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

FORM 10-Q

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

For the quarterly period ended June 30, 2005

OR

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

For the transition period from _____ to _____

Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

Class of Common Stock	**Outstanding at July 31, 2005**
$0.16 2/3 par value	162,419,402 shares

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

	June 30, 2005	December 31, 2004
	(in thousands, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 603,790	$ 580,079
Investment securities	2,217,698	2,145,645
Receivables, less allowance for doubtful accounts of $30,997 in 2005 and $34,506 in 2004:		
Premiums	588,706	554,661
Administrative services fees	19,448	24,954
Securities lending collateral	76,998	77,840
Other	236,430	212,958
Total current assets	3,743,070	3,596,137
Property and equipment, net	437,393	399,506
Other assets:		
Long-term investment securities	358,643	348,465
Goodwill	1,221,663	885,572
Other	517,138	427,937
Total other assets	2,097,444	1,661,974
Total assets	$ 6,277,907	$ 5,657,617
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical and other expenses payable	$ 1,677,551	$ 1,422,010
Trade accounts payable and accrued expenses	385,313	488,332
Book overdraft	182,493	192,060
Securities lending payable	76,998	77,840
Unearned revenues	121,148	146,326
Total current liabilities	2,443,503	2,326,568
Long-term debt	878,388	636,696
Other long-term liabilities	639,828	604,229
Total liabilities	3,961,719	3,567,493
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 178,064,599 shares issued at June 30, 2005 and 176,044,649 shares issued at December 31, 2004	29,677	29,340
Capital in excess of par value	1,068,406	1,017,156
Retained earnings	1,423,755	1,229,823
Accumulated other comprehensive income	13,115	16,526
Unearned stock compensation	(16,074)	(1,721)
Treasury stock, at cost, 15,832,428 shares at June 30, 2005 and 15,778,088 shares at December 31, 2004	(202,691)	(201,000)
Total stockholders' equity	2,316,188	2,090,124
Total liabilities and stockholders' equity	$ 6,277,907	$ 5,657,617

See accompanying notes to condensed consolidated financial statements.

Humana Inc.
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(Unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
	(in thousands, except per share results)			
Revenues:				
Premiums	$3,446,019	$3,303,712	$6,736,834	$6,482,893
Administrative services fees	64,902	81,346	126,637	159,583
Investment and other income	35,440	46,420	70,115	75,951
Total revenues	3,546,361	3,431,478	6,933,586	6,718,427
Operating expenses:				
Medical	2,888,509	2,789,740	5,642,242	5,473,256
Selling, general and administrative	486,460	486,895	960,493	956,524
Depreciation and amortization	31,763	27,165	61,012	53,477
Total operating expenses	3,406,732	3,303,800	6,663,747	6,483,257
Income from operations	139,629	127,678	269,839	235,170
Interest expense	10,322	5,325	18,845	10,044
Income before income taxes	129,307	122,353	250,994	225,126
Provision for income taxes	45,170	41,600	57,062	76,543
Net income	$ 84,137	$ 80,753	$ 193,932	$ 148,583
Basic earnings per common share	$ 0.52	$ 0.50	$ 1.20	$ 0.92
Diluted earnings per common share	$ 0.51	$ 0.50	$ 1.18	$ 0.91

See accompanying notes to condensed consolidated financial statements.

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

	For the six months ended June 30,	
	2005	2004
	(in thousands)	
Cash flows from operating activities		
Net income	$ 193,932	$ 148,583
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	61,012	53,477
Provision for deferred income taxes	10,919	29,964
Changes in operating assets and liabilities, net of effect of businesses acquired:		
Receivables	(26,250)	(15,518)
Other assets	(28,514)	(23,884)
Medical and other expenses payable	218,166	111,006
Other liabilities	(107,733)	(32,175)
Unearned revenues	(44,951)	(228,019)
Other, net	4,504	(18,579)
Net cash provided by operating activities	281,085	24,855
Cash flows from investing activities		
Acquisitions, net of cash acquired	(352,726)	(68,735)
Purchases of property and equipment	(67,227)	(48,046)
Proceeds from sales of property and equipment	38	28,728
Purchases of investment securities	(1,245,605)	(2,241,196)
Maturities of investment securities	393,612	346,187
Proceeds from sales of investment securities	759,835	1,316,824
Change in securities lending collateral	842	25,676
Net cash used in investing activities	(511,231)	(640,562)
Cash flows from financing activities		
Borrowings under credit agreement	294,000	—
Repayments under credit agreement	(50,000)	—
Change in securities lending payable	(842)	(25,676)
Common stock repurchases	(1,691)	(48,802)
Change in book overdraft	(9,567)	(46,992)
Proceeds from stock option exercises and other	21,957	9,409
Net cash provided by (used in) financing activities	253,857	(112,061)
Increase (decrease) in cash and cash equivalents	23,711	(727,768)
Cash and cash equivalents at beginning of period	580,079	931,404
Cash and cash equivalents at end of period	$ 603,790	$ 203,636
Supplemental cash flow disclosures:		
Interest payments	$ 22,040	$ 13,302
Income tax payments, net	$ 95,409	$ 42,979

See accompanying notes to condensed consolidated financial statements.

Humana Inc.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
Unaudited

(1) Basis of Presentation

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

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

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

(2) Significant Accounting Policies

Stock-Based Compensation

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

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

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

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
	(in thousands, except per share results)			
Net income, as reported	$84,137	$80,753	$193,932	$148,583
Add: Stock-based employee compensation expense included in reported net income, net of related tax	1,947	90	2,996	872
Deduct: Total stock-based employee compensation expense determined under fair value based method for all awards, net of related tax	(4,672)	(3,285)	(8,780)	(6,117)
Adjusted net income	$81,412	$77,558	$188,148	$143,338
Earnings per share:				
Basic, as reported	$ 0.52	$ 0.50	$ 1.20	$ 0.92
Basic, pro forma	$ 0.50	$ 0.48	$ 1.17	$ 0.89
Diluted, as reported	$ 0.51	$ 0.50	$ 1.18	$ 0.91
Diluted, pro forma	$ 0.49	$ 0.48	$ 1.14	$ 0.88

Recently Issued Accounting Pronouncements

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

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

(3) Acquisitions

On February 16, 2005, we acquired CarePlus Health Plans of Florida, or CarePlus, as well as its affiliated 10 medical centers and pharmacy company. CarePlus provides Medicare Advantage HMO plans and benefits to Medicare eligible members in Miami-Dade, Broward and Palm Beach counties. This acquisition enhances our Medicare market position in South Florida. We paid approximately $444.8 million in cash including transaction costs. We financed the transaction with $294.0 million of borrowings under our credit agreement and $150.8 million of cash on hand. The purchase price is subject to a balance sheet settlement process with a nine month claims run-out period. The preliminary fair value of the acquired tangible assets (liabilities), which is subject to further refinement, consisted of the following:

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

The purchase price exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $390.2 million. We preliminarily have allocated the excess purchase price over the fair value of the net tangible assets acquired to other intangible assets of $86.9 million and associated deferred tax liabilities of $32.8 million, and goodwill of $336.1 million. The other intangible assets, which consist primarily of subscriber contracts, have a weighted-average useful life of approximately 10 years. Approximately $46.9 million of the acquired goodwill is deductible for income tax purposes. We are using an independent third party valuation specialist firm to assist us in evaluating the fair value of assets acquired. The purchase price allocation is preliminary pending completion of the independent valuation analysis of the tangible and intangible net assets and the balance sheet settlement process.

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

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

	For the three months ended June 30,		For the six months ended June 30,	
	2005	2004 (1)	2005 (2)	2004 (3)
	(in thousands, except per share results)			
Revenues	$3,546,361	$3,550,972	$7,006,137	$7,142,748
Net income	$ 84,137	$ 86,270	$ 197,243	$ 161,513
Earnings per share:				
Basic	$ 0.52	$ 0.54	$ 1.22	$ 1.00
Diluted	$ 0.51	$ 0.53	$ 1.20	$ 0.99

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

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

(4) Goodwill and Other Intangible Assets

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

	Commercial	Government	Total
		(in thousands)	
Balance at December 31, 2004	$698,430	$187,142	$ 885,572
CarePlus acquisition	—	336,091	336,091
Balance at June 30, 2005	$698,430	$523,233	$1,221,663

Other intangible assets primarily relate to acquired subscriber and provider contracts and are included with other long-term assets in the condensed consolidated balance sheets. Amortization expense for other intangible assets was approximately $11.4 million for the six months ended June 30, 2005 and $5.3 million for the six months ended June 30, 2004. The following table presents our estimate of amortization expense for the remaining six months of 2005, and for each of the five next succeeding fiscal years:

	(in thousands)
For the six month period ending December 31, 2005	$ 12,036
For the years ending December 31,:	
2006	$ 16,941
2007	$ 13,800
2008	$ 11,260
2009	$ 7,517
2010	$ 7,030

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

	Weighted Average Life at 6/30/05	June 30, 2005			December 31, 2004		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in thousands)			
Other intangible assets:							
Subscriber contracts	9.8 yrs	$179,256	$ 91,734	$ 87,522	$ 97,256	$ 82,343	$14,913
Provider contracts	9.6 yrs	22,428	12,581	9,847	22,428	11,022	11,406
Licenses and other	18.3 yrs	10,690	2,228	8,462	5,790	1,787	4,003
Total other intangible assets	10.1 yrs	$212,374	$ 106,543	$105,831	$125,474	$ 95,152	$30,322

(5) Comprehensive Income

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

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
			(in thousands)	
Net income	$ 84,137	$ 80,753	$193,932	$148,583
Net unrealized investment gains (losses), net of tax	18,763	(41,397)	(3,411)	(33,665)
Comprehensive income, net of tax	$102,900	$ 39,356	$190,521	$114,918

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

(6) Earnings Per Common Share

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

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

	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
	(in thousands, except per share results)			
Net income available for common stockholders	$ 84,137	$ 80,753	$193,932	$148,583
Weighted average outstanding shares of common stock used to compute basic earnings per common share	161,492	160,832	161,202	161,399
Dilutive effect of:				
Employee stock options	3,351	1,476	3,304	1,905
Restricted stock	65	45	37	51
Shares used to compute diluted earnings per common share	164,908	162,353	164,543	163,355
Basic earnings per common share	$ 0.52	$ 0.50	$ 1.20	$ 0.92
Diluted earnings per common share	$ 0.51	$ 0.50	$ 1.18	$ 0.91
Number of antidilutive stock options excluded from computation	2	4,271	1	2,197

(7) Income Taxes

The effective income tax rate was 34.9% for the three months ended June 30, 2005 and 22.7% for the six months ended June 30, 2005 compared to 34.0% for the three and six months ended June 30, 2004. The effective tax rate for the six months ended June 30, 2005 primarily reflects the favorable impact from the resolution of a contingent gain of $22.8 million during the first quarter of 2005 in connection with the expiration of the statute of limitation on a tax position related to the 2000 tax year.

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

(8) Long-term Debt

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

	June 30, 2005	December 31, 2004
	(in thousands)	
Long-term debt:		
6.30% senior, unsecured notes due Aug. 1, 2018, net of unamortized discount of $751 at June 30, 2005 and $780 at December 31, 2004	$299,249	$ 299,220
7.25% senior, unsecured notes due Aug. 1, 2006, net of unamortized discount of $159 at June 30, 2005 and $231 at December 31, 2004	299,841	299,769
Fair value of interest rate swap agreements	20,051	17,082
Deferred gain from interest rate swap exchange	11,282	16,338
Total senior notes	630,423	632,409
Credit agreement	244,000	—
Other long-term borrowings	3,965	4,287
Total long-term debt	$878,388	$ 636,696

Swap Agreements

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

Our interest rate swap agreements exchange the fixed interest rate under our 6.30% and 7.25% senior notes for a variable interest rate based on LIBOR. At June 30, 2005, the effective interest rate was 4.40% for the 6.30% senior notes and 5.23% for the 7.25% senior notes, including the amortization of the deferred swap gain. The $300 million swap agreements for the 6.30% senior notes mature on August 1, 2018, and the $300 million swap agreements for the 7.25% senior notes mature on August 1, 2006, and each has the same critical terms as the related senior notes.

At June 30, 2005, the fair value of our swap agreements related to the 6.30% senior notes was in our favor by $26.4 million and is included in other long-term assets and the fair value of our swap agreements related to the 7.25% senior notes was out of our favor by $6.3 million and is included in other long-term liabilities. Likewise, the carrying value of our senior notes has been increased $20.1 million to reflect their fair value. The counterparties to our swap agreements are major financial institutions with which we also have other financial relationships.

In June 2003, we recorded a deferred gain and received proceeds of $31.6 million in exchange for new swap agreements discussed above related to our 7.25% senior notes. The corresponding deferred swap gain of $31.6 million is being amortized to reduce interest expense over the remaining term of the 7.25% senior notes. Amortization of the deferred swap gain reduced interest expense $2.5 million for the three months ended June 30, 2005 and $2.4 million for the three months ended June 30, 2004. Amortization of the deferred swap gain reduced interest expense $5.1 million for the six months ended June 30, 2005 and $4.9 million for the six months ended June 30, 2004.

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

Credit Agreement

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

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

On February 16, 2005, we borrowed $294.0 million under the credit agreement to finance the CarePlus acquisition. Since the CarePlus transaction, we have repaid $50 million under the credit agreement. In addition, we have outstanding letters of credit of $35.1 million secured under the credit agreement. No amounts have ever been drawn on these letters of credit. As of June 30, 2005, we have $320.9 million of remaining borrowing capacity under the credit agreement.

Commercial Paper Program

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

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

Other Borrowings

Other borrowings of $4.0 million at June 30, 2005 represent financing for the renovation of a building, bear interest at 2% per annum, are collateralized by the building, and are payable in various installments through 2014.

Shelf Registration

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

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

(9) Guarantees and Contingencies

Indemnifications and Guarantees

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

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

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

Government Contracts

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

Our TRICARE business, which accounted for approximately 17% of our total premiums and ASO fees for the six months ended June 30, 2005, primarily consisted of the South Region contract. The 5-year South Region contract is subject to annual renewals at the Government's option and expires March 31, 2009. This contract also is generally subject to frequent change from events and circumstances such as the escalated conflict in the Middle East. These changes may include a reduction or increase in the number of persons enrolled or eligible to enroll, in the revenue we receive or in our administrative or health care costs. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs could have a material adverse effect on our business.

Our Medicaid business, which accounted for approximately 4% of our total premiums and ASO fees for the six months ended June 30, 2005, consisted of contracts in Puerto Rico, Florida and Illinois. Our contracts with the Puerto Rico Health Insurance Administration, which accounted for approximately 3% of our total premium and ASO fees for the six months ended June 30, 2005, were scheduled to expire on June 30, 2005, but currently have been extended through August 31, 2005. Due to recent changes in leadership and policy revisions under consideration, the government of Puerto Rico has decided to delay the bid process for new contracts. We currently are negotiating the terms of contract extensions for a period of up to one year. At this time we are unable to predict the ultimate impact that any government policy revisions might have on our Medicaid contracts in Puerto Rico.

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

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

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

Legal Proceedings

Managed Care Industry Purported Class Action Litigation

We have been involved in several purported class action lawsuits that are part of a wave of generally similar actions that target the health care payer industry and particularly target managed care companies. These include a lawsuit against us and originally nine of our competitors that purports to be brought on behalf of physicians who have treated our members. As a result of action by the Judicial Panel on Multidistrict Litigation ("JPML"), the case was consolidated in the United States District Court for the Southern District of Florida, and has been styled *In re Managed Care Litigation*.

The plaintiffs assert that we and other defendants improperly paid providers' claims and "downcoded" their claims by paying lesser amounts than they submitted. The complaint alleges, among other things, multiple violations under the Racketeer Influenced and Corrupt Organizations Act, or RICO, as well as various breaches of contract and violations of regulations governing the timeliness of claim payments. The complaint was subsequently amended to add as plaintiffs several medical societies, including the Texas Medical Association, the Medical Association of Georgia, the California Medical Association, the Florida Medical Association, and the Louisiana State Medical Society, each of which purports to bring its action against specified defendants.

On September 26, 2002, the Court certified a global class consisting of all medical doctors who provided services to any person insured by any defendant from August 4, 1990, to September 26, 2002. The class included two subclasses. A national subclass consisted of medical doctors who provided services to any person insured by a defendant when the doctor had a claim against such defendant and was not required to arbitrate that claim. A California subclass consisted of medical doctors who provided services to any person insured in California by any defendant when the doctor was not bound to arbitrate the claim.

On September 1, 2004, the Court of Appeals for the Eleventh Circuit ("Eleventh Circuit") agreed with the District Court's ruling as to the class for the RICO claims, although it suggested that the class should be split so that claims involving capitation and fee-for-service payments would be handled separately. However, it reversed the lower court as to state law claims, including breach of contract, unjust enrichment and violations of prompt pay laws. It found that the state claims were too individualized to be dealt with in a class action. The California subclass was not specifically challenged and therefore was permitted to remain. A Petition for a Writ of Certiorari to the United States Supreme Court, asking for review of the Eleventh Circuit's decision, was denied on January 10, 2005.

On September 17, 2004, the plaintiffs filed an amended motion for class certification, seeking a global fee-for-service class and five subclasses for the time period from January 1, 1996, to the date of certification. The global class would consist of any medical doctor who provided service on a fee-for-service basis to any person insured by Cigna Corporation or any other defendant for claims of RICO conspiracy and aiding and abetting. The motion seeks subclasses for the conspiracy counts for capitation damages and capitation injunctive relief consisting of all medical doctors who provided services on a capitated basis. The motion also requests a subclass for a direct RICO claim consisting of medical doctors who provided services on a fee-for-service basis to any person insured by Humana pursuant to a contract without an arbitration clause or without a contract. The motion also seeks two California subclasses, one involving physicians who provided services on a fee-for-service basis and the other for capitated physicians. The Court has not ruled on these motions.

On February 10, 2005, the Court ruled that the trial would be bifurcated so that the issue of liability would be tried first, followed by proof of damages, if liability is found. On April 22, 2005, the defendants filed an omnibus motion for summary judgment as to all counts of the complaint. No ruling has been issued on the motions. On June 15, 2005, the Court rescheduled the trial for January 23, 2006.

Two defendants, Aetna Inc. and Cigna Corporation, have entered into settlement agreements which have been approved by the Court. On May 3, 2005, Health Net, Inc. and The Prudential Insurance Company of America announced settlement agreements with the plaintiffs, and Wellpoint, Inc. (formerly WellPoint Health Networks, Inc. and Anthem, Inc.) announced a settlement agreement on July 11, 2005.

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

We continue to defend this action vigorously.

Other Litigation and Proceedings

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

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

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

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

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

The likelihood or outcome of current or future suits, like the purported class action lawsuit described above, or governmental investigations, cannot be accurately predicted with certainty. In addition, the potential for increased liability for medical negligence arising from claims adjudication, along with the increased litigation that has accompanied the negative publicity and public perception of our industry, adds to this uncertainty. Therefore, such legal actions and government audits and investigations could have a material adverse effect on our financial position, results of operations, and cash flows.

(10) Segment Information

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

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

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

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

	Commercial Segment			
	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
	(in thousands)			
Revenues:				
Premiums:				
Fully insured				
PPO	$ 910,013	$ 941,388	$1,814,486	$1,885,544
HMO	602,265	759,371	1,215,186	1,432,335
Total fully insured	1,512,278	1,700,759	3,029,672	3,317,879
Specialty	95,390	86,139	188,928	172,110
Total premiums	1,607,668	1,786,898	3,218,600	3,489,989
Administrative services fees	51,263	40,768	101,374	82,464
Investment and other income	29,661	37,937	59,051	61,575
Total revenues	1,688,592	1,865,603	3,379,025	3,634,028
Operating expenses:				
Medical	1,347,413	1,512,413	2,672,116	2,935,190
Selling, general and administrative	290,640	295,608	582,497	582,335
Depreciation and amortization	18,977	16,400	36,985	32,465
Total operating expenses	1,657,030	1,824,421	3,291,598	3,549,990
Income from operations	31,562	41,182	87,427	84,038
Interest expense	6,347	4,270	12,749	8,040
Income before income taxes	$ 25,215	$ 36,912	$ 74,678	$ 75,998

	Government Segment			
	Three months ended June 30,		Six months ended June 30,	
	2005	2004	2005	2004
	(in thousands)			
Revenues:				
Premiums:				
Medicare Advantage	$1,092,442	$ 774,604	$2,075,583	$1,480,922
TRICARE	611,179	616,412	1,173,507	1,265,405
Medicaid	134,730	125,798	269,144	246,577
Total premiums	1,838,351	1,516,814	3,518,234	2,992,904
Administrative services fees	13,639	40,578	25,263	77,119
Investment and other income	5,779	8,483	11,064	14,376
Total revenues	1,857,769	1,565,875	3,554,561	3,084,399
Operating expenses:				
Medical	1,541,096	1,277,327	2,970,126	2,538,066
Selling, general and administrative	195,820	191,287	377,996	374,189
Depreciation and amortization	12,786	10,765	24,027	21,012
Total operating expenses	1,749,702	1,479,379	3,372,149	2,933,267
Income from operations	108,067	86,496	182,412	151,132
Interest expense	3,975	1,055	6,096	2,004

Income before income taxes	$ 104,092	$ 85,441	$ 176,316	$ 149,128

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

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

Overview

Headquartered in Louisville, Kentucky, Humana Inc. is one of the nation's largest publicly traded health benefits companies, based on our 2004 revenues of $13.1 billion. We offer coordinated health insurance coverage and related services through a variety of traditional and Internet-based plans for employer groups, government-sponsored programs, and individuals. As of June 30, 2005, we had approximately 7.0 million members in our medical insurance programs, as well as approximately 1.8 million members in our specialty products programs.

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

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

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

Our strategy to drive Commercial segment profitability focuses on providing solutions for employers to the rising cost of health care through the use of a variety of innovative and consumer-choice product designs. These products are supported by electronic informational capabilities, including education, tools, and technologies provided primarily through the Internet. To that end, we have developed an innovative suite of products styled as "Smart" products. We believe that these Smart products offer the best solution for many employers to the problem of quickly rising health care costs for their employees. Membership in our Smart products and other consumer-choice

health plans exceeded 350,000 members at June 30, 2005, increasing approximately 40% since December 31, 2004. We believe that growth in these products, which are offered both on a fully-insured and ASO basis and may ultimately be competitively priced to produce higher margins, is a key component, among other items, for further improvement in the results of our Commercial segment. Additionally, we have increased the diversification of our commercial membership base, not only through our consumer-choice products, but also by (1) expanding our ASO membership in the mid-market group segment to take advantage of our network discounts and (2) launching our HumanaOne individual product to address an increasing migration of insureds from small group. While we expect our consumer-choice products to become a driver of growth in the years ahead as health care inflation persists, we also are enhancing the traditional products which comprise the bulk of our commercial portfolio today by applying our consumer-choice innovation.

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

In our Government segment, the passage of the Medicare Prescription Drug, Improvement, and Modernization Act, or MMA, in December 2003 demonstrated the federal government's commitment to providing health benefits and options to seniors and has started the resurgence of Medicare as a business line that should bring us accelerating growth in 2005 and 2006. Our current Medicare presence today includes almost 475,000 members in 12 HMO markets, 30 local PPO markets, and 35 states in which we have a private fee-for-service offering. Medicare Private Fee-For-Service plans generally offer additional benefits compared to traditional Medicare in exchange for a monthly premium paid by the member. These plans typically include a prescription drug benefit with no provider network restrictions. Local Medicare PPO plans typically offer an even higher level of benefits to members, including a prescription drug benefit and a lower level of member cost-sharing on many benefits while seeking medical services from in-network providers. By December 31, 2005, we anticipate having approximately 540,000 to 550,000 Medicare Advantage members.

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

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

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

- In the Government segment, we completed the acquisition of CarePlus Health Plans of Florida, increasing our Medicare presence in South Florida. This transaction is more fully-described below and in Note 3 to the condensed consolidated financial statements.
- Membership in Medicare Advantage products grew by 97,100 members from December 31, 2004, including 50,400 members from the acquisition of CarePlus and 46,700 members in our existing products.
- We filed numerous applications with CMS to expand our Medicare business through local PPOs, private fee-for-service plans, and, in 2006, through regional PPOs and the PDP.
- In the Commercial segment, fully-insured membership declined 265,200 members, or 12%, since December 31, 2004 due to continued competitive pricing pressures. This decline was partially offset by an increase of 159,800 ASO members.

- The resolution of a contingent tax gain during the first quarter of 2005 contributed to the lower effective tax rate of 22.7% during the first six months of 2005 compared to 34.0% during the first six months of 2004.

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

Recent Acquisitions

On February 16, 2005, we acquired CarePlus Health Plans of Florida, or CarePlus, as well as its affiliated 10 medical centers and pharmacy company for approximately $444.8 million in cash including transaction costs, adding approximately 50,400 Medicare eligible beneficiaries in Miami-Dade, Broward and Palm Beach counties. This acquisition enhances our Medicare market position in South Florida. We financed the transaction with $294.0 million of borrowings under our credit agreement and $150.8 million of cash on hand. The purchase price is subject to a balance sheet settlement process with a nine month claims run-out period. This transaction is more fully described in Note 3 to the condensed consolidated financial statements.

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

Recently Issued Accounting Pronouncements

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

Comparison of Results of Operations

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

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

	For the three months ended June 30,		Change	
	2005	2004	Dollars	Percentage
	(in thousands, except ratios)			
Premium revenues:				
Fully insured	$1,512,278	$1,700,759	$(188,481)	(11.1)%
Specialty	95,390	86,139	9,251	10.7%
Total Commercial	1,607,668	1,786,898	(179,230)	(10.0)%
Medicare Advantage	1,092,442	774,604	317,838	41.0%
TRICARE	611,179	616,412	(5,233)	(0.8)%
Medicaid	134,730	125,798	8,932	7.1%
Total Government	1,838,351	1,516,814	321,537	21.2%
Total	$3,446,019	$3,303,712	$ 142,307	4.3%
Administrative services fees:				
Commercial	$ 51,263	$ 40,768	$ 10,495	25.7%
Government	13,639	40,578	(26,939)	(66.4)%
Total	$ 64,902	$ 81,346	$ (16,444)	(20.2)%
Income before income taxes:				
Commercial	$ 25,215	$ 36,912	$ (11,697)	(31.7)%
Government	104,092	85,441	18,651	21.8%
Total	$ 129,307	$ 122,353	$ 6,954	5.7%
Medical expense ratios (a):				
Commercial	83.8%	84.6%		(0.8)
Government	83.8%	84.2%		(0.4)
Total	83.8%	84.4%		(0.6)
SG&A expense ratios (b):				
Commercial	17.5%	16.2%		1.3
Government	10.6%	12.3%		(1.7)
Total	13.9%	14.4%		(0.5)

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

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	For the six months ended June 30,		Change	
	2005	2004	Dollars	Percentage
	(in thousands, except ratios)			
Premium revenues:				
Fully insured	$3,029,672	$3,317,879	$(288,207)	(8.7)%
Specialty	188,928	172,110	16,818	9.8%
Total Commercial	3,218,600	3,489,989	(271,389)	(7.8)%
Medicare Advantage	2,075,583	1,480,922	594,661	40.2%
TRICARE	1,173,507	1,265,405	(91,898)	(7.3)%
Medicaid	269,144	246,577	22,567	9.2%
Total Government	3,518,234	2,992,904	525,330	17.6%
Total	$6,736,834	$6,482,893	$ 253,941	3.9%
Administrative services fees:				
Commercial	$ 101,374	$ 82,464	$ 18,910	22.9%
Government	25,263	77,119	(51,856)	(67.2)%
Total	$ 126,637	$ 159,583	$ (32,946)	(20.6)%
Income before income taxes:				
Commercial	$ 74,678	$ 75,998	$ (1,320)	(1.7)%
Government	176,316	149,128	27,188	18.2%
Total	$ 250,994	$ 225,126	$ 25,868	11.5%
Medical expense ratios (a):				
Commercial	83.0%	84.1%		(1.1)
Government	84.4%	84.8%		(0.4)
Total	83.8%	84.4%		(0.6)
SG&A expense ratios (b):				
Commercial	17.5%	16.3%		1.2
Government	10.7%	12.2%		(1.5)
Total	14.0%	14.4%		(0.4)

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

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

			Change	
	2005	2004	Members	Percentage
Commercial segment medical members:				
Fully insured	2,021,300	2,407,700	(386,400)	(16.0)%
ASO	1,178,400	996,700	181,700	18.2%
Total Commercial	3,199,700	3,404,400	(204,700)	(6.0)%
Government segment medical members:				
Medicare Advantage	474,300	367,900	106,400	28.9%
TRICARE	1,733,600	1,856,900	(123,300)	(6.6)%
TRICARE ASO	1,142,800	786,000	356,800	45.4%
Medicaid	477,900	466,400	11,500	2.5%
Total Government	3,828,600	3,477,200	351,400	10.1%
Total medical membership	7,028,300	6,881,600	146,700	2.1%

Summary

Net income was $84.1 million, or $0.51 per diluted share in the 2005 quarter compared to $80.8 million, or $0.50 per diluted share in the 2004 quarter. Net income was $193.9 million, or $1.18 per diluted share in the 2005 period compared to $148.6 million, or $0.91 per diluted share in the 2004 period. The 2005 period included the beneficial effect of an effective tax rate of approximately 22.7% compared to 34.0% in the 2004 period, primarily due to the resolution of a contingent gain during the first quarter of 2005 in connection with the expiration of the statute of limitation on a tax position related to the 2000 tax year. Enrollment growth in our Medicare Advantage products also contributed to the increase in net income.

Premium Revenues and Medical Membership

Premium revenues increased 4.3% to $3.45 billion for the 2005 quarter, compared to $3.30 billion for the 2004 quarter. For the 2005 period, premium revenues were $6.74 billion, an increase of 3.9% compared to $6.48 billion for the 2004 period. Higher premium revenues resulted primarily from enrollment growth in our Medicare Advantage products partially offset by a decrease in fully-insured commercial membership.

Commercial segment premium revenues decreased 10.0% to $1.61 billion for the 2005 quarter, compared to $1.79 billion for the 2004 quarter. For the 2005 period, commercial segment premium revenues were $3.22 billion, a decrease of 7.8% compared to $3.49 billion for the 2004 period. Lower premium revenues primarily resulted from a reduction of fully-insured membership partially offset by increases in per member premiums. Our fully insured membership decreased 16.0%, or 386,400 members, to 2,021,300 at June 30, 2005 compared to 2,407,700 at June 30, 2004. The decrease is primarily due to the relinquishment of an 89,000-member unprofitable account on January 1, 2005 and continued attrition due to the ongoing competitive environment within the small to mid-market fully-insured group accounts, partially offset by membership gains in the individual and consumer-choice product lines. For the full year 2005, we expect fully insured commercial per member premiums to increase in the 8% to 10% range for our group accounts and 6% to 8% for our total commercial block, including the individual major medical products.

Government segment premium revenues increased 21.2% to $1.84 billion for the 2005 quarter, compared to $1.52 billion for the 2004 quarter. For the 2005 period, government segment premium revenues were $3.52 billion, an increase of 17.6% compared to $2.99 billion for the 2004 period. This increase primarily was attributable to our Medicare Advantage operations. Medicare Advantage membership was 474,300 at June 30, 2005, compared to 367,900 at June 30, 2004, an increase of 106,400 members, or 28.9%, due to the CarePlus acquisition combined with expanded participation in various Medicare Advantage programs. The February 16, 2005 CarePlus acquisition added 50,400 members. The April 1, 2004 Ochsner acquisition also contributed $120.6 million to the increase in Government segment premium revenues for the 2005 period. Per member premiums for our Medicare Advantage business increased approximately 11% for the 2005 quarter and period. For the full year 2005, we expect premium increases per member in the range of 11% to 13% including the impact of higher reimbursement associated with completing the risk adjustment settlement process with CMS in the second half of 2005. Medicare Advantage geographic expansions during 2005 are anticipated to contribute to continued enrollment growth, with projected membership in the range of 540,000 to 550,000 by December 31, 2005. TRICARE premium revenues decreased 0.8% for the 2005 quarter and 7.3% for the 2005 period, reflecting the transition to the new South Region contract, which covered fewer benefits and services than the previous contracts. Medicaid membership declined by approximately 20,000 members on August 1, 2005 as we did not renew our participation in the Medicaid program for the State of Illinois. The Illinois Medicaid business was not material to our results of operations, financial position, or cash flows.

Administrative Services Fees

Our consolidated administrative services fees for the 2005 quarter were $64.9 million, a decrease of $16.4 million, or 20.2%, from $81.3 million for the 2004 quarter. For the 2005 period, administrative services fees were $126.6 million, a decrease of 20.6% compared to $159.6 million for the 2004 period.

For the Commercial segment, administrative services fees increased $10.5 million, or 25.7%, from $40.8 million for the 2004 quarter to $51.3 million for the 2005 quarter, and increased $18.9 million, or 22.9%, from $82.5 million to $101.4 million when comparing the 2005 period to the 2004 period. This increase corresponds to the higher level of ASO membership at June 30, 2005, which was 1,178,400 members, compared to 996,700 at June 30, 2004, an increase of 18.2%.

Administrative services fees for the Government segment decreased $26.9 million, or 66.4%, from $40.6 million for the 2004 quarter to $13.6 million for the 2005 quarter, and decreased $51.9 million, or 67.2%, from

$77.1 million to $25.3 million when comparing the 2005 period to the 2004 period. This decline resulted from the transition to the new South Region contract which carved out certain government programs including the administration of pharmacy and medical benefits to senior members over the age of 65. We stopped providing services under these separate programs beginning June 1, 2004.

Investment and Other Income

Investment and other income totaled $35.4 million for the 2005 quarter, a decrease of $11.0 million from $46.4 million for the 2004 quarter. For the 2005 period, investment and other income totaled $70.1 million, a decrease of $5.9 million from $76.0 million for the 2004 period. The decrease for the quarter and period was primarily attributable to a $16.0 million capital gain from the sale of a privately held venture capital investment in the prior year period.

Medical Expense

Total medical expenses as a percentage of premium revenues, or medical expense ratio (MER), for both the 2005 quarter and the 2005 period were 83.8%, decreasing 60 basis points from 84.4% for both the 2004 quarter and the 2004 period.

The Commercial segment's MER for the 2005 quarter was 83.8%, decreasing 80 basis points from the 2004 quarter of 84.6%, and a decrease of 110 basis points from 84.1% to 83.0% was experienced comparing the 2005 period to the 2004 period. The decrease in MER reflects the improving risk profile in the commercial portfolio, including the absence of the unprofitable 89,000-member large group account that lapsed on January 1, 2005 and changing membership mix to lower MER individual and consumer-choice members. For the full year 2005, we continue to expect our fully insured commercial medical cost trends to rise in the range of 8% to 10% for our group accounts and 6% to 8% for our total commercial block, including our individual major medical products.

The Government segment's MER for the 2005 quarter was 83.8%, decreasing 40 basis points from the 2004 quarter of 84.2%, and a decrease of 40 basis points from 84.8% to 84.4% was experienced comparing the 2005 period to the 2004 period. These improvements primarily were attributable to the increase in Medicare revenues as a percentage of the total revenues. Medicare medical cost trends are expected to increase in the range of 9% to 11% for 2005.

SG&A Expense

Total selling, general and administrative, or SG&A, expenses as a percentage of premium revenues and administrative services fees, or SG&A expense ratio, for the 2005 quarter was 13.9%, decreasing 50 basis points from the 2004 quarter of 14.4%. For the 2005 period, the SG&A expense ratio was 14.0%, decreasing 40 basis points when compared to the 2004 period of 14.4%. These improvements resulted as the increase in premium revenues outpaced administrative expense trends despite increased spending on new Medicare opportunities. We continue to anticipate our consolidated SG&A expense ratio to be in the range of 13.5% to 14.5% for the full year of 2005, including the impact of our estimated additional spending for our Medicare expansion initiatives.

The Commercial segment SG&A expense ratio increased 130 basis points from 16.2% to 17.5% for the 2005 quarter versus the 2004 quarter. For the 2005 period, the Commercial segment SG&A expense ratio was 17.5%, increasing 120 basis points from the 2004 period of 16.3%. This increase resulted from a mix shift to a greater percentage of ASO members as well as a higher proportion of fixed overhead cost relative to revenues due to a reduction in membership.

The Government segment SG&A expense ratio decreased 170 basis points from 12.3% to 10.6% for the 2005 quarter versus the 2004 quarter. For the 2005 period, the Government segment SG&A expense ratio was 10.7%, decreasing 150 basis points from the 2004 period of 12.2%. The decrease in the Government segment SG&A expense ratio was attributable to the transition to the TRICARE South contract partially offset by increased spending associated with the Medicare business.

Depreciation and amortization for the 2005 quarter totaled $31.8 million compared to $27.2 million for the 2004 quarter, an increase of $4.6 million, or 16.9%. For the 2005 period, depreciation and amortization totaled $61.0 million compared to $53.5 million for the 2004 period, an increase of $7.5 million, or 14.1%. Amortization of other intangible assets increased $4.1 million for the 2005 quarter and $6.1 million for the 2005 period primarily as a result of intangible assets recorded in connection with the CarePlus acquisition.

Interest Expense

Interest expense was $10.3 million for the 2005 quarter, compared to $5.3 million for the 2004 quarter, an increase of $5.0 million. For the 2005 period, interest expense was $18.8 million, increasing $8.8 million compared to $10.0 million for the 2004 period. This increase primarily resulted from higher interest rates and higher average outstanding debt. The borrowing of $294 million under our credit agreement to finance the February 16, 2005 CarePlus acquisition increased interest expense $2.4 million during the 2005 quarter and $3.6 million during the 2005 period. The average interest rate during the 2005 period of 4.8% increased 150 basis points compared to 3.3% during the 2004 period.

Income Taxes

On an interim basis, the provision for income taxes is provided for at the anticipated effective tax rate for the year. Our effective tax rate for the 2005 quarter was approximately 34.9%, compared to 34.0% for the 2004 quarter. For the 2005 period, the effective tax rate was 22.7%, compared to 34.0% for the 2004 period. The effective tax rate for the 2005 period reflects the favorable impact from the resolution of a contingent gain in the first quarter of 2005 in connection with the expiration of the statute of limitation on a tax position related to the 2000 tax year. We expect our effective tax rate will be in the range of 34% to 36% for the remaining two 2005 quarters and approximately 30% for the year.

Membership

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

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

Liquidity

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

Cash and cash equivalents increased to $603.8 million at June 30, 2005 from $580.1 million at December 31, 2004. The change in cash and cash equivalents for the six months ended June 30, 2005 and 2004 is summarized as follows:

	2005	2004
	(in thousands)	
Net cash provided by operating activities	$ 281,085	$ 24,855
Net cash used in investing activities	(511,231)	(640,562)
Net cash provided by (used in) financing activities	253,857	(112,061)
Increase (decrease) in cash and cash equivalents	$ 23,711	$(727,768)

Cash Flow from Operating Activities

The comparison of our operating cash flows for the 2005 and 2004 periods were significantly impacted by the timing of the monthly Medicare Advantage premium remittance. We received six monthly Medicare Advantage premium receipts during the 2005 period compared to only five premium receipts received during the 2004 period because the January 1, 2004 premium receipt of $211.9 million was received in December 2003. In addition, there were no corresponding premium receipts for the February CarePlus Medicare Advantage revenues of $19.8 million because these premium receipts were received prior to the February 16, 2005 acquisition date.

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

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

	June 30, 2005	December 31, 2004	Change
		(in thousands)	
TRICARE:			
Base receivable	$414,945	$ 396,355	$ 18,590
Bid price adjustments (BPAs)	—	25,601	(25,601)
Change orders	13,764	6,021	7,743
TRICARE subtotal	428,709	427,977	732
Commercial and other	210,442	186,144	24,298
Allowance for doubtful accounts	(30,997)	(34,506)	3,509
Total net receivables	$608,154	$ 579,615	28,539
Reconciliation to cash flow statement:			
Receivables from acquisition			(2,289)
Change in receivables in cash flow statement			$ 26,250

Under the TRICARE South region contract reimbursement model, claims paid by us are reimbursed by the federal government generally within 30 business days. The delivery of health care services results in a lag between the time the service is provided and ultimately reimbursed by the federal government, typically three months. Thus, TRICARE base receivables are generally collected over a three to four month period. Likewise, TRICARE medical claims payable are generally paid over the same three to four month period.

The $24.3 million increase in commercial and other receivables was primarily due to the timing of the receipt of the monthly Puerto Rico Medicaid premium. Approximately $16.1 million of the June 2005 premium was received on July 1, 2005.

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

	June 30, 2005	December 31, 2004	Change
		(in thousands)	
IBNR (1)	$1,285,988	$1,164,518	$121,470
Reported claims in process (2)	128,204	97,801	30,403
Other medical expenses payable (3)	263,359	159,691	103,668
Total medical and other expenses payable	$1,677,551	$1,422,010	255,541
Reconciliation to cash flow statement:			
Medical and other expenses payable from acquisition			(37,375)
Change in medical and other expenses payable in cash flow statement			$218,166

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

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling.
(3) Other medical expenses payable includes capitation, risk share, and pharmacy payables. The balance due to our pharmacy benefit administrator fluctuates due to bi-weekly payments and the month-end cutoff.

Medical and other expenses payable primarily increased during the 2005 period due to medical claims inflation, an increase in the payable associated with the risk sharing provisions of the TRICARE contracts, and the timing of the payable to our pharmacy benefit administrator.

Cash Flow from Investing Activities

During 2005, we paid $444.8 million to acquire CarePlus, net of $92.1 million of cash acquired.

Our ongoing capital expenditures primarily relate to our technology initiatives and administrative facilities necessary for activities such as claims processing, billing and collections, medical utilization review, and customer service. Total capital expenditures, excluding acquisitions, were $67.2 million for the 2005 period and $48.0 million for the 2004 period. Excluding acquisitions, we expect our total capital expenditures in 2005 to range between $155 million and $165 million, increasing from the full year 2004 spending of $114.1 million due to our Medicare expansion initiative.

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

Cash Flow from Financing Activities

During the 2005 period, we borrowed $294 million under our 5-year $600 million credit agreement to finance the CarePlus acquisition. Since the CarePlus acquisition, we have repaid $50 million under the credit agreement. The remainder of the cash provided by financing activities in the 2005 and 2004 periods resulted primarily from proceeds from stock option exercises, the change in the book overdraft, and the change in the securities lending payable.

Long-term Debt

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

	June 30, 2005	December 31, 2004
	(in thousands)	
Long-term debt:		
6.30% senior, unsecured notes due Aug. 1, 2018, net of unamortized discount of $751 at June 30, 2005 and $780 at December 31, 2004	$299,249	$ 299,220
7.25% senior, unsecured notes due Aug. 1, 2006, net of unamortized discount of $159 at June 30, 2005 and $231 at December 31, 2004	299,841	299,769
Fair value of interest rate swap agreements	20,051	17,082
Deferred gain from interest rate swap exchange	11,282	16,338
Total senior notes	630,423	632,409
Credit agreement	244,000	—
Other long-term borrowings	3,965	4,287
Total long-term debt	$878,388	$ 636,696

Swap Agreements

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

Our interest rate swap agreements exchange the fixed interest rate under our 6.30% and 7.25% senior notes for a variable interest rate based on LIBOR. At June 30, 2005, the effective interest rate was 4.40% for the 6.30% senior notes and 5.23% for the 7.25% senior notes, including the amortization of the deferred swap gain. The $300 million swap agreements for the 6.30% senior notes mature on August 1, 2018, and the $300 million swap agreements for the 7.25% senior notes mature on August 1, 2006, and each has the same critical terms as the related senior notes.

At June 30, 2005, the fair value of our swap agreements related to the 6.30% senior notes was in our favor by $26.4 million and is included in other long-term assets and the fair value of our swap agreements related to the 7.25% senior notes was out of our favor by $6.3 million and is included in other long-term liabilities. Likewise, the carrying value of our senior notes has been increased $20.1 million to reflect their fair value. The counterparties to our swap agreements are major financial institutions with which we also have other financial relationships.

In June 2003, we recorded a deferred gain and received proceeds of $31.6 million in exchange for new swap agreements discussed above related to our 7.25% senior notes. The corresponding deferred swap gain of $31.6 million is being amortized to reduce interest expense over the remaining term of the 7.25% senior notes. Amortization of the deferred swap gain reduced interest expense $2.5 million for the three months ended June 30, 2005 and $2.4 million for the three months ended June 30, 2004. Amortization of the deferred swap gain reduced interest expense $5.1 million for the six months ended June 30, 2005 and $4.9 million for the six months ended June 30, 2004.

Credit Agreement

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

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

On February 16, 2005, we borrowed $294.0 million under the credit agreement to finance the CarePlus acquisition. Since the CarePlus transaction, we have repaid $50 million under the credit agreement. In addition, we have outstanding letters of credit of $35.1 million secured under the credit agreement. No amounts have ever been drawn on these letters of credit. As of June 30, 2005, we have $320.9 million of remaining borrowing capacity under the credit agreement.

Commercial Paper Program

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

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

Other Borrowings

Other borrowings of $4.0 million at June 30, 2005 represent financing for the renovation of a building, bear interest at 2% per annum, are collateralized by the building, and are payable in various installments through 2014.

Shelf Registration

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

Regulatory Requirements

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

As of June 30, 2005, we maintained aggregate statutory capital and surplus of $1,090.9 million in our state regulated health insurance subsidiaries. Each of these subsidiaries was in compliance with applicable statutory requirements which aggregated $776.2 million. Although the minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Certain states rely on risk-based capital requirements, or RBC, to define the required levels of equity. RBC is a model developed by the National Association of Insurance Commissioners to monitor an entity's solvency. This calculation indicates recommended minimum levels of required capital and surplus and signals regulatory measures should actual surplus fall below these recommended levels. If RBC were adopted by all states at June 30, 2005, each of our subsidiaries would be in compliance and we would have $255.8 million of aggregate capital and surplus above any of the levels that require corrective action under RBC.

The expansion of our business in connection with the Medicare Modernization Act will require the maintenance of additional amounts of capital by our subsidiaries. The amounts that will be required will depend upon the volume of business generated.

Cautionary Statements

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

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

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

These factors may include:

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

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

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

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

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

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

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

Our future performance depends in large part upon our management team's ability to execute our strategy to position the Company for the future. This strategy includes opportunities created with the new Medicare Advantage products. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, or MMA, was signed into law. We believe MMA offers new opportunities in our Medicare programs, including our HMO, PPO, and Private Fee-For-Service products. We have made additional investments in the Medicare Advantage program to enhance our ability to participate in these expanded programs. We have announced plans to double the size of our Medicare geographic reach through expanded Medicare Advantage product offerings. We intend to offer both the stand-alone Medicare Prescription Drug Coverage (PDP) and Medicare Advantage Health Plan with Prescription Drug Coverage (MA-PD) in addition to our current product offerings. We currently offer Medicare Advantage HMO and PPO health plans in nearly 40 markets nationwide as well as the private fee-for-service plan in eleven states with plans for expansion into more than twenty additional states in the coming months. Enrollment in the new Part D prescription drug plans will begin in November 2005, with the plans becoming effective January 1, 2006. We have announced our intention to offer the Medicare prescription drug plan in 46 states and the District of Columbia.

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

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

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

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

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

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

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

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

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

We, together with some of our competitors in the health benefits business are defendants in a number of purported class action lawsuits. These include an action originally filed against us and nine of our competitors that purports to be brought on behalf of health care providers. Six of those companies have now entered into agreements to settle this action. This suit alleges breaches of federal statutes, including ERISA and RICO. Depending upon the outcome of these cases, these lawsuits may cause or force changes in the practices of the managed care industry.

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

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

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

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

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

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

- At June 30, 2005, under one of our contracts with the Centers for Medicare and Medicaid Services, or CMS, we provided health insurance coverage to approximately 288,700 members in Florida. This contract accounted for approximately 19% of our total premiums and ASO fees for the six months ended June 30, 2005.

The loss of this and other CMS contracts or significant changes in the Medicare Advantage program as a result of legislative or administrative action, including reductions in payments to us or increases in benefits to members without corresponding increases in payments, may have a material adverse effect on our financial condition, results of operations and cash flows;

- At June 30, 2005, our TRICARE business, which accounted for approximately 17% of our total premiums and ASO fees during the six months ended June 30, 2005, primarily consisted of the South Region contract. The South Region contract is a five-year contract, subject to annual renewals at the Government's option that covers approximately 2.9 million beneficiaries. This contract also is generally subject to frequent change from events and circumstances such as the escalated conflict in the Middle East. These changes may include a reduction or increase in the number of persons enrolled or eligible to enroll, in the revenue we receive or in our administrative or health care costs. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs could have a material adverse effect on our business. The loss of our current TRICARE contract would have a material adverse effect on our financial position, results of operations and cash flows;
- At June 30, 2005, under our contract with the Puerto Rico Health Insurance Administration, we provided health insurance coverage to approximately 397,400 Medicaid members in Puerto Rico. This contract, accounted for approximately 3% of our total premiums and ASO fees for the six months ended June 30, 2005. We currently have Medicaid contracts with the Puerto Rico Health Insurance Administration that were scheduled to expire on June 30, 2005, but have currently been extended through August 31, 2005. Due to recent changes in leadership and policy revisions under consideration, the government of Puerto Rico has decided to delay the bid process for new contracts. We are currently negotiating the terms of contract extensions for a period of up to one year. At this time we are unable to predict the ultimate impact that any government policy revisions might have on our Medicaid contracts in Puerto Rico. The loss of this contract or significant changes in the Puerto Rico Medicaid program as a result of legislative or administrative action, including reductions in payments to us or increases in benefits to members without corresponding increases in payments, may have a material adverse effect on our financial condition, results of operations and cash flows;
- the possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act;
- CMS has implemented a risk adjustment model which apportions premiums paid to Medicare health plans according to health severity. A risk adjustment model thus pays more for enrollees with predictably higher costs. Under the new risk adjustment methodology, Humana and all Medicare health plans must collect, capture and submit the necessary diagnosis code information to CMS at least twice a year. The CMS risk adjustment model uses the diagnosis data from inpatient and ambulatory treatment settings to calculate the risk adjusted premium payment to Medicare health plans. The risk adjustment model is being phased in. The portion of the risk adjusted payment was increased from 10% in 2003 to 30% in 2004. The portion of risk adjusted payment for 2005 is 50%, increasing to 75% in 2006 and 100% beginning in 2007. As a result of the CMS payment methodology described above, the amount and timing of our CMS monthly premium payments per member may change materially, either favorably or unfavorably;
- changes to these government programs in the future may also affect our ability or willingness to participate in these programs;
- higher comparative medical costs;
- government regulatory and reporting requirements; and
- higher marketing and advertising costs per member as a result of marketing to individuals as opposed to groups.

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

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

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

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

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

- rules tightening time periods in which claims must be paid;
- medical malpractice reform;
- health insurance access and affordability;
- provider compensation and contract language;
- disclosure of provider fee schedules and other data about payments to providers, sometimes called transparency;
- product flexibility and use of innovative technology;
- disclosure of provider quality information;
- health plan liability to members who fail to receive appropriate care;
- disclosure and composition of physician networks;
- formation of regional/national association health plans for small employers;
- physicians' ability to collectively negotiate contract terms with carriers, including fees; and
- mental health parity.

All of these proposals could apply to us.

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

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

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

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

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

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

Our ability to manage administrative costs could hamper profitability

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

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

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

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

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

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

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

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

Our ability to obtain funds from our subsidiaries is restricted.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., the parent company. These subsidiaries generally are regulated by states' Departments of Insurance. 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. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries.

Debt ratings are an important factor in our competitive position.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations have become an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers, and our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such. Downgrades in our ratings, should they occur, may adversely affect our business, financial condition and results of operations.

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

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

Item 3. Quantitative and Qualitative Disclosure about Market Risk

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

Item 4. Controls and Procedures

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

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

As permitted by the SEC, our evaluation did not include the disclosure controls and procedures of the acquired operations of CarePlus Health Plans of Florida (CarePlus), which is included in the Company's consolidated financial statements as of June 30, 2005 and for the period from February 17, 2005 through June 30, 2005. Consolidated operations of CarePlus constituted approximately $579.8 million, or 9% of the Company's total assets as of June 30, 2005, and approximately $206.6 million, or 3% of the Company's revenues for the period from February 17, 2005 through June 30, 2005.

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

Part II. Other Information

Item 1: Legal Proceedings

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

Item 2: Unregistered Sales of Equity Securities and Use of Proceeds

None.

We repurchased 54,340 shares in connection with employee equity-based compensation plans during the six months ended June 30, 2005.

Item 3: Defaults Upon Senior Securities

None.

Item 4: Submission of Matters to a Vote of Security Holders

Reported in the first quarter.

Item 5: Other Information

None.

Item 6: Exhibits

12	Computation of ratio of earnings to fixed charges.
31.1	CEO certification pursuant to Section 302 of Sarbanes–Oxley Act of 2002.
31.2	CFO certification pursuant to Section 302 of Sarbanes–Oxley Act of 2002.
32	CEO and CFO certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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SIGNATURES

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

HUMANA INC.
(Registrant)

Date:	August 5, 2005	By:	/S/ STEVEN E. MCCULLEY
			Steven E. McCulley Vice President and Controller (Principal Accounting Officer)
Date:	August 5, 2005	By:	/S/ ARTHUR P. HIPWELL
			Arthur P. Hipwell Senior Vice President and General Counsel

Exhibit 12

Humana Inc.
Computation of Ratio of Earnings to Fixed Charges

	For the six months ended June 30,	For the twelve months ended December 31,				
	2005	2004	2003	2002	2001	2000
	(Dollars in thousands)					
Income before income taxes	$ 250,994	$415,850	$344,716	$209,934	$183,080	$113,990
Fixed charges	31,136	49,246	40,972	44,349	52,010	52,843
Total earnings	$ 282,130	$465,096	$385,688	$254,283	$235,090	$166,833
Interest charged to expense	$ 18,845	$ 23,172	$ 17,367	$ 17,252	$ 25,302	$ 28,615
One-third of rent expense	12,291	26,074	23,605	27,097	26,708	24,228
Total fixed charges	$ 31,136	$ 49,246	$ 40,972	$ 44,349	$ 52,010	$ 52,843
Ratio of earnings to fixed charges (1)(2)	9.1x	9.4x	9.4x	5.7x	4.5x	3.2x

Notes

(1) For the purposes of determining the ratio of earnings to fixed charges, earnings consist of income or loss before income taxes and fixed charges. Fixed charges include gross interest expense, amortization of deferred financing expenses and an amount equivalent to interest included in rental charges. One-third of rental expense represents a reasonable approximation of the interest amount.

(2) There are no shares of preferred stock outstanding.

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Michael B. McCallister, principal executive officer of Humana Inc., certify that:

1. I have reviewed this Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending June 30, 2005;

2. Based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this quarterly report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of the annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 5, 2005

Signature: /s/ Michael B. McCallister

Michael B. McCallister
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, James H. Bloem, principal financial officer of Humana Inc., certify that:

1. I have reviewed this Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending June 30, 2005;

2. Based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this quarterly report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of the annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 5, 2005

Signature: /s/ James H. Bloem

James H. Bloem
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Humana Inc. (the "Company") on Form 10-Q for the period ending June 30, 2005 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ Michael B. McCallister

Michael B. McCallister
Principal Executive Officer

August 5, 2005

/s/ James H. Bloem

James H. Bloem
Principal Financial Officer

August 5, 2005

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.