concentra Operating Corporation
13. Concentra St. Louis, L.L.C.
14. Concentra Solutions, Inc.
15. Concentra South Carolina, L.L.C.
16. Concentra-UPMC, L.L.C.
17. DefenseWeb Technologies, Inc.
18. Emphesys, Inc. – Doing Business As:
    a. Texas-Emphesys, Inc. (TX)
19. Green Ribbon Health, L.L.C.

20. Health Value Management, Inc. – Doing Business As:
    a. ChoiceCare Network
    b. National Transplant Network
21. HUM INT, LLC
22. Humana Government Network Services, Inc.
23. Humana Inc. – Doing Business As:
    a. H.A.C. Inc. (KY)
    b. Humana of Delaware, Inc. (CO)
24. Humana Innovation Enterprises, Inc. – Doing Business As:
    a. Personal Nurse (KY)
25. Humana Military Dental Services, Inc.
26. Humana Military Healthcare Services, Inc. – Doing Business As:
    a. Humana Clinical Resources (AL, AZ, CA, FL, GA, KY, LA, MA, MI, MS, ND, NY, OK, PA, TN, TX, WY)
    b. Humana Military Health Services, Inc. (IL)
27. Humana Pharmacy, Inc. – Doing Business As:
    a. Humana Mail (TX)
    b. The Pharmacy (TX)
    c. PrescribeIT Rx (AZ,CO, FL, and TX)
    d. RightSource
    e. RightSource Mail (IL, LA, and PA)

DELAWARE (Continued)

28. Humana Veterans Healthcare Services, Inc. – Doing Business As:
    a. HVHS, Inc. (TX)
29. Humana WellWorks LLC
30. HumanaDental, Inc.
31 HumanaVitality, LLC
32 HUMphire, Inc
33 Humsol, Inc.
34. KMG Capital Statutory Trust I
35. Latin Healthcare Fund, L.P.
36. National Healthcare Resources, Inc.
37. Occupational Health + Rehabilitation LLC
38. Sensei, Inc.

ENGLAND & WALES

1. Humana Europe, Ltd.

FLORIDA

1. CAC-Florida Medical Centers, LLC – Doing Business As:
    a. Medical Specialty and Ancillary Care Centers
    b. Medi-Cab
    c. Physicians Group of Florida
2. CarePlus Health Plans, Inc. – Doing Business As:
    a. Solicare Health Plans
3. CompBenefits Company – Doing Business As:
    a. Primary Plus
    b. Vision Cares, Inc.
    c. Vision Care Plan
4. CPHP Holdings, Inc.
5. HomeCare Health Solutions, Inc.
6. HUM-e-FL, Inc.
7. Humana AdvantageCare Plan, Inc. – Doing Business As:
    a. HomeCare Docs
8. Humana Dental Company – Doing Business As:
    a. Humana Oral Care Company (TN)
9. Humana Health Insurance Company of Florida, Inc.
10. Humana Medical Plan, Inc. – Doing Business As:
    a. Florida Comfort Choice
    b. Florida Senior's Choice
    c. Humana Family
11. HumanaCares, Inc.

GEORGIA

1. CompBenefits of Georgia, Inc.
2. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS

1. CompBenefits Dental, Inc.
2. Competitive Health Analytics, Inc.
3. Dental Care Plus Management, Corp. – Doing Business As:
    a. CompBenefits
4. Humana Benefit Plan of Illinois, Inc.
5. The Dental Concern, Ltd. – Doing Business As:
    a. TDC (MO)

KENTUCKY

1. CHA HMO, Inc.
2. CHA Service Company
3. Crescent Centre Condominium Ltd. Partnership
4. HUM-Holdings International, Inc.
5. Humana Active Outlook, Inc.
6. Humana Health Plan, Inc. – Doing Business As:
    a. Humana Health Care Plans of Indiana (IN)
7. Humana Insurance Company of Kentucky
8. Humana MarketPOINT, Inc. – Doing Business As:
    a. Humana MarketPOINT Insurance Sales (CA)
9. Humana Pharmacy Solutions, Inc.
10. Humco, Inc.
11. Preservation on Main, Inc.
12. The Dental Concern, Inc. – Doing Business As:
    a. The Dental Concern/KY, Inc. (IN)
    b. The Dental Concern/KY, Inc. (MO)
13. The Humana Foundation Inc.
14. 516-526 West Main Street Condominium Council of Co-Owners, Inc.

LOUISIANA

1. Humana Health Benefit Plan of Louisiana, Inc. – Doing Business As:
    a. Humana
2. Humana Health Plan Interests, Inc.

MAINE

1. CM Occupational Health, Limited Liability Company
2. OHR/Baystate, LLC

MASSACHUSETTS

1. Concentra Integrated Services, Inc.
2. OHR/MMC, Limited Liability Company

MICHIGAN

1. Humana Medical Plan of Michigan, Inc.

NEVADA

1. Concentra Health Services, Inc. – Doing Business As:
    a. Concentra Medical Centers

NEW YORK

1. Humana Insurance Company of New York

NORTH CAROLINA

1. American Dental Plan of North Carolina, Inc.

OHIO

1. Humana Health Plan of Ohio, Inc. – Doing Business As:
2. Hummingbird Coaching Systems LLC – Doing Business As:
    a. Hummingbird Coaching Services (IL, OH)

PENNSYLVANIA

1. Concentra Occupational Healthcare Harrisburg, L.P.
2. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO

1. Healthcare E-Commerce Initiative, Inc.
2. Humana Health Plans of Puerto Rico, Inc.
3. Humana Insurance of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

SOUTH CAROLINA

1. Kanawha Insurance Company – Doing Business As:
    a. Kanawha Adjusters (NY)

TENNESSEE

1. Cariten Health Plan Inc.
2. Cariten Insurance Company
3. Kanawha Healthcare Solutions, Inc. – Doing Business As:
    a. Kanawha HealthCare Solutions Administrators (CA)
4. PHP Companies, Inc. – Doing Business As:
    a. Cariten Healthcare
5. Preferred Health Partnership, Inc. – Doing Business As:
    a. Cariten TPA Services
6. Preferred Health Partnership of Tennessee, Inc.

TEXAS

1. CompBenefits Insurance Company
2. Concentra Occupational Health Research Institute:
3 Corphealth, Inc. – Doing Business As:
    a. LifeSynch
4. Corphealth Provider Link, Inc.
5. Denticare, Inc. – Doing Business As:
    a. CompBenefits

6. Emphesys Insurance Company
7. Humana Health Plan of Texas, Inc.
8. Texas Dental Plans, Inc.

UTAH

1. Humana Medical Plan of Utah, Inc.

VERMONT

1. Managed Care Indemnity, Inc. – Doing Business As:
    a. Witherspoon Parking Garage (KY)

VIRGINIA

1. KMG America Corporation

WISCONSIN

1. CareNetwork, Inc. – Doing Business As:
    a. CARENETWORK
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation – Doing Business As:
    a. WHOIC
    b. WHO
4. HumanaDental Insurance Company
5. Independent Care Health Plan

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (No. 33-49305, No. 33-54455, 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. 333-132878 and No. 333-157797) of Humana Inc. of our report dated February 24, 2012 relating to the financial statements, 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 24, 2012

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Michael B. McCallister, principal executive officer of Humana Inc., certify that:

1. I have reviewed this 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 24, 2012

Signature: /s/ MICHAEL B. MCCALLISTER

Michael B. McCallister
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, James H. Bloem, principal financial officer of Humana Inc., certify that:

1. I have reviewed this 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 24, 2012

Signature: /s/ JAMES H. BLOEM

James H. Bloem
Principal Financial Officer

Exhibit 32

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

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2011 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934; and

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

/s/ MICHAEL B. MCCALLISTER
Michael B. McCallister
Chairman of the Board and Chief Executive Officer

February 24, 2012

/s/ JAMES H. BLOEM
James H. Bloem
Senior Vice President, Chief Financial Officer and Treasurer

February 24, 2012

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.